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Psych-iatric Mental Health Nursing

Psychiatric-Mental Health Nursing

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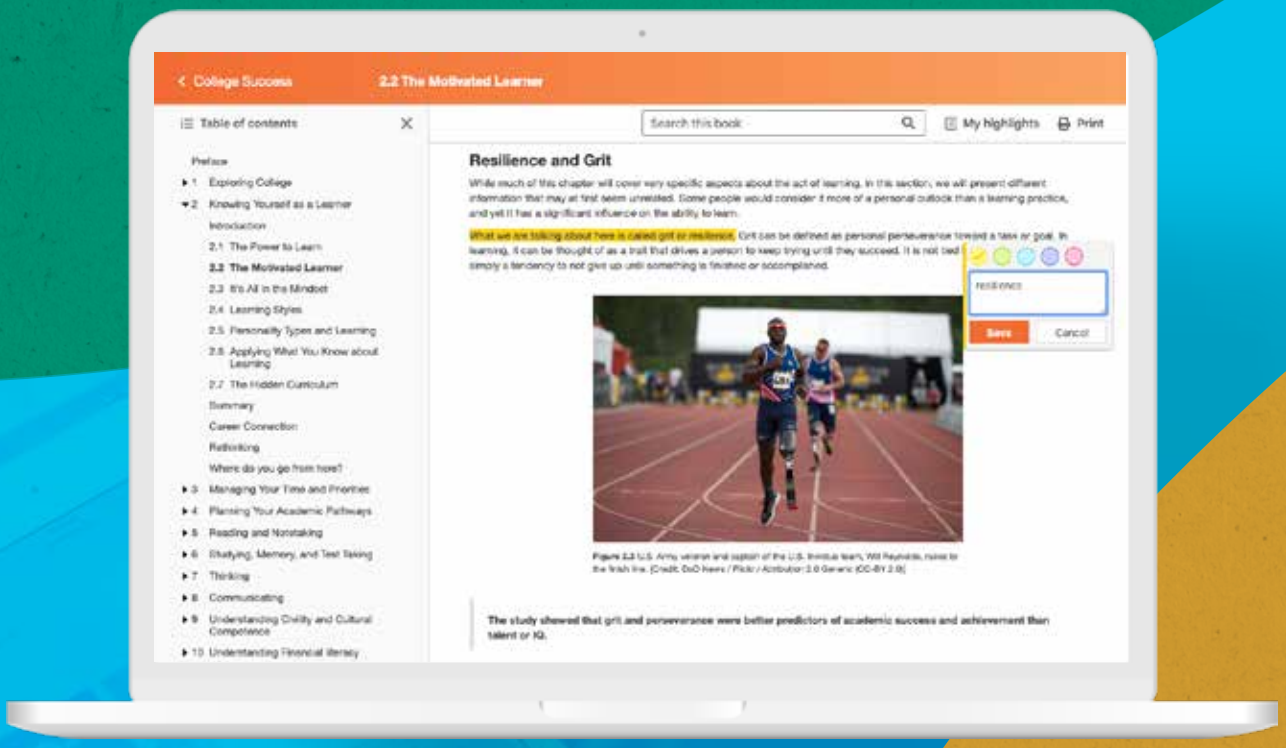

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PREFACE

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About *Psychiatric-Mental Health Nursing*

Summary

Because mental health is an important aspect of an individual's total health, every nurse, no matter their work setting, needs a foundational knowledge of managing patients with psychiatric and mental health conditions. *Psychiatric-Mental Health Nursing* is designed to support a one-semester psychiatric-mental health nursing course offered at both two-year and four-year institutions. Serving a student base of both students specializing in psychiatric nursing and those from other health disciplines, the course integrates evidence-based practices with practical strategies for communication, readying students to build therapeutic relationships with clients and caregivers.

Psychiatric-Mental Health Nursing emphasizes the importance of critical thinking and clinical judgment—skills essential for making informed decisions and providing high-quality care. Embedded throughout the text are opportunities for students to apply the Clinical Judgment Measurement Model to patient cases related to the unit or chapter theme. Ethical practice, client safety, and clinical professionalism are central to the narrative, reflecting the complex landscapes nurses navigate in mental health care. The text is committed to enhancing ethical awareness, patient safety, and clinical competence among nursing students.

Authentic learning experiences are prioritized to ensure a seamless transfer of theoretical knowledge to practical application. Through detailed case studies and real-world scenarios, the text bridges the gap between academic learning and the realities of today's medical environments, preparing students for impactful careers in mental health nursing.

Psychiatric-Mental Health Nursing invites students to explore the integral role of psychiatric mental health nursing within the broader healthcare spectrum. Students will leave the course equipped with the knowledge and skills necessary to improve the well-being of individuals and communities through dedicated, informed nursing care.

Pedagogical Foundation

Psychiatric-Mental Health Nursing uses a logical, thematic organization that breaks content down into manageable sections. Each unit is designed to foster a deep understanding of the biological, psychological, and social dimensions of mental health. The text helps students make meaningful connections between various psychiatric conditions and the corresponding nursing approaches. The text takes a comprehensive approach, integrating theoretical concepts with practical applications. By focusing on tailored psychiatric interventions and emphasizing patient-centered approaches, *Psychiatric-Mental Health Nursing* equips students with the knowledge and skills necessary to navigate diverse mental health settings.

Organizational Framework

The table of contents for *Psychiatric-Mental Health Nursing* presents content in 28 chapters, organized into 6 thematic units.

- **Unit 1** introduces the foundational theories and practices of psychiatric-mental health nursing. It covers the evolution of mental health concepts, various therapeutic theories and their applications, and the latest trends in mental health care, including the integration of research and evidence-based practices.
- **Units 2–6** explore more specialized topics, each dedicated to different facets of psychiatric nursing:
  - **Therapeutic Considerations in Mental Health:** Discusses the settings, relationships, and interprofessional care crucial for effective mental health treatment.
  - **Client Rights and Legal Issues:** Explores the legal and ethical frameworks that safeguard client rights and outlines the responsibilities of mental health professionals.
  - **Psychiatric Nursing Practice:** Focuses on clinical guidelines, practice standards, and specific disorders including mood, anxiety, and personality disorders.
  - **Special Populations:** Addresses the unique needs of children, adolescents, and older adults within psychiatric care.
  - **Mental Health Care in the Community:** Examines community-based approaches, current trends, and the broader societal impacts on mental health care. The final chapter focuses on the vital role of critical thinking in psychiatric-mental health nursing. The core of this chapter revolves around the application of clinical judgement through the dissection of an unfolding case study. This practical approach helps students see how theoretical knowledge and critical thinking translate into real world problem-solving.

Nursing Features

To further enhance learning, *Psychiatric-Mental Health Nursing* includes the following features:

- **Clinical Judgment Measurement Model** boxes guide students through the application of the Clinical Judgment Measurement Model in psychiatric nursing. The content explores the critical thinking and decision-making processes necessary to navigate patient care at different points in the process, from recognizing cues to evaluating outcomes.
- **Clinical Safety and Procedures (QSEN)** align with the Quality and Safety Education for Nursing competencies by providing detailed explanations of safety protocols and procedures specific to psychiatric nursing. This feature emphasizes the importance of patient safety and quality care and offers checklists, step-by-step, or

tips on various safety practices.
- **Cultural Context** boxes explore the impact of cultural factors on psychiatric nursing. This feature offers insights into how cultural beliefs, values, and practices can affect the perception and treatment of mental health conditions.
- **Life-Stage Context** features address the specific needs and considerations of different life stages in psychiatric care from childhood to older adulthood. This feature provides age-specific insights and tips for adapting psychiatric assessment and interventions according to the developmental state of the patient.
- **Link to Learning** features provide a very brief introduction to online resources—videos, interactives, collections, maps, and other engaging resources that are pertinent to students' exploration of the topic at hand.
- **Psychosocial Considerations** explore the social and psychological aspects that affect individuals with mental health conditions. The features examine factors like social support networks, socioeconomic status, and psychological resilience, and their impact on mental health.
- **Real RN Stories** feature firsthand accounts from registered nurses in the field of psychiatric-mental health nursing. These stories provide practical insights and real-world experiences that highlight the challenges and rewards of psychiatric nursing.
- **Unfolding Case Studies** present a hypothetical client scenario that unfolds in three parts throughout the chapter, with each subsequent part presenting new information on the same client, to help foster clinical judgment. In each part of an unfolding case feature, the scenario is followed by two questions that require students to apply their knowledge of evidence-based care and allow them to practice with questions that mimic the style of Next-Gen NCLEX. The answers to these questions, with explanations, are included in the Answer Key for students at the end of the book.

Pedagogical Features

To support student learning, *Psychiatric-Mental Health Nursing* includes the following standard elements:

- **Learning Outcomes:** Every chapter section begins with a set of clear and concise student learning outcomes. These outcomes are designed to help the instructor decide what content to include or assign and can guide students on what they can expect to learn and be assessed on.
- **Assessments:** A variety of assessments allow instructors to confirm core conceptual learning, elicit brief explanations that demonstrate student understanding, and offer more in-depth assignments that enable learners to dive more deeply into a topic or history-study skill.
    - **Review Questions** test for conceptual apprehension of key concepts.
    - **Check Your Understanding Questions** require students to explain concepts in words.
    - **Reflection Questions and Competency-Based Assessment Questions** dive deeply into the material to support longer reflection, group discussion, or written assignments.
    - **What Should the Nurse Do? and Critical Thinking About Case Study Questions** assess students' clinical judgment skills using case-based scenarios. Students review either a single case or an unfolding case that reveals information gradually. In response to their observations of the patient, students must decide how to navigate the Clinical Judgment Measurement Model process. This approach challenges them to apply theoretical knowledge to practical situations, determining the most appropriate interventions based on the patient's specific circumstances.
- **Answers to Questions in the Book:** Assessments are intended for homework assignments or classroom discussion; thus, student-facing answers are not provided in the book. Answers and sample answers are provided in the Instructor Answer Guide for instructors to share with students at their discretion, as is standard for such resources.
- **Chapter Summary:** Chapter summaries assist both students and instructors by outlining the primary subtopics addressed within the chapter.
- **Key Terms:** Key terms are presented in bold text and are followed by an explanation in context. Definitions of key terms are also listed in the end-of-chapter glossary.
- **References:** References are listed at the end of each chapter.

About the Authors

Senior Contributing Authors

Senior contributing authors: Rebecca Puchkors (left), Jeanne Saunders (middle), David Sharp (right)

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David Sharp, Mississippi College. Dr. David Sharp began his nursing career in 1978 in Scotland, working in acute psychiatry, long-term psychiatric care, elderly care, and forensic services. In 1988, he moved into nursing education and has had extensive experience teaching at both undergraduate and graduate levels and continuing education. He developed and delivered the first distance learning degree for Community Psychiatric Nursing in the UK and the inaugural degree-level program for Forensic Nursing aimed at nurses working with offenders in hospitals or the prison system. In 2000, he moved to the United States and has taught courses on mental health issues across four states. As an active member of the American Psychiatric Nurses Association for the past twelve years, he has held leadership roles in the association's education committees. His work has led to the creation of a toolkit for faculty teaching psychiatry nursing programs and the development of recommendations with the Institute for Safe Environments that seek to reduce the levels of workplace violence across the healthcare sector. David regularly presents at local, national, and international conferences on issues relating to mental health, psychiatric nursing care, and nursing education.

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Test bank. With more than 1,100 assessments, instructors can customize tests to support a variety of course objectives. The test bank includes review questions (multiple-choice, identification, fill-in-the-blank, true/false), short answer questions, and long answer questions to assess students on a variety of levels. The test bank is available in Word format.

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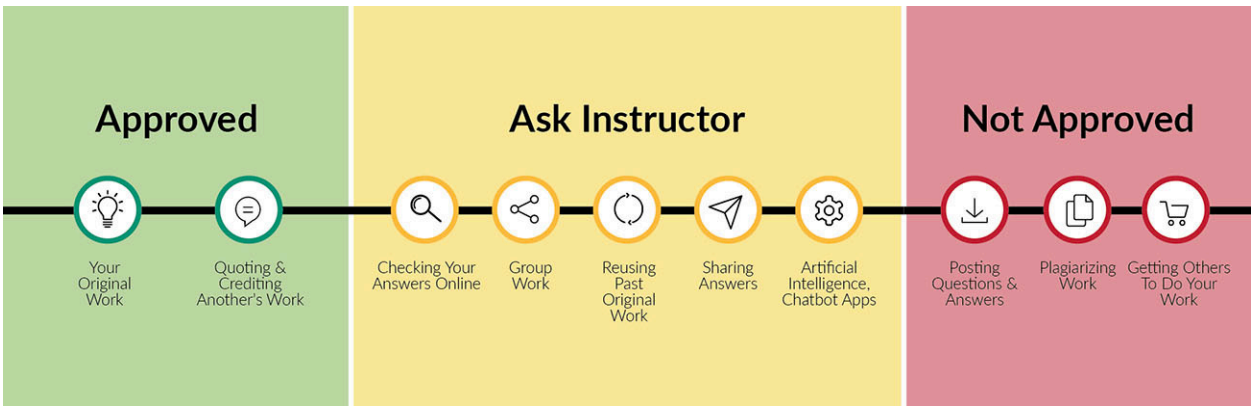
We realize that students benefit when academic integrity ground rules are established early in the course. To that end, OpenStax has created an interactive to aid with academic integrity discussions in your course.



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At OpenStax we are also developing resources supporting authentic learning experiences and assessment. Please visit this book's page for updates. For an in-depth review of academic integrity strategies, we highly recommend visiting the International Center of Academic Integrity (ICAI) website at https://academicintegrity.org/ (https://academicintegrity.org/).

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CHAPTER 1

Foundations of Psychiatric-Mental Health Nursing

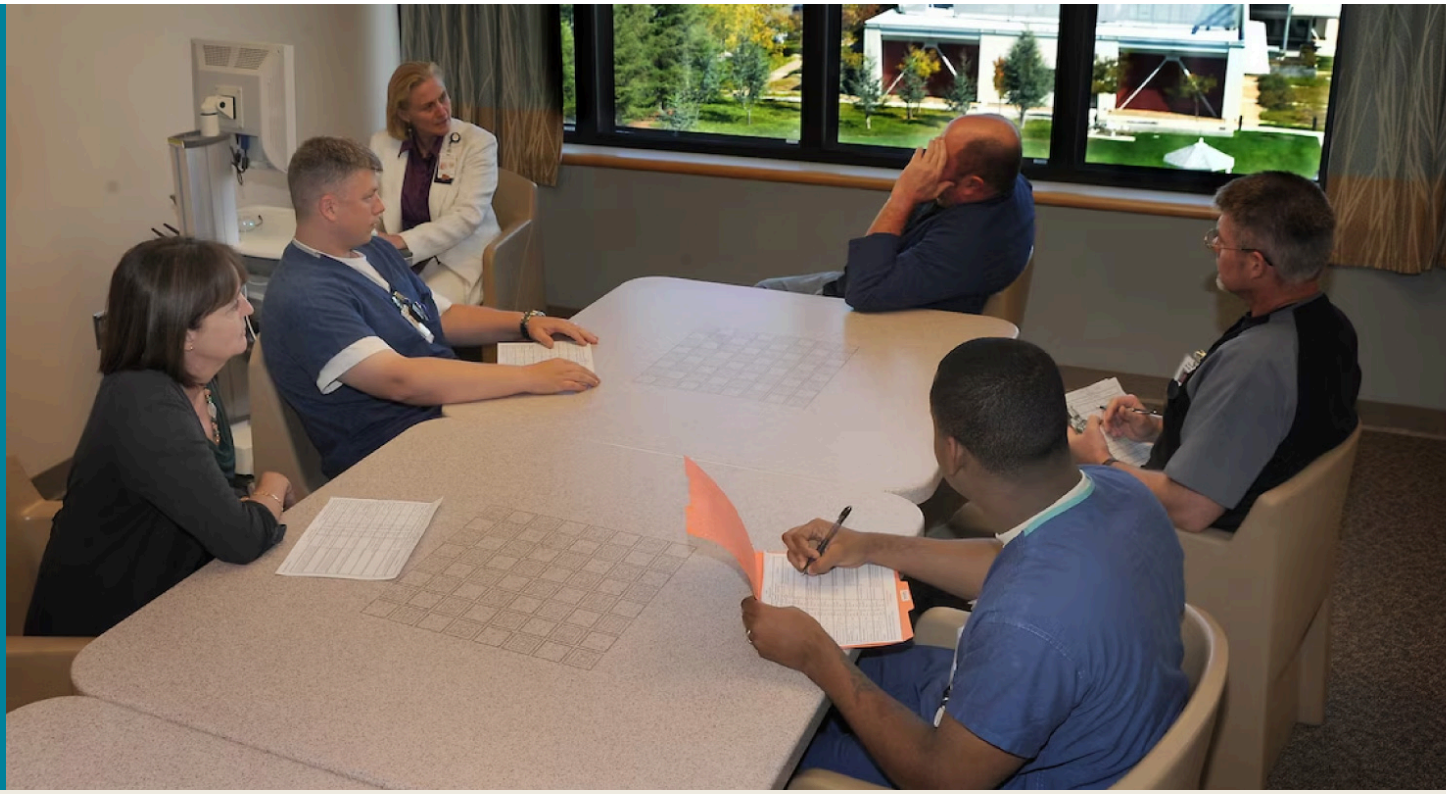


FIGURE 1.1 Psychiatric-mental health nurses are important members of an interdisciplinary team that collaborates to evaluate and treat clients. (credit: U.S. Air Force photo/Staff Sgt. Lillian Moreno, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Mental health is a critical component of a person's overall health. All nurses, regardless of the environment in which they work, must have a foundational knowledge of how to care for clients with a psychiatric-mental health diagnosis. Nurses working in this specialty area of nursing must use a holistic approach to assess the client's mind, body, and spirit as one unit that works together. Just as being proactive is important to staying physically healthy, it is also important to understand protective factors against a decline in mental health. Nurses should actively assist clients to learn to recognize both physical and psychological triggers in order to safeguard and bolster their mental health.

1.1 Mental Health and Mental Illness

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Compare and contrast psychiatric-mental health to psychiatric-mental illness
- List standard nursing practices in psychiatric mental health

It is important for nurses to understand the line between mental health and mental illness. The human body has physical and psychological responses to stress that psychiatric-mental health nurses are trained to observe in their clients. The nurse's role is to assess, plan, implement, and evaluate, all while collaborating with the client. Collaboration between the nurse and the client is an essential part of the mental health-care nursing process.

Psychiatric-Mental Health versus Psychiatric-Mental Illness

The term **mental health** refers to a state of well-being in which individuals realize their own abilities, cope with the normal stresses of life, work productively, and contribute to their community. Mental health is an essential component of overall health. The World Health Organization (WHO) defines overall health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Conversely, according to the American Psychiatric Association, **mental illness** is a health condition involving changes in emotion, thinking, or behavior (or a combination of these) associated with emotional distress and problems functioning in social, work, or family activities (American Psychiatric Association, n.d.).

It is important that "health services . . . devote as much attention to mental health as they do to physical health care" (Happell et al., 2021, p. 560). The World Health Organization's slogan agrees: "There is no health without mental health." Yet attitudes toward choosing mental health nursing as a specialty are ambivalent. Nurses should receive education that reduces stigma surrounding mental health and its treatment, increases their knowledge about mental health/illness, and exposes them to caring for clients with mental health problems in all nursing settings.

As a note, medical orientation to mental health treatment may refer to recipients of care as *patients* where the person is receiving acute treatment or assistance from a medical provider. *Client* is more often used in the community setting in which a person is in a collaborative solution-based relationship with a therapist (Spector, 2016). In the 1990s, nurses began to use the term *client* more regularly in an effort to show that the person was working in collaboration with their health-care team (American Psychiatric Nurses Association [APNA], 2022). This text will, for the most part, use the word *client*.

Psychiatric-Mental Health

The promotion, protection, and restoration of mental health is a vital concern of individuals, nurses, communities, and societies throughout the world (Figure 1.2).

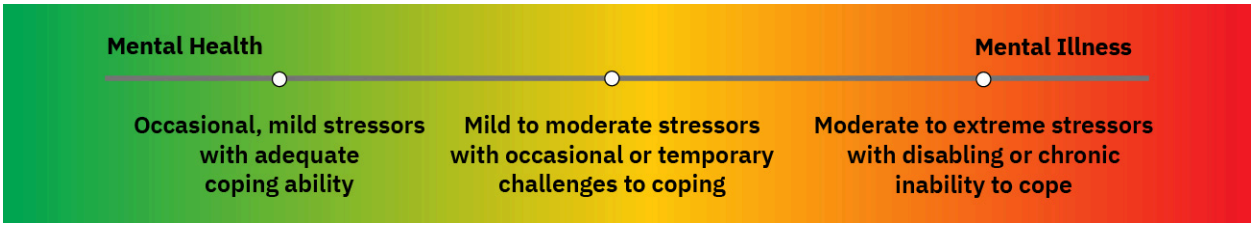


FIGURE 1.2 Mental health and mental illness exist on a continuum. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Mental health fluctuates over the course of an individual's life span and can range from well-being to emotional problems and/or mental illness, as indicated on the mental health continuum. Well-being is on the "healthy" range of the mental health continuum, where individuals are experiencing a state of good mental and emotional health. They may experience stress and discomfort resulting from occasional problems of everyday life, but they are able to cope effectively with the stressors and experience no impairments to daily functioning.

PSYCHOSOCIAL CONSIDERATIONS

Stress and Physical Response

The body's response to stress, often called the fight-or-flight response, can initiate both physical and psychological symptoms. The fight-or-flight response is triggered when a stressful situation puts hormones into overdrive. Even if the stress is not life-threatening, this response has evolved over the years as a survival mechanism against situations deemed dangerous (Harvard Health Publishing, 2020). This response can entail a person sweating, enduring chest pain, panic, stomach upset, headache, and an overall sense of doom. Chronic stress can lead to high blood pressure, insomnia, anxiety, depression, poor appetite or overeating, and substance use. Stress, of course, does not equal mental illness.

Psychiatric-Mental Illness

Mental illness is common in the United States. Nearly one in five (19 percent) of adults experience some form of mental illness, one in twelve (8.5 percent) have a substance use disorder, and one in twenty-four (4 percent) have a serious mental illness (American Psychiatric Association, 2022). Poor mental health increases the risk of chronic physical illnesses, such as heart disease, cancer, and strokes, and can lead to thoughts and intentions of suicide. Suicide is a common symptom associated with mental illness and is the second leading cause of death in Americans aged fifteen to thirty-four (Centers for Disease Control and Prevention, 2021a).

Emotional problems become classified as *mental illness* when an individual's level of distress becomes significant, and they have moderate to severe impairment in daily functioning at work, school, or home. Mental illness includes relatively common disorders, such as depression and anxiety, as well as less common disorders, such as schizophrenia. Mental illness is characterized by alterations in thinking, mood, or behavior. The term serious mental illness refers to that which causes disabling functional impairment that substantially interferes with one or more major life activities.

Standards of Psychiatric-Mental Health Nursing Practice

The American Psychiatric Nurses Association (APNA), the International Society of Psychiatric-Mental Health Nurses (ISPN), and the American Nurses Association (ANA) have established standards of care for psychiatric-mental health nursing practice. These standards include that individuals with mental health and substance use conditions should be treated with respect and dignity in a culturally appropriate manner. Health-care professionals should consider the preferences of people with mental health and substance use disorders and support them, their family members, and their loved ones in an inclusive manner.

History of Psychiatric Nursing

In the late 1800s, Edward Cowles, a physician at McLean Asylum in Massachusetts, began the first program to train nurses to care for psychiatric clients (APNA, 2022). Prior to that, the caregivers were called "keepers" (p. 8). In the early 1900s, Effie Jane Taylor at Johns Hopkins Hospital organized the first nurse-taught course to train psychiatric nurses. Before that time, physicians trained nurses. The first psychiatric nursing textbook was published in 1920 (p. 8). World War II expanded the need for psychiatric nurses as veterans returned from war with combat-related mental health problems.

It was in the 1950s that Hildegard Peplau rose to prominence as the "mother of psychiatric nursing" with her development of the theory of interpersonal relations, a theory and model of the therapeutic nurse-client relationship that focused on the "therapeutic use of self in promoting the well-being of individuals, families, groups, and communities" (Haber, 2000, p. 56) (Figure 1.3). Her theory not only helped nurses to become self-aware in their therapeutic relationships, but also assisted clients to build autonomy in problem-solving due to the support they received from the nurse while moving forward toward better mental health. Peplau's mission was to redefine the scope of work of the psychiatric nurse as a collaborative part of the health-care team and not just as the physician's "handmaiden" (p. 57).

FIGURE 1.3 Hildegard Peplau's model for the therapeutic nurse-client relationship shows what the nurse and the client bring to the therapeutic relationship. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

LINK TO LEARNING

The National Council of State Boards of Nursing created the Clinical Judgment Measurement Model (CJMM) (https://openstax.org/r/77CJMM) to explore new ways of testing clinical judgment in nursing as part of the National Council Licensure Examination (NCLEX). The diagram at this site shows the layers of the model.

CLINICAL JUDGMENT MEASUREMENT MODEL

What Is the Clinical Judgment Measurement Model (CJMM)?

Designed by the National Council of State Boards of Nursing (NCSBN), the CJMM measures a nursing licensure candidate's ability to exercise sound clinical judgment and decision-making. Grounded in the nursing process, the CJMM includes six components: (1) recognize cues, (2) analyze cues, (3) prioritize hypotheses, (4) generate solutions, (5) take actions, and (6) evaluate outcomes. Built in layers, the CJMM provides a framework for thought processes and actions to take in exercising clinical judgment in a nursing scenario.

Current Scope of Psychiatric Nursing Practice

All nursing practice is based on theory and a caring philosophy toward the provision of holistic care. Psychiatric-mental health nursing is a specialty practice focused on the client's psychological and emotional responses, level of risk, and coping abilities. The client's recovery is the goal, with individualized care as the process. The therapeutic nurse-client relationship is key to this process.

Mental health nursing takes place across settings, in the emergency room, in the community, in schools, in jails, in medical offices, in person, and through telehealth. Psychiatric nurses not only assess and provide care for the client's health-care needs, but are also involved in education, administration, and research (APNA, 2023, p. 40). When evaluating a client's mental health, the nurse uses a variety of assessments in addition to the traditional physical examination:

- performing a mental status examination
- completing a psychosocial assessment
- reviewing the client's use of psychotropic medications (drugs that treat psychiatric symptoms) and/or other medications that can cause psychiatric symptoms as side effects
- screening for suicidal ideation, exposure to trauma or violence, and substance misuse
- incorporating a spiritual assessment while assessing the client's coping status
- incorporating life span, developmental, and cultural considerations
- reviewing specific laboratory results related to the client's use of psychotropic and other medications

LINK TO LEARNING

The full scope of psychiatric nursing (https://openstax.org/r/77fullscope) can be accessed on the American

Psychiatric Nurses Association website.

Nursing assessments related to mental health disorders differ from physiological assessments because they have a greater focus on collecting subjective data: information provided by the client from the client's point of view or a description of their experience. For example, prior to administering a cardiac medication to a client with a heart condition, a nurse will assess objective data, such as blood pressure and an apical heart rate, to determine the effectiveness of the medication treatment.

Prior to administering an antidepressant, however, a nurse uses therapeutic communication to ask questions and gather subjective data about how the client is feeling in order to determine the effectiveness of the medication. The nurse will also observe client behaviors, speech, mood, and thought processes as part of the assessment. Nurses cannot directly measure a neurotransmitter to determine the effects of an antidepressant, for instance, but they can ask questions to determine how the client is feeling emotionally and perceiving the world, two factors influenced by neurotransmitter levels. An example of a nurse using therapeutic communication to perform subjective assessment is, "Tell me more about how you are feeling today." The nurse may also use general survey techniques, such as simply observing the client, to assess for cues of behavior. Examples of data collected by a general survey could be evaluating the client's mood, hygiene, appearance, or movement.

Nurses in any setting holistically observe and process their clients' physical, emotional, and mental health, as well as any impairments affecting their functioning. They must recognize subtle cues of undiagnosed or poorly managed physical and mental disorders and follow up appropriately with other members of the interprofessional health-care team (Figure 1.4).

FIGURE 1.4 The QSEN model includes six competencies, along with knowledge, skills, and attitudes (KSAs) for each competency. (credit: "Core Competency Framework for Undergraduate Nursing Student" by Dena Attallah and Abd Alhadi Hasan/Nursing Reports, CC BY)

CLINICAL SAFETY AND PROCEDURES (QSEN)

Competency: Description of QSEN Competencies

The references to Quality and Safety Education for Nurses (QSEN) competencies throughout this text refer to the educational repository created through funding by the Robert Wood Johnson Foundation to provide evidence-based teaching resources for nursing curricula. This was in response to the Institute of Medicine's call to improve the quality of healthcare in its report on healthcare safety in 1999. QSEN competencies are aligned with concepts that

can be expected to be tested on the NCLEX Next Gen, and with concepts presented in National Patient Safety Goals published annually by the Joint Commission.

The overall goal of QSEN is to prepare future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health-care systems within which they work. QSEN helps nurses to identify and bridge the gaps between nursing school and nursing practice. QSEN includes six core QSEN competencies, KSAs, teaching strategies, and faculty development resources. The competencies arose after the Institute of Medicine (IOM) released a report in 2000 that highlighted the need for health-care system redesign. The six QSEN competencies are:

- patient-centered care
- teamwork and collaboration
- evidence-based practice (EBP)
- quality improvement (QI)
- safety
- informatics

These competencies align with both the components of the NCLEX and the Joint Commission 2024 Behavioral Health Care National Patient Safety Goals (Table 1.1). The QSEN Competency of EBP aligns with the NCLEX Integrated Process of clinical judgment.

QSEN Competencies	Components of NCLEX Test Plan 2023, Client Needs	The Joint Commission 2024 Behavioral Health Care National Patient Safety Goals
Quality improvement (QI) Safety Informatics	Safe and Effective Care Environment Management of Care Safety and Infection Control Reduction of Risk Potential	Identify individuals served correctly Use medicines safely Prevent infection
Patient-centered care Teamwork and collaboration	Health Promotion and Maintenance Psychosocial Integrity Physiological Adaptation	Identify individuals served safety risks Improve health care equity

TABLE 1.1 QSEN Competencies (Sources: Ferro & Yoder, 2023; Joint Commission, 2024; QSEN Institute, 2022; Stanley et al., 2023)

1.2 Risk and Protective Factors of Mental Health

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss various risk factors of psychiatric-mental illness
- Describe various protective factors for psychiatric-mental illness
- Identify nursing implications associated with risk and protection factors

A **risk factor** increases the chances of developing a mental illness, may determine the probability of having a psychiatric-mental illness, and can change through the life span. Some risk factors may be modifiable, while others may be genetic or biological. Both internal and external environments of the person may pose risk. All of these factors can be addressed in nursing assessment. Having risk factors does not necessarily mean that a client will develop a disorder, and nurses shouldn't assume that a client is experiencing or will develop a disorder or illness. In fact, although risk factors can increase the chances of developing a mental illness, having an array of protective factors can decrease that risk. Nurses should help clients understand what these risk and protective factors are and potential ways to minimize risk factors and maximize protective factors.

Risk Factors

Mental health researchers have developed several theories to explain the causes of mental health disorders, but

they have not reached consensus Figure 1.5. One point on which they agree is that an individual is not at fault for the condition; they cannot simply turn symptoms on or off at will. There are likely several environmental, biological, and genetic risk factors that, when combined, trigger a mental health disorder (University of Michigan Human Resources, n.d.).

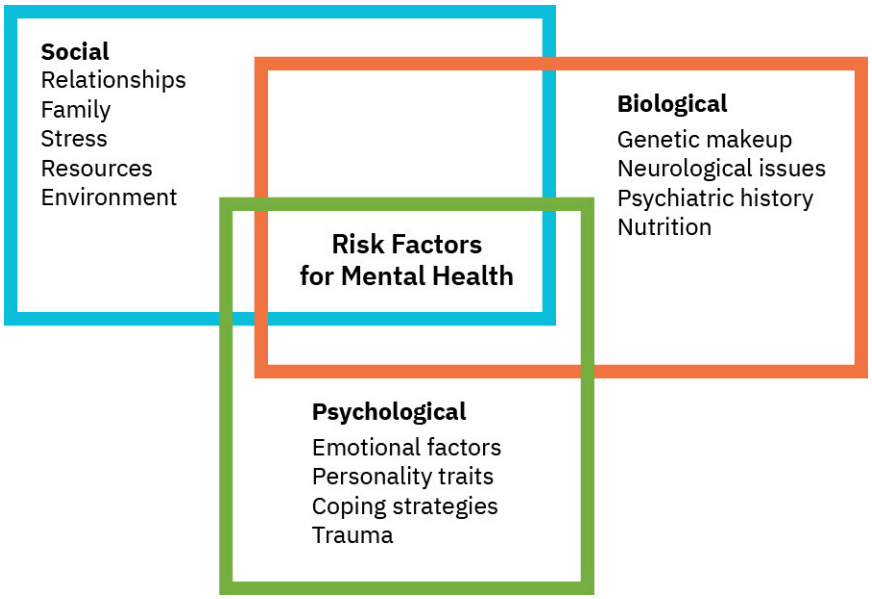


FIGURE 1.5 Risk factors for psychiatric-mental health conditions include social, biological, and psychological factors. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Risk factors from biological, social, and psychological factors can overlap. Some risk factors change over time, such as age, health history, availability of resources, and psychiatric history. Others are considered variable risk factors and include "income level, peer group, adverse childhood experiences (ACEs), and employment status" (SAMHSA, n.d.-a). Current stressors, such as relationship difficulties, the loss of a job, the birth of a child, a move, or prolonged problems at work can also be important contributory environmental factors (University of Michigan Human Resources, 2023).

Internal Environment: Physiological

Current research shows that the brain can have an imbalance of neurotransmitters, such as dopamine, acetylcholine, gamma-aminobutyric acid (GABA), norepinephrine, glutamate, and serotonin, resulting in changes in behavior, mood, and thought. While causes of fluctuations in brain chemicals aren't fully understood, contributing factors can include physical illness, hormonal changes, reactions to medication, substance misuse, diet, and stress (University of Michigan Human Resources, 2024). Organic delirium and infections can also cause changes to mood and behavior, until these conditions are successfully treated.

Kraybill (2019) found research suggesting that some mental health disorders are accompanied by immune system dysregulation and inflammation. The immune system can be disturbed by stress and environmental toxins, affecting human responses, nutritional intake, and immunity. Inflammation develops in the body as a response. Inflammation is also a trigger for depression (Kraybill, 2019).

Genetics and Medical Comorbidities

There appears to be a hereditary pattern to some mental illnesses. For example, individuals with major depressive disorder often have parents or other close relatives with the same illness. Huntington disease is another example, wherein the cognitive and motor impairment can be misdiagnosed as a psychiatric disorder. Researchers continue to investigate genes involved in specific disorders in order to target treatment to individuals.

People with mental illness may also have medical comorbidities, such as diabetes, endocrine dysfunction, Alzheimer's disease, cancer, and traumatic brain injuries (TBI) (American Mental Wellness Association, 2023). Psychiatric symptoms, medication side effects, ability for self-care, and provider focus may influence overall health.

Intrapartum Complications

People with a history of mental health issues prior to becoming pregnant are at a 40 percent higher risk of having a complication during pregnancy, a 50 percent higher risk for a non-live birth, and double the risk for having a baby born with a low birth weight (Witt et al., 2012). Some of these problems are due in part to lower socioeconomic status, lower education level, lack of access to medical care, and not being adequately followed to check their mental health status during pregnancy.

Moreover, Ross et al. (2015) reports that drug use among pregnant females aged fifteen to forty-four is at nearly 6 percent. Though the effects of maternal drug use on the babies differ depending on the drug used, some of the more common mental health effects on babies include cognitive delays, behavioral problems, attention-deficit hyperactivity disorder (ADHD), increased impulsivity, anxiety, depression, future substance use, and adolescent aggression (Table 1.2). Legal substances also are an intrapartum risk factor for mental illness. Tobacco exposure while in utero can cause children to develop ADHD, conduct disorder, behavioral disorders like aggression, and increased risk of drug abuse problems later on (Ross et al., 2015). Alcohol use in pregnancy can lead to fetal alcohol syndrome (FAS), which causes "morphogenic effects on limb and facial development, reduced brain and birth weight, and cognitive delays and impairments" (p. 74).

Drug	Effects
Cannabinoids	Attention deficits Future substance abuse Future depression Poor growth Long-term problems with executive function
Caffeine	Increased chance of prematurity Problems in executive function once in school
Psychostimulants	Preterm labor Behavioral problems Attention deficits Brain abnormalities Cardiac anomalies Aggression Anxiety/depression
Alcohol	Decreased growth Attention deficits Prematurity or spontaneous abortion Cognitive delays Brain abnormalities Problems with limb and facial development

TABLE 1.2 Effects of Maternal Drug Use

Drug	Effects
Tobacco	Lower birthweight ADHD Poor academic performance Aggression in adolescence Oppositional defiance
Opiates	Neonatal abstinence syndrome Preterm birth Lower weight Heart defects Low IQ Behavioral problems Respiratory problems

TABLE 1.2 Effects of Maternal Drug Use

Substance Use Disorders and Addictions

In addition to the negative effects that substance use and addiction have on the developing fetus, about half of the people living with a mental health disorder are also living with a substance use disorder (Medline Plus, 2019). Each of these things, mental health disorders and substance use disorder, can contribute to the development of the other. Many people who have mental illness use drugs or alcohol to cope with their symptoms.

Brain Injury

Another internal physiological risk factor for mental illness that can affect children and adults is experiencing a **traumatic brain injury (TBI)**, a brain injury that can cause short- or long-term problems with thinking, physical movement, communication, and functional abilities. In some cases, it may result in permanent disability or death. A TBI "can be caused by a forceful bump, blow, or jolt to the head or body, or from an object that pierces the skull and enters the brain" (National Institute on Neurological Disorders and Stroke, n.d., para 1). According to the Centers for Disease Control and Prevention (2022), a TBI in children can affect their development and lead to problems with learning, thinking, and behavior. These effects can last a lifetime. The most common causes of TBIs are falls, firearm injury, car accidents, and assaults. Experiencing a TBI can lead to years of medical care, rehabilitation, PTSD from memories of the event, a decrease in physical and mental functioning, financial concerns, and mental health issues for partners or family members (Tsur & Haller, 2020).

Internal Environment: Psychological

Factors that affect a person's psychological self include their emotions, coping ability, spirituality, self-concept and self-esteem, learned and conditioned behaviors, and personality traits. Plus, individual trauma resulting from an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful can have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (U.S. Department of Health and Human Services, 2020).

Low Self-Esteem, Poor Self-Concept

Having a poor self-concept or low self-esteem can lead to a person having negative thoughts about themselves. These feelings can lead to a sense of isolation and can cause poor relationships with others. Continued negative thoughts can lead a person to use substances as they try to make themselves feel better. Low self-esteem can also be associated with depression and anxiety (Gold, 2016).

Dysfunctional Relationships and Trust Violations

A relationship that is characterized as a **dysfunctional relationship** is one in which unhealthy behavior patterns exist among members of a group. These patterns can include poor communication styles, conflict between people in the relationship, and even emotional and/or physical abuse (Harold, 2023). In families, while it is often the parent who engages in the dysfunctional behavior, it is the child who suffers the consequences with an increased risk of developing anxiety, low self-esteem, post-traumatic stress disorder (PTSD), substance misuse, depression, and

problems building healthy relationships. In dysfunctional families, children can lose their ability to trust others based on their experiences of not being able to depend on their parents (Martin, 2018).

One example of dysfunctional relationships is gang affiliation. Gang affiliation is an unsafe environment that worsens existing problems. Children brought up in a family setting that includes a parent who uses substances, is abusive, or is a gang member themselves are at greater risk of socializing with gang members they meet in school or on the streets (Macfarlane, 2018). As children push away from these families, their vulnerability draws them toward gang membership. Research has shown that high rates of "depression, psychosis, anxiety, alcohol and drug dependence, antisocial personality disorder and history of attempted suicide" (p. 414) occur in gang members.

External Environment: Social

Individuals are affected by broad social and cultural factors, as well as by unique factors in their personal environments. Social risk factors, such as racism, discrimination, poverty, and violence (often referred to as "social determinants of health") can increase the chances of a person developing a mental illness.

While many social relationships act as sources of support, there are situations where relationships are toxic and can potentially increase the risk of mental health problems; fatigue; lack of motivation; difficulty concentrating; and cardiovascular, immune, and endocrine problems (André & Baumeister, 2023). Marital problems, demanding or intense relationships, and caregiving burnout are examples of relationships that could be toxic.

CULTURAL CONTEXT

Cultural Influences on Mental Health and Mental Illness

The culture of a client influences many aspects of mental health and mental illness. Be mindful, however, that general statements about cultural characteristics of a given group may also invite stereotyping. Cultural information should not be broadly applied to any individual member of a racial, ethnic, or cultural group.

In fact, only 66 percent of adults from underrepresented groups in the United States will get help for their mental health problems. There are four ways that culture affects mental health: stigma, understanding symptoms, lack of support from others in the same culture, and not having resources available that meet cultural needs (Mental Health First Aid, 2019).

Abuse/Neglect, Social Oppression/Victimization

In 2019, there were 656,000 victims of child abuse and neglect, with a victim rate calculated as nine victims per 1,000 children across the United States. More specifically, 74.9 percent of victims were neglected, 17.5 percent were physically abused, and 9.3 percent were sexually abused (Administration for Children & Families, 2021). Neglect is a situation in which a parent or caretaker fails, refuses, or is unable, for reasons other than poverty, to provide the necessary care, food, clothing, or medical or dental care, seriously endangering the physical, mental, or emotional health of the child. Physical abuse is defined as injury inflicted on a child by other than accidental means. Physical injury includes, but is not limited to, lacerations, fractured bones, burns, internal injuries, severe or frequent bruising, or great bodily harm. Sexual abuse is defined as sexual intercourse or sexual touching of a child; sexual exploitation; human trafficking of a child; forced viewing of sexual activity; or permitting, allowing, or encouraging a child to engage in prostitution. Emotional abuse is defined as harm to a child's psychological or intellectual functioning, which often results in severe anxiety, depression, withdrawal, or aggression. Emotional damage may show up in substantial and observable changes in behavior, emotional response, or learning that are incompatible with the child's age or stage of development. All of these types of abuse are considered adverse childhood experiences (ACEs).

It is estimated that 61 percent of adults have experienced early ACEs, such as abuse, neglect, or growing up in a household with violence, mental illness, substance misuse, incarceration, or divorce. Chronic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood (National Center for Injury Prevention and Control, Division of Violence Protection, 2022).

Adults at risk for abuse are defined as adults who have a physical or mental condition that impairs their ability to

care for their own needs (Wisconsin Department of Health Services, 2018). Older adults at risk are potentially susceptible to abuse, neglect, or financial exploitation by caregivers or a person they trust (Centers for Disease Control and Prevention, 2021b).

LIFE-STAGE CONTEXT

Older Adult Risk Factors for Psychiatric-Mental Illness

Risk factors for mental disorders in older adults include being female, loneliness, alcohol abuse, lack of education, financial difficulties, family history of mental diseases, and severe physical disease. In addition, adults with serious mental illness over age fifty have a high rate of medical comorbid conditions (SAMHSA, 2021).

Social oppression and victimization—bullying, violence, and stigmatization of people from underrepresented groups, for instance—can occur across the life span and are also significant risk factors for mental illness. It is **stereotyping** when someone has a generalized and prejudiced opinion about members of a particular group of people. Stereotyping can cause the marked population to feel stigmatized, disrespected, and become the target of bullying. Atunah-Jay et al. (2022) studied the concepts of school-based and electronic bullying in relation to their connection to an increase in suicidality in a group of North Dakota middle school students, specifically within the American Indian/Alaska native (AI/AN) population. Results revealed that "compared to other forms of bullying, electronic bullying is associated with unique and significant negative mental health concerns, including anxiety, depression, and suicidality" (p. 28).

Lack of a Support System, Loss, Economic Disadvantage

Risk factors for mental illness include the lack of a support system. This could be because the person is not physically or emotionally close to family members, has few friends, or lives in an area in which they do not feel connected to others. Loss includes anything that creates a negative effect for a person—loss of a spouse (divorce or death), loss of a job, and moving away from family are examples. Economic disadvantage can be related to the loss of a job or not having the skills to work beyond a minimum wage job. While lack of a support system, loss, and economic disadvantage have always been risk factors for developing mental health issues, the recent COVID-19 pandemic, and the measures taken to mitigate the spread, highlighted new examples of these risks. In particular was the practice of social distancing and social isolation. While these practices began to keep the public physically safer, there was a marked increase in anxiety, depression, and self-perceived stress related to loss of contact with others, loss of family and friends to the illness, sleep difficulties, financial insecurities among those with lower incomes, and misinterpretation (fake news) of the vast amount of information shared in mass media (Daclan, Ferreira, & Guzella, 2022).

LINK TO LEARNING

The Mayo Clinic provides a list of mental illness risk factors (https://openstax.org/r/77riskfactors) with more information about mental illness symptoms, causes, treatment, and resources.

Protective Factors

There is a link between protective factors and resilience, or the ability to "bounce back," and overcome stressful barriers to living a healthy life. Protective factors reduce the risk for mental illness, suicide, and other detrimental behaviors. Some of these biological, social, and psychological factors can be developed over time in the individual, family, and community (Connect Online, 2023). Examples of protective factors include support received from family and friends, religious practices, being part of a social group, getting physical activity, eating healthy foods, and using positive coping skills (Mental Health First Aid, 2022).

Internal Environment: Physiological

Living a healthy lifestyle that includes attention to diet, getting plenty of exercise and sleep, and having access to regular medical care provides a protective factor against the development of a mental illness. Other protective factors include avoiding high-risk substance use and receiving appropriate care for medical conditions (American

Mental Wellness Association, 2023).

Exercise is known to reduce all mortality risks, including poor mental health (Prakash, 2020). "Evidence suggests an exercise duration of 45 min 3–5 days a week to be optimal for good mental health" (p. 186). Physical activity is an appropriate intervention for the prevention of depression symptoms. Diet is also known to affect mental health, either positively or negatively. What a person eats can influence the development and progression of mental illness. Mental health professionals are encouraged to address nutrition in client care (Prakash, 2020).

LINK TO LEARNING

Dietary antioxidants may help to alleviate depression, anxiety, and stress. A study of the Mediterranean and DASH diet (https://openstax.org/r/77MedDASH) investigates the relationship between diet and psychological disorders.

Internal Environment: Psychological

Other protective factors include having healthy development and good attachment to parents (American Mental Wellness Association, 2023). Fei, et al. (2021) found that secure attachment creates comfort with self and was associated with higher levels of self-esteem.

Moreover, having high self-esteem means that a person can see their own value and have that attitude affect their social interactions, job satisfaction, and overall sense of well-being (Prakash, 2020). High self-esteem decreases anxiety, depression, and attention disorders due to the person using more positive coping skills. Finding a purpose in life also acts as a protective factor; it has been found to positively affect depression and anxiety, while contributing a 2.4 percent reduction to the chance of developing Alzheimer's disease (Prakash, 2020). High self-esteem and having a purpose in life are related to a person's resilience. Also connected to developing resilience are task-oriented coping mechanisms. People learn to use these methods, practicing them throughout their lives, changing them as needed. The current use of mental health apps provides "on the go" coping mechanisms to people who are socially isolated and to the younger generation (Varela et al., 2021).

LINK TO LEARNING

University of California at San Francisco offers this resource for recommended, evidence-based apps (https://openstax.org/r/77copingresources) for wellness and mental health.

In, addition, the use of mindfulness techniques—being fully present in the moment, being aware of surroundings, environment, and senses—is another protective factor that reduces stress and thereby lowers risk factors for mental illness. Examples of mindfulness techniques include meditation and keeping gratitude journals, instead of ruminating about the "what-ifs."

Spirituality, Morals, and Beliefs

The positive (protective) effects of religion and spirituality include promoting positive behaviors, giving people something to believe in, and offering purpose and meaning. The added benefit of the social connectedness that comes from being part of a religious community enhances positive health behaviors and outcomes. It is an important part of the nursing assessment to ask about a client's religious practices because this information helps to build interventions around the client's beliefs in health practices and allows nurses to utilize all of the resources that a client may have at their disposal.

LINK TO LEARNING

This scoping review of scholarly databases (https://openstax.org/r/77scopingreview) identified a need for spiritual care to be included in nursing education programs and in staff development efforts in the workplace. The researchers advocate for inclusion of spirituality into nursing practice and call for enhanced overall awareness of needs of health-care recipients.

Motivation/Achievement

Intrinsic motivation is the incentive to do something for internal or inherent satisfaction. Extrinsic motivation, such as working for a paycheck, does not have the same protective factors as intrinsic motivation. Extrinsic motivation can result in burnout and depression, when external rewards are not achieved. Intrinsic motivation is connected with more positive outcomes, such as well-being, satisfaction with life, and using ethical judgment (Kotera & Ting, 2019, p. 229). Being motivated by setting a goal and then achieving that goal is rewarding and can boost self-esteem, contribute to a feeling of fulfillment, and create a more hopeful outlook on life.

Childhood Attachments, Emotional Stability, Coping Skills

Children raised in loving environments are more likely to have good attachments to their parents or primary caregivers. This attachment decreases the likelihood of the child developing aggressive behavior and promotes their ability to express empathy as compared with children who were maltreated (FRIENDS National Center, 2023). The use of positive coping skills to overcome adversity combines cognitive and behavioral techniques that may change over time as the person experiences different stressors (Varela et al., 2021). These strategies are considered either task-oriented or emotionally oriented and each has a different effect on the person's ability to get past the stressor. Being able to have a variety of positive coping skills to use when life gets stressful enhances emotional stability.

External Environment

Social connectedness has been shown to reduce feelings of mental health stigma, to increase feeling supported, and to enhance the use of positive coping skills (Prakash, 2020). The support provided by a social milieu is helpful throughout the span of life. It is also helpful when someone is diagnosed with a mental illness because it provides the support needed to make the person feel validated as they navigate a life that can sometimes be very difficult. Without social support and connectedness, people become lonely, which has been shown to cause detrimental outcomes in people with depression, anxiety, bipolar disorder, and schizophrenia (Prakash, 2020).

Safety, Security, Caregiver Support

Having the support of those around you is an important protective factor. People need to feel secure in their relationships with family, friends, and caregivers. The safety and security they feel from a healthy, nurturing relationship provide a lifeline in times of mental distress. Sometimes just knowing there is one person to depend on makes a difference in being able to overcome a stressful life event. For example, children who are allowed to take risks with the guidance of a parent learn how to be self-sufficient in a safe environment (Prevention United, n.d.).

Participation in Sports, Clubs, Activities, or Groups

Participation in sports, clubs, activities, or groups is a social support that gives the client the feeling of being involved with others. Plus, being physically active releases the "feel good" brain chemicals called endorphins. Endorphins can help reduce depression, stress, and anxiety (Cleveland Clinic, 2023). Doing enjoyable things, such as laughing with friends, listening to music, meditating, and doing volunteer work also releases endorphins.

When encountering stressful situations, the Mayo Clinic (2023) suggests joining mental health support groups. These groups provide a safe and supportive environment in which to meet other people/families going through similar situations. They also provide education and online resources that offer information to help mitigate the risks of normal stress becoming a psychiatric condition. Such groups are provided by the National Alliance on Mental Illness (NAMI), which offers fact sheets and search features for local support groups, and the Department of Veterans Affairs (VA), which offers resources for coaching and connecting.

Access to Medical Care

Having access to health care is a protective factor when it comes to mental illness. According to Mental Health America (2023), barriers to accessing medical care include lack of mental health coverage in a client's private insurance plan, the large number of clients assigned to each mental health provider, and not being able to afford treatment. Public assistance programs, including health insurance, are examples of protective effects of access to medical care; they lift the barrier people have to getting appropriate prenatal care, thus decreasing the risk of a non-live birth (Witt et al., 2012). An additional benefit of being enrolled in a public health program is access to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which will increase prenatal and postnatal nutrition and overall wellness. The support that these people gain through such programs can help to reduce stress and anxiety during pregnancy.

Nursing Implications Associated with Factors of Risk or Protection

As the nurse completes a full assessment of the client, using purposeful questions and active listening are important parts of the process. The nurse must maintain a nonjudgmental attitude during the assessment (Higgins et al., 2015). The assessment builds a rapport between the nurse and client, creating an environment of trust. This is **professional intimacy** in the therapeutic nurse-client relationship, wherein the nurse gains an understanding of the client through respect and empathy, with compassion and recognition of the client's experience. Higgins et al. (2015) explains that the nurse uses three approaches to gather information: unstructured clinical judgment, assessment tools, and structured clinical judgment. Unstructured clinical judgment includes using critical thinking skills, observation, and intuition. Using standardized assessment tools is part of the mental health nursing process that provides insight into risk factors. Structured clinical judgment entails using a combination of the first two approaches to get an overall picture of the person's risk and protective factors.

A psychosocial assessment is a component of the nursing assessment process that obtains additional subjective data to detect risks and identify treatment opportunities and resources. Learning about the client's risk and protective factors will guide the development of appropriate interventions and outcomes. Agencies have specific forms used for psychosocial assessments that typically consist of several components (Glasner, Baltag, & Ambresin, 2021; GW School of Medicine & Health Sciences, n.d.):

- cultural assessment
- reason for seeking health care (i.e., "chief complaint")
- thoughts of self-harm or suicide
- current and past medical history
- current medications
- history of previously diagnosed mental health disorders
- previous hospitalizations
- educational background
- occupational background
- family dynamics
- history of exposure to psychological trauma, violence, and domestic abuse
- substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- family history of mental illness
- coping mechanisms
- functional ability/activities of daily living
- spiritual assessment

Risk Assessment

The availability of standardized web-based or paper risk assessment tools can make the risk assessment an easier task for the health-care provider or nurse. Ayhan and Ustun (2021) identified eighteen risk assessment tools that have been developed since 1970. While these individual tools have all been developed to measure levels of risk, each one is based on the client population being assessed. Clinicians must be comfortable with using the correct tool for the environment in which they work, whether it be in-hospital treatment, community care, or forensic psychiatry.

Strengths Assessment

An important question to ask is, "What positive coping skills have you used in the past to get through difficult times?" Assessing and reminding a client of their strengths is an integral part of instilling hope in the client. Who are their support persons? What do they see as their personal strengths? Engaging the client in thinking from a positive standpoint begins the trajectory toward reaching healthy treatment outcomes.

LINK TO LEARNING

The QSEN competency client centered care includes care of a client with a psychiatric-mental illness. The Client Centered Care competency knowledge, skills, and attitudes (KSAs) (https://openstax.org/r/77KSAs) are expected of

the student nurse as they transition to practice as a licensed nurse. The table serves as a resource to guide curricular development in formal academic nursing programs.

1.3 Mental Health Stigma

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss stigma surrounding psychiatric-mental health and illness
- Explain the importance of representation and acceptance of mental health in the community
- Describe the nurse's role in stigma reduction

According to the National Alliance on Mental Illness (NAMI) (n.d.-a), "One in 5 Americans is affected by mental health conditions" (para 4). Due to the stigma surrounding mental illness, people delay getting treatment for an average of eight to ten years and less than half will ever seek help (NAMI, n.d.-a). Stigma affects the quality of life for the millions of people with mental illness. Nurses are in a position and have an obligation to educate the public about mental illness to reduce stigma, to help create positive change through engagement in public health advocacy efforts, and to model compassion for those affected by mental illness.

Stigma toward Mental Illness

Despite a recent focus on mental health in the United States, there are still many harmful attitudes and misunderstandings surrounding mental illnesses that lead people to ignore their mental health and make it more difficult for them to reach out for help (Centers for Disease Control and Prevention, 2021a; Corrigan & Watson, 2002). The term **stigma** refers to a cluster of negative attitudes and beliefs that motivates the general public to fear, reject, avoid, and discriminate (Figure 1.6). In this case, the discrimination is against people with mental health disorders (SAMHSA, n.d.-b).

Self	Public	Institutional	Affiliated
Internalizing negative stereotypes related to mental illness	Endorsing negative stereotypes about others with mental illness	Maintaining policies that can lead to decreased access to services for people with mental illness	Being affected by stigma directed at another person with mental illness

FIGURE 1.6 There are four main types of stigma surrounding mental health issues. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Estimates report that nearly two-thirds of people with diagnosable mental health disorders do not seek treatment due to the stigma of mental illness. The *U.S. Surgeon General's Report* in 1999 was a milestone report that sought to dispel the stigma of mental illness and its impact on those seeking care (Hegner, 2000). This was the first surgeon general report to discuss mental health and mental illness, the first to put mental health in the spotlight. The National Alliance on Mental Illness (NAMI) seeks to improve the lives of those with mental illness and reduce stigma through education, support, and advocacy. NAMI encourages people to share their stories to discredit stereotypes, break the silence, and document discrimination (Abderholden, 2019).

PSYCHOSOCIAL CONSIDERATIONS

Stigma

To fully understand the impact of stigma, it is important to understand several types: self-stigma, public stigma, and institutional stigma. There is also a fourth type of stigma relating to the caretakers of people with mental illness, internalized stigma or affiliated stigma (Kaggwa et al., 2023). Public stigma includes negative or discriminatory attitudes that individuals have about mental illness. Self-stigma involves negative attitudes, including internalized shame, that individuals with mental illness have about their own condition. Institutional stigma is more systemic, involving government and private organization policies that limit opportunities for individuals with mental illness.

Implicit and Explicit Bias

The term **implicit bias** refers to prejudice evidenced in attitudes beyond consciousness or control (Stull et al., 2013). Implicit bias may be automatic and unintentional. Bias against those with mental health disorders comes up in communities, within the health-care sector, and in those with mental illness themselves. Each person's social conditioning affects their implicit bias (Cherry, 2023).

The term **explicit bias** refers to attitudes people are aware of, endorse, and communicate (Vela et al., 2022). Explicit bias interferes with inclusion, equity, and access in health care and negatively affects communication and teaching (Vela et al., 2022). Researchers examining bias in health care call for systemic change to address both implicit and explicit bias (Vela et al., 2022). It is important to work with and advocate for people who have mental illness toward more support and better outcomes for this population. Positive attitudes increase the desire to help and influence behaviors, which is especially important in those who are caring for people with mental illness.

Prejudice

The term **prejudice** refers to the beliefs, thoughts, feelings, and attitudes someone holds about a group. A prejudice is not based on personal experience; instead, it is a prejudgment, originating outside actual experience. While prejudice is based in beliefs outside of experience, experience can lead people to feel that their prejudice is confirmed or justified. This is a type of confirmation bias. For example, if someone is taught to believe that a certain ethnic group has negative attributes, every negative act committed by someone in that group can be seen as confirming the prejudice. Even a minor social offense committed by a member of the group, like crossing the street outside the crosswalk or talking too loudly on a bus, could confirm the prejudice.

Prejudice—as well as the stereotypes that lead to it and the discrimination that stems from it—is most often taught and learned. The teaching arrives in many forms, from direct instruction or indoctrination, to observation and socialization. Movies, books, charismatic speakers, and even a desire to impress others can all support the development of prejudices.

Discrimination

Though prejudice refers to biased thinking, **discrimination** consists of actions against a group of people. Discrimination can be based on race, ethnicity, age, religion, health, sexual orientation, gender identity, or disability. For example, discrimination based on race or ethnicity can take many forms, from unfair housing practices, such as redlining, to biased hiring systems. Overt discrimination has long been part of U.S. history. In the late nineteenth century, it was not uncommon for business owners to hang signs that read, "Help Wanted: No Irish Need Apply." And Southern Jim Crow laws, with their "Whites Only" signs, exemplified overt discrimination that is not tolerated today.

Discrimination can be intentional in the way that someone else makes a derogatory comment about another's mental illness or treatment, or it can be unintentional when someone is afraid to be close to a person with mental illness due to their lack of understanding about the disease (Mayo Clinic, 2023). This type of discrimination extends to primary caretakers of people with mental illness who may feel judged and unsupported by society (Kaggwa, 2023). Discrimination presents barriers for people with mental health conditions obtaining "good jobs, safe housing, satisfactory health care, and diverse social interactions" (Stull et al., 2013, para 1).

Representation and Acceptance of Mental Health in the Community

Despite the number of people who experience mental illness in any given year, stigma continues to be a social problem in the United States (Ma & Nan, 2018). People with mental illness have ongoing problems finding jobs and affordable and safe housing and are faced with the public's fear of being in close contact with them. Media campaigns can have a positive effect on changing public attitudes. One such campaign is Bring Change 2 Mind hosted by Glenn Close. This program has provided educational public service announcements about mental health/illness since 2009 (Bring Change 2 Mind, 2023).

Gender differences play a role in acceptance of mental illness. In 2018, Ma and Nan found that females are more likely to have positive attitudes toward and empathy for stigmatized groups than their male counterparts. Males have more often been found to want to deal with mental health issues on their own due to fear of stigma (Coveney, 2023).

Culture and Mental Health

Cultural and ethnic considerations are paramount in perceptions of mental health. Culture and ethnicity not only influence the way the disease develops, but also the way it is expressed, accepted, and understood (Mizock & Russinova, 2013). “The explanatory model a culture has for mental illness can both enhance and reduce stigma faced by people with serious mental illness” (p. 231). Cultural values and beliefs affect how a person views certain ideas or behaviors. In the case of mental health, it can determine whether or not the individual seeks help, the type of help sought, and the support available. Every individual has different cultural beliefs and faces a unique journey to recovery. In general, historically marginalized communities in the United States are less likely to access mental health treatment, or they wait until symptoms are severe before seeking assistance (Mental Health First Aid USA, 2019).

Four ways that culture can impact mental well-being are (Mental Health First Aid USA, 2019):

- Cultural stigma: Every culture has a different perspective on mental health, and many cultures have a stigma surrounding mental illness. Mental health challenges may be considered a weakness and something to hide, which can make it harder for those struggling to talk openly and ask for help.
- Describing symptoms: Culture can influence how people describe or feel about their symptoms. It can affect whether someone chooses to recognize and talk openly about physical symptoms, emotional symptoms, or both. For example, members of the Amish community are typically stoic and endure physical and emotional pain without complaining.
- Community support: Cultural factors can determine how much support someone gets from their family and community when it comes to mental health. Because of existing stigma, it can be challenging for individuals to find mental health treatment and support. Globally, there are different beliefs and practices related to the care of mental health problems. Some communities offer support to those with mental illness and others shun or ignore its presence. The treatment received by those defined as mentally ill or disabled varies greatly from country to country.
- Resources: When looking for mental health treatment, it can be difficult to find resources and treatment options that take into account a specific culture's concerns and needs.

Communication problems interfere with the spread of mental health knowledge from culture to culture when specific descriptors of diagnoses are not expressed the same ways in different cultures. A solution to this is the use of Transnational and Inclusive Mental Health De-stigmatizing Education (TIMHDE). This concept involves people from all different continents, cultures, and lived experience working together to establish a mutual way to present educational content about mental health (Illingworth, 2021).

Barriers to Mental Health Care

Barriers to mental health care vary. There can be barriers that the client places on themselves by not wanting to admit that they need help. Barriers can also be connected to fear of stigma from friends and family, cultural biases, not having health insurance to cover the costs of treatment, and not having adequate information about the mental health resources available in their community (Heath, 2017).

For those who live in rural areas, finding treatment sources is also not always easy. There may be limited options, especially in rural areas and low-income urban areas; waiting lists; poor quality of care available for indigent clients; and financial obstacles, such as co-pays, deductibles, and time off from work. There is also the consideration that in small rural communities where everybody knows everyone, people may fear getting the help they need because of the stigma associated with mental health care.

Availability, accessibility, and acceptability (the stigma attached to mental illness) are all problems in rural areas. Approximately two-thirds of those with symptoms receive no care at all (U.S. Department of Health and Human Services, 2005; Wagenfeld, Murray, Mohatt, & DeBruiynb, 1994). At the end of 2013, the U.S. Department of Agriculture announced an investment of $50 million to help improve access and treatment for mental health problems as part of the Obama administration’s effort to strengthen rural communities.

LINK TO LEARNING

The Rural Health Information Hub provides data and resources, including a Mental Health Toolkit (https://openstax.org/r/77MHTookit) for communities in rural areas of the United States. The site is supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Veterans and military personnel make up a large portion of those who encounter barriers to receiving mental health care. Despite the implementation of post deployment screening to help identify signs and symptoms of mental health problems in veterans returning from Iraq and Afghanistan, stigma is still present in the military community (Warner et al., 2011; Brown & Hardey, 2023). Many veterans remain hesitant to disclose their symptoms for fear of it negatively affecting their reputation. Those in the military are trained to be tough, so they fear that "members of my unit might view me differently," and "It would hurt my career" (para 13).

Nursing Implications

Stigma and negative attitudes toward mental illness can still be found among nurses. Several studies from a variety of countries indicated that health-care professionals can be classified in three categories in relation to stigma, including "stigmatizers," "the stigmatized," and "de-stigmatizers." *Stigmatizers* refer to nurses in medical settings with stereotypical attitudes toward clients with mental illnesses, psychiatric-mental health nurses, and/or psychiatry. Nurses classified as *the stigmatized* have mental health disorders or perceive stigma regarding their roles as psychiatric-mental health nurses. *De-stigmatizers* actively work to reduce stigma surrounding mental health disorders. The authors of the studies found that many nurses share commonly held stereotypical beliefs portrayed in the media. For example, clients with mental health disorders have been portrayed in the media as dangerous, unpredictable, violent, or bizarre, and these portrayals can cause fearful attitudes. Nurses in the studies were concerned about inadvertently saying or doing "the wrong thing" or "setting off" uncontrollable behavior. Many nurses in general medical settings felt they lacked the skills to manage behavioral symptoms of clients with mental health disorders. The authors of the review reported that their findings support additional mental health education for entry-level nurses and practicing nurses to enhance their knowledge base on mental health (Ross & Goldner, 2009).

REAL RN STORIES

Nurse: Lenore, MSN, RN-BC
Years in Practice: 20 years
Clinical Setting: Psychiatric-mental health nurse
Geographic Location: Texas

As a board-certified psychiatric-mental health nurse and university-level instructor, I find it important to teach my nursing students the importance of accepting all people despite what some might think is a derogatory aspect of their being (i.e., diagnosed with a mental illness). In my first class of the semester, I always talk about stigma and show two videos available through Bring Change 2 Mind. The first video "Grand Central Terminal" lets the viewer meet people talking about the diagnosis printed on their white t-shirt. The second video features Ron Howard, who directed "Grand Central Terminal," sharing why he felt this story was important to tell. After we watch these videos together, I open up the floor for conversation. I ask if seeing visual representation of stigma helps them to better understand this concept. I ask if anyone in class would like to share about a time they may have felt stigmatized. I explain that what happens in class is akin to what happens in Vegas—what happens in the classroom stays in the classroom; it is a safe space for sharing. I also tell my students to compare educating others about stigma to dropping a pebble into a body of water and watching the ripples extend. Much like the ripples in the water, each person they educate has the potential to share that knowledge with others, in effect decreasing the stigma toward mental illness one person at a time.

Nursing Interventions for Client Care

Nurses can reduce stigma and advocate for a client's needs and dignity by establishing a therapeutic nurse-client

relationship. A therapeutic nurse-client relationship is essential in all settings, but it is especially important in mental health care where the therapeutic relationship is considered the foundation of client care and healing. Although nurse generalists are not expected to perform advanced psychiatric-mental health nursing interventions, all nurses are expected to engage in compassionate, supportive relationships with their clients (Ross & Goldner, 2009). This is even supported in the *Nursing: Scope and Standards of Practice* (American Nurses Association, 2021).

Nurses' Self-Care

Nurses spend a lot of time and energy caring for others. Regis College's 2023 article about self-care tips for nurses highlights five problems that nurses face: "Stress, burnout, bullying, exhaustion, and inadequate sense of support from employers" (para 4). Self-care is an important part of being able to take care of others. If you do not take time to take care of yourself, you will have nothing left to give your clients. Some ideas for self-care include maintaining a sleep schedule as a way to recharge the body, recognizing when to talk to someone about your feelings, making time for exercise, maintaining a healthy diet, and practicing mindfulness (Regis College, 2023). When at work, nurses should make a point of taking breaks, eating lunch, mentoring other nurses (this provides an environment of support), and sharing a laugh with coworkers. In the psychiatric-mental health environment, it is especially important to practice self-care as the clients are often at their most acute level, staffing ratios can be low, and there is the constant need to be vigilant in maintaining a safe environment. These factors increase the stress level of the nurses.

The psychiatric-mental health nurse is taught to be self-aware of their own attitudes toward others and triggers that may occur with certain clients. This self-awareness can help decrease possible stigmatization. For example, there may be a client who reminds the nurse of an abusive family member. In this case, the nurse recognizes the trigger and utilizes reflection and possibly seeks peer or mentor support. By admitting that there are preexisting thoughts about a certain type of client, the nurse is acknowledging that they may not be able to provide nonjudgmental care and reach optimum treatment goals for that client. The role of being a nurse is very rewarding and exhausting all in one. Taking care of self is just as important as the care provided to clients.

LINK TO LEARNING

Are you or someone you know affected by stigma? Take this quiz at NAMI (https://openstax.org/r/77stigmaquiz) and learn more about being stigma free.

1.4 Mental Health Recovery and Wellness

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss principles central to the recovery model
- Identify stages of psychiatric-mental health recovery
- List strategies for psychiatric-mental health wellness

Recovery in mental health is a nonlinear process. According to Mental Health America's 2023 survey, over half of the people in the United States who have mental health disorders, and a staggering 93.5 percent of people with substance use problems, do not get treatment (para 2). People can get better, but they need to understand what resources are available. Health-care providers can educate the individual, families, and communities about the steps of recovery. The goal is to instill hope that with support, the client can maintain wellness throughout their lifetime. Hope is the basis of recovery (SAMHSA, 2023).

Principles of the Recovery Model

Mental illness is treatable. Research reveals that people with mental illness can get better, and many recover completely (Centers for Disease Control and Prevention, 2021a). The majority of individuals with mental illness continue to function in their daily lives. The term **recovery** refers to a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (Center for Substance Abuse Treatment, 2014). Dimensions that support a life in recovery include the following:

- Health: Overcoming or managing one's disease(s), as well as living in a physically and emotionally healthy way
- Home: Having a stable and safe place to live
- Purpose: Participating in meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- Community: Enjoying relationships and social networks that provide support, friendship, love, and hope

There are ten principles of recovery and five stages of recovery. According to the American Psychological Association (2012), the ten principles of recovery are:

1. Self-direction: The journey to recovery is determined by the person recovering.
2. Individualized and person-centered: The chosen road to recovery should be tailored and customized to the client in terms of ability, background, inclinations, and assets.
3. Empowerment: Clients participate in the decision-making process.
4. Holistic: Recovery involves the entire person, including mind, body, spirit, and community.
5. Nonlinear: Recovery is not linear and may entail setbacks. It involves continuing to grow and learning from the setbacks.
6. Strengths-based: Recovery takes what clients are already good at and enhances it.
7. Peer support: Support from others enriches recovery.
8. Respect: Recovery requires acceptance by clients' communities, families, peers, and health-care providers.
9. Responsibility: Clients must take ownership of their own recovery path.
10. Hope: The drive to recover stems from hope of getting better and knowing that it is possible (p. 5).

Additionally, participation in mutual aid groups can be one pathway to recovery. Such groups include twelve-step programs, like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Gamblers Anonymous (GA), that provide support for addictions and compulsions. The twelve steps are guidelines for persons to acknowledge and surrender their addiction, and to draw strength from a higher power, as they personally conceptualize that to be.

Hope

Hope is the foundation of the recovery process. Hope in this context is the belief that one can overcome their challenges (SAMHSA, 2023). The nurse helps clients increase their sense of hope by looking beyond the current stressful situation and toward a healthier future. The nurse helps the client identify their "strengths, talents, coping abilities, resources and inherent values" (para 3). Hope is "the catalyst for change" (Laranjeira & Querido, 2022, p. 2). By using a recovery-oriented approach, nurses create a feeling of hope even when the client feels hopeless (Dallum et al., 2015).

Self-Determination, Self-Management, and Empowerment

Recovery is centered around the client developing their own autonomy in making choices about treatment and resources used to achieve their self-directed goal (SAMHSA, 2012). Empowerment begins from the moment a person makes the decision to get treatment. With self-determination, a support system, and learning what feels right in terms of treatment options, a person's sense of empowerment grows. The adage "knowledge is power" is true in recovery. It is here that **psychosocial rehabilitation** comes into play; it helps individuals develop the social, emotional, and intellectual skills needed to live happily with the smallest amount of professional assistance manageable.

CULTURAL CONTEXT

Cultural Views of Drug Use in China

Managed by the courts, compulsory detoxification centers in China have been criticized for human rights violations. However, community-based treatment and voluntary treatment with medical management also exist in the country. Yang and Giummarra (2021) propose evidence-based treatment while acknowledging the Chinese population size, history, and culture.

Criminalization of drug use in China may be preventing incorporation of drug treatment into the health-care system (Yang & Giummarra, 2021).

Advocacy

Advocacy comes in two forms: for the client and for education. A nurse can advocate for the client's needs when they are in too acute a condition to be able to make decisions for themselves. As the client begins to feel better, the nurse steps back and begins to let the client advocate for themselves. One of the foundations of recovery-oriented care is creating safe spaces for healing (Solomon, Sutton, & McKenna, 2021). The high numbers of people with mental health and substance use problems who do not seek treatment attest to the fact that education is important. Nurses can advocate for education in communities about the resources available to fight against substance misuse.

CLINICAL JUDGMENT MEASUREMENT MODEL

Generate Solutions: Advocating for Clients

After completing a client assessment and determining a nursing diagnosis, the nurse must then generate solutions. These must be individualized interventions to address the problems the client is currently facing. The client must be involved in the decision-making process as much as possible in order to have the best chance at achieving the projected outcomes. For example, telling a client that they need to eat healthier foods and then removing certain foods that are culturally relevant to that client will likely not be a maintainable intervention. To make this intervention individualized, it might include advocating for their dietary needs, especially if the intervention is occurring in a facility treatment setting.

Five Stages of the Psychiatric-Mental Health Recovery Model

The five stages of recovery include starting treatment, mental illness education, making a change, finding new meaning, and sticking with recovery (Georgetown Behavioral Hospital, 2023) (Figure 1.7). While each stage builds on the prior one, it is important to remember that recovery itself is a nonlinear process. In the first stage, the person realizes that they need help. During the second stage, the person starts gaining education about their illness and coping skills that can be used during the recovery process. The third stage, making a change, refers to the changes that a person needs to make in their lifestyle, friends, and environment in which they live in order to be able to recover and maintain recovery. The fourth stage encourages trying new positive experiences, making new supports, and finding joy in life. The final stage is planning what recovery is going to look like throughout life: treatment, therapy, and medication are examples. Each of these stages helps the person learn about "self-care, determination, and persistence" (para 10).

The 5 Stages of Recovery				
Starting treatment	**Learning about mental illness**	**Making a change**	**Finding new meaning**	**Sticking with recovery**
Realizes that help is needed	Gains education about illness and coping skills	Commits to making a change	Begins to make new connections and tries positive experiences, finds the joy in life	Does what is necessary to stay in recovery: treatment, therapy, medication, sponsor
1	2	3	4	5

FIGURE 1.7 In this model, the five stages of recovery have a starting point and a future achievement goal. Stage five is the most difficult and may require starting again at stage one. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Acceptance

Learning to accept oneself is an important part of recovery. It helps people let go of the past and move forward (Linney, 2022). Accepting that they have an illness helps people face mistakes made in the past and adopt a mindset toward future problem-solving. Part of the process is understanding that recovery will have some rocky spots, but with support people in place and the use of positive coping skills, it is possible to get through those tough times.

Nurses and other health-care personnel must also practice acceptance of the clients for whom they are caring.

Realizing that the client is a human who comes with a history, individual needs, strengths, and values will improve the nurse-client relationship (Solomon, Sutton, & McKenna, 2021).

Insight

As the individual and family become more educated about mental illness and substance misuse (psychoeducation), they begin to gain insight into how their lives are affected by it. Being taught that there are peer support resources available in the community can be invaluable in making the individual feel less alone. Peer support services (see 6.3 Peer Support) provide the individual with a sense of belonging and acceptance (Dell, Long, & Mancini, 2021). Listening to the experiences of the peer support people can help individuals build insight into their own illness and recovery. Family education helps family members to be more understanding, supportive, and can increase the family bond.

Action

One nursing intervention to help individuals take action is to get them involved in illness self-management (ISM). Such programs are meant to help the individual design their recovery in a way that works best for them in their daily lives. Wellness Recovery Action Plan (WRAP) is one of the most often suggested ISMs due to the way it "enhances recovery, self-advocacy, and hope" (Petros, & Solomon, 2021, p. 631). WRAP is led by a trained peer support person and usually consists of a small group that meets over eight to twelve sessions. Instilling hope is the basis for this ISM. Over the course of the program, participants learn how to enhance or maintain their wellness through self-reflecting, being proactive, recognizing triggers, and setting up plans for crisis intervention (Petros & Solomon, 2021).

Self-Esteem

Self-esteem has three parts: (1) the positive and negative thoughts people have about themselves, (2) how people rate their self-worth, and (3) evaluating their own abilities and personal characteristics (Hasani, Aung, & Mirghafourvand, 2021). Low self-esteem is associated with higher rates of depressive symptoms. On the other hand, if a person has a high level of self-esteem, they are more likely to be able to manage stressful events successfully.

The inclusion of self-esteem in Maslow's hierarchy of needs supports the importance of fulfilling this need in one's life (Family Addiction Specialist, n.d.). The recovery process helps individuals increase their self-esteem as they begin to rebuild relationships, jobs, and their health.

Healing

Healing is not immediate. It takes time, patience, and education. The medical model for mental health focuses on biology while recovery-oriented mental health focuses on holistic healing (Chisholm & Petrakas, 2021). Medication management can be a viable part of the healing process for people with severe mental illness (SMI) as it can decrease symptoms and help them feel better (Jessell & Stanhope, 2022). Collaboration between the client and the prescriber ensures the client's autonomy in discussing medication options, side effects, and contributions toward the person's healing. Healing is not a cure, but is a chance to live a better life than they did before they recognized their illness and entered into recovery. The recovery process involves the client and their families. The hope is that with education about the illness, family members, too, can heal, thus improving perceptions they may have developed about the illness and their loved one (Galimidi, & Shamai, 2022).

Meaning

Finding meaning in life provides individuals protection from stressful situations by helping them to effectively cope and move beyond that challenge (Prakash et al., 2020). Going through the lows of addiction or severe mental illness is sometimes the catalyst for making a positive change (Family Addiction Specialist, n.d.). It is often at the lowest point that an individual finds their purpose to move forward. The individual finds meaning from realizing that they need to make positive changes in their lives.

Strategies for Psychiatric-Mental Health Wellness

Adopting healthier life choices is the most important factor in recovery and working toward/maintaining psychiatric-mental health wellness. Prakash et al. (2020) suggest that the difference in mental illness and mental wellness is that in illness the focus is on management of the illness while wellness focuses on all the aspects in life that can help people live and participate in the world around them. Some wellness strategies include getting good sleep;

eating a diet that includes a balance of fruits, vegetables, lean meats, fish, and whole grains; limiting caffeine use; exercising three to five days per week for forty-five minutes; and maintaining connections to others.

PSYCHOSOCIAL CONSIDERATIONS

What Is Psychosocial Rehabilitation?

Psychosocial rehabilitation helps individuals develop the skills to live happily with the smallest amount of professional intervention manageable. Psychosocial rehabilitation uses two strategies: coping skills to empower the client to more successfully handle stressful situations and resource development to reduce future stressors. Treatments and resources vary case to case but may include medication management, psychological support, family counseling, vocational and independent living training, housing, job coaching, educational assistance, and social support.

Focus on the Positive

Focusing on the positive, despite what may seem like insurmountable obstacles, changes one's perspective. The mindset of always looking at the negative aspects of life can only have a poor effect on one's mental health and hope for recovery. Encouraging a focus on the positive is one of the interventions that nurses can offer to individuals or as a part of therapeutic group work.

Practice Gratitude

Practicing gratitude is embraced by twelve-step programs and recovery specialists and can be an intervention implemented by psychiatric nurses. Encouraging clients to keep a gratitude journal allows them to sit down at the end of the day and reflect on the things for which they are grateful that day. This changes the focus to positive events, no matter how insignificant they may seem and helps the client realize that even when everything seems dismal, there are things to be thankful for in life.

Connect with Others

Learning to have healthy relationships means understanding that sometimes relationships require boundaries in order to stay healthy. When a person is actively using substances or in the midst of severe mental illness, they often make bad choices about the people with whom they connect socially. These connections can negatively affect their mental health. Healthy relationships offer support by increasing one's sense of well-being (Family Addiction Specialist, 2023). Though it may be a difficult decision to cut ties with people and places, it is a necessary part of staying healthy in recovery. As individuals work on their recovery, they begin to learn that in order to become a healthier version of themselves, they need to find and make new friends.

Maintain Physical Health

Physical health and mental health are often connected. Many people have co-occurring diagnoses. For instance, diabetes and depression often co-occur. Teaching clients the importance of maintaining their physical health is just as important as watching for signs and symptoms of mental illness. Again, a holistic approach to the client's health means that mind, body, and spirit are all connected. There are certain things nurses can teach their clients about maintaining better physical health. These include smoking cessation, recovery from substance misuse, improving their diet and exercise routines, and getting plenty of sleep.

In Kesavayuth, Shangkhum, and Zikos (2022), several studies showed connections between health and certain health factors. One study from Nova Scotia reported a connection between having depression and developing coronary artery disease. This connection is further supported by research showing that people with higher levels of physical health are also more likely to have better mental health.

LINK TO LEARNING

Faces and Voices of Recovery tries to remove barriers to recovery. They believe that overall health can influence recovery. Read their article The Impact of Wellness on Recovery (https://openstax.org/r/77recovery) for additional information.

1.5 Integration of Research- and Evidence-Based Standards

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify credible sources of research evidence for psychiatric-mental health nursing
- Apply concepts of evidence-based practice (EBP) to psychiatric-mental health nursing
- Locate evidence on representation and acceptance of mental health in the community

The foundation of any effective nursing practice is the use of evidence-based practice in caring for clients. Research completed by nurses contributes to the wealth of knowledge that forms evidence-based practice. Basing nursing practice on evidence leads to the most positive client outcomes.

Credible Sources and Types of Research

Throughout the nursing process, it is important to be sure to use evidence-based practice (EBP). The term evidence-based practice refers to:

> A process used to review, analyze, and translate the latest scientific evidence with the goal of quickly incorporating the best available research, along with clinical experience and client preference, into clinical practice, so nurses can make informed client-care decisions (John Hopkins Medicine, 2023, para 1).

In this description, review means locate and study, analyze means determine the meaning, and translate means to move the evidence into practice.

Starting with a professional database is best to locate credible sources. Many databases require a subscription in order to access them. If the nurse works at a hospital or a university, then there is likely access to these sources. Popular databases include Cumulative Index to Nursing and Allied Health Literature (CINAHL) found within EBSCO (subscription needed), Agency for Healthcare Research and Quality (AHRQ) (available for free), MEDLINE (free online source), ERIC (provides links to sources available for free), PsychINFO (accessed through a vendor, such as OVID), and Cochrane Database of Systematic Reviews (contains free access to reviews).

The term **empirical research** refers to scholarly work from actual observation and measurement of experience, in contrast to theory. Empirical research is primary research, which means the authors of the study conducted the investigation. There are two basic types of research that fall under empirical research: qualitative and quantitative. Qualitative research pulls data from the subjective responses of the participants. It asks the questions of who, what, where, when, and how. Its goal is to determine how an individual or community feels about and is affected by a particular topic. Quantitative research deals with numbers and statistical data (McCusker & Gunaydin, 2015). Some studies combine aspects of qualitative and quantitative research called mixed method. The qualitative data can provide client insight into the statistical results from the quantitative data. Before selecting a research study for evidence-based practice, the nurse must determine which type best fits the problem being investigated.

Applying EBP to Psychiatric-Mental Health Nursing

Application of evidence-based practice (EBP) concepts to psychiatric-mental health nursing begins with definitions. In both the clinical and research settings, defining the question requires delineating a particular problem that has been identified by the nurse (Bermudez, 2021). In the research sector, the question arises after performing a thorough literature review and finding treatment gaps. In the clinical setting, the nurse develops the question first and then performs a literature review. Good research questions can be written using the FINER technique: “feasible, interesting, novel, ethical, and relevant” (Bermudez, 2021, p. 71).

Search Terms and Web Addresses

Effectively gathering data depends upon the search terms used. When choosing keywords, the focus should be on the main words or phrases that describe the research topic (American Psychological Association, 2020). For example, if a nurse is searching for information on barriers to care, they might use the words barriers to care, access, mental health care, medical care, and community health resources. As the search continues, the nurse can hone in on more terms based on what comes up in the search. Sometimes a good article will contain references that the nurse can access to find additional information.

Beyond using a database to locate professional journals and peer-reviewed articles, nurses can perform a general

internet search. Extensions at the end of website names will help the nurse locate good sources. The most common extension is .com. This delegation is for businesses and news. Nonprofit organizations use .org. Higher education, such as colleges and universities, will have .edu. Government websites will use .gov. Military sites use .mil. With all sites, it is best to assess the source and the information for accuracy and bias before deciding to use it as a basis for research (Central Michigan Libraries, 2022).

Levels of Evidence

The levels of research evidence are organized below as lower-level evidence or higher-level evidence. This can be a guide for nurses who are beginners working on research and a reminder for more experienced nurses. Information across the levels can be combined to give a realistic view of the topic. These levels correspond to the types of items a nurse might find when conducting a literature review Table 1.3.

Lower-level Sources of Research Evidence:	Higher-level Sources of Research Evidence:
Evidence from a cohort study, observational, nonexperimental	Systematic review/meta-analysis of RCTs (highest level)
Systematic review or meta-synthesis of qualitative studies	Evidence from a large randomized controlled trial (RCT)
One qualitative study or descriptive study, or a quality improvement project	Evidence from a nonrandomized controlled trial, quasi-experimental study or a mixed-method intervention study
Non-research source; expert opinion (lowest level) (Note: Expert opinion is valid data, especially in the PMH nursing specialty, though this level of evidence should be made clear in the research report.)	

TABLE 1.3 Levels of Evidence

Evidence-Based Practice in Psychiatric-Mental Health Nursing

It is vital for nurses to protect and promote the mental well-being of all individuals and address the needs of individuals with diagnosed mental disorders (World Health Organization, 2018). The World Health Organization (WHO) published the Mental Health Intervention Guide for nurses and primary health-care providers. It provides evidence-based guidance and tools for assessing and managing priority mental health and substance use disorders using clinical decision-making protocols. Essential principles for providing mental health care include promoting respect and dignity for the individuals seeking care; using effective communication skills to ensure care is nonjudgmental, nonstigmatizing, and supportive; and conducting comprehensive assessments (mhGAP Intervention Guide, 2016). Nurses can provide this care using the three components of EBP: best available research, tapping into client preferences, and applying their own expertise.

Best Available Research

Nurses may wonder, “How do I know what evidence-based nursing interventions to include in the nursing care plan regarding mental health care?” Finding the best available research may seem daunting to the new nurse, but it is as simple as consulting a current, evidence-based nursing care planning resource when planning nursing interventions individualized to each client’s needs. There are several sources nurses can reference to select nursing interventions. Many agencies have care planning tools and references included in the electronic health record that are easily documented in the client chart. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an evidence-based resource center (Substance Abuse and Mental Health Services Administration, n.d.).

Client Preferences

Within the evidence-based practice formula is the process of evaluating how well the new evidence works when applied to individual clients in a clinical setting. In other words, how do the evidence and the client’s preferences

connect? It is important for clinicians to realize that although the evidence may point toward making a change, the client's preferences may not. What modifications need to be made so that the new information is applicable to the client and accords with the client's preferences? As with any nursing-client interaction, the goal is to reach the best client outcomes.

Nursing Expertise

There are different levels of mental health nursing expertise based on degree and licensing. The bachelor's level nurse learns about evidence-based practice (EBP) through their own use of PICOT (Population/Problem, Intervention, Comparison, Outcomes, and Time) based projects, which translate their research into practice (Grys, 2022). According to Grys (2022), the PICOT format provides focus to the literature search and is key to clinical application of evidence.

Nurses prepared at the doctoral levels may perform actual research that translates into new approaches and changes to the knowledge base (Grys, 2022), as may those with a master of science in nursing (MSN). Nurses may become experienced at using the **quality improvement (QI) process** through the requirements of their degree program (Grys, 2022), or in the workplace. As the name implies, QI involves looking at a problem; utilizing data, decision-making tools, and testing; and making an improvement—this then becomes the new evidence-based practice (QSEN Institute, 2022). The results of QI and EBP research are used specifically at the client care level of practice.

Define a Clinical Question in PMH Nursing

As stated, professional databases and scholarly resources are available with evidence to answer clinical questions. Steps in the process are:

- Nursing recognition of a problem and nursing inquiry
  - What contributes to client readmissions? Do they forget to pick up their medication, or miss their clinic appointments? Would it help for us to call and remind them?
- Phrase the inquiry as a clinical question
  - For discharged clients, would follow-up phone calls result in higher percentage of adherence to post-hospital care?
- Format the question as PICOT
  - P=discharged clients
  - I=follow-up phone call within twenty-four hours to check on medications and clinic appointments
  - C=no phone call
  - O=readmissions reduced by 25 percent
  - T=over six months
- Utilize the question and the PICOT to identify key search terms
  - *Follow-up phone calls*; *Readmissions*
- Enter the terms in the Search field of the database
  - On CINAHL, enter in the Search fields – *nurse follow-up phone call* AND *reduce readmissions*
  - Select from the resulting list of articles

Evaluating Client Outcomes

After application of the EBP model, the nurse evaluates how the interventions worked for the client. At this time, adjustments can be made to the intervention to make the treatment plan most applicable to the individual. Again, the goal of the entire process is for the client to have the best possible outcomes based on the best evidence-based practice for their situation.

LINK TO LEARNING

Often, an evidence-based practice committee responds to client care questions that come up; members are assigned parts of the research process and share all of the information in order to make an informed decision. They can then base interventions on that new information, try them with the client, and evaluate outcomes for applicability and success. Johns Hopkins Nursing's Center for Nursing Inquiry provides an Inquiry Toolkit

(https://openstax.org/r/77inquirytoolkit) for helping nurses and students during an inquiry project.

Research Evidence on Representation and Acceptance of Mental Health in the Community

Mental health practitioners, including psychiatrists, social workers, nurses, clinical psychologists, and therapists, are in a position to increase the representation and acceptance of mental health in the community. These professionals work with people and their mental health on a daily basis. Their job experiences, intellectual knowledge, research, and involvement in policy change make them "practical experts" (Morant 2006, p. 819) in mental health care.

Morant (2006) reminds us that over the last fifty years, much has changed in the way that society views mental health, with the move from institutional to community care of mental illness. A review of research in Morant's article reveals that the differences in care provided can be partly attributed to age and location of the practitioner. Older practitioners were trained in the years of institutionalized clients so it may be difficult for them to transition to today's treatment. Comparisons of the way that different communities represent and accept mental health can be seen across the globe. In France, long-term therapy and lack of community care are the norm, whereas in England, short-term therapy and lack of financial resources is more prominent. In the United States, it is evident that more research is needed in the area of mental health due to the increase in symptoms since the COVID-19 pandemic. The *White House Report on Mental Health Research Priorities* (2023) details the need for more U.S. research aimed at inequities, especially in areas with poorer mental health outcomes. This would include research to determine ways to create more community-based service areas.

Access to Care: Gaps in the System

Research conducted by the White House (2023) has identified several system gaps. The first is the need for better coordination of mental health and substance use services. The use of "wraparound services" (p. 14) for the acutely mentally ill client is effective because it involves engaging a multiple disciplinary approach to care. This includes training providers to be proficient in recognizing the signs and symptoms of mental illness and substance use disorder. This approach would also focus on the physical effects of substance use disorder across the life span.

The next big system gap relates to adolescents. Research has revealed a connection between mental illness and use of social media, particularly in the context of body image. More research is needed to determine ways that social media could be used to positively impact mental health of both individuals and communities. School systems have potential to create mental health teaching programs that would address the needs of children from elementary school through college, so there is a need for research on how to implement and what to include in such programs.

Societal View

Although stigma still exists surrounding mental health, there are more programs and resources available to educate the public. Through these efforts, it is becoming more widely accepted that prevention and early symptom recognition have positive effects on community mental health. Holt and DeTore (2021) share that the most promising preventive mental health efforts have been school-based. One such program is the Sandy Hook Promise (2023), which was developed after the December 2012 shootings at the Sandy Hook Elementary School in Newtown, Connecticut. This important program teaches young people to know the signs of potential gun violence.

Some workplaces have Employee Assistance Programs, which provide access to facilities providing time-limited free mental health services. Public service announcements on TV, radio, and social media provide information and resources to help reduce depression, anxiety, and suicidality. All of these resources help to increase general knowledge, decrease stigma, and promote a more positive societal view of mental health.

LINK TO LEARNING

This video provides mental health professionals with an introduction to evidence-based practice (https://openstax.org/r/77evidencebased) that can be used for better client care.

Summary

1.1 Mental Health and Mental Illness

Nurses working in all settings must understand the difference between mental health and mental illness. Nurses will come across clients in various stages of the mental health continuum in every setting, age group, and community. Gathering both subjective and objective data during the nursing assessments is an important part of nursing practice. A nurse uses therapeutic communication to ask questions and gather subjective data about how the client is feeling in order to determine the effectiveness of the treatment plan. Psychiatric nurses not only assess and provide care for the client's health-care needs, but are also involved in education, administration, and research. Developing therapeutic nurse-client relationships is a core element of the scope of the psychiatric-mental health nursing practice.

1.2 Risk and Protective Factors of Mental Health

Familiarity with the many risk and protective factors for mental illness is an important part of the nursing process in caring for individuals with potential or diagnosed mental health disorders. While some risk and protective factors are biological and/or genetic, others are caused by psychological and external circumstances and characteristics, such as level of self-esteem, resilience, healthy behaviors, level of activity, social support system, religious/cultural beliefs, substance use, childhood development, and chronic illness.

Nursing assessments must include the use of standardized tools to determine risks and strengths in each client. The nurse-client therapeutic relationship should feature active listening while gathering client data, and the use of critical thinking in order to piece together an appropriate treatment plan.

1.3 Mental Health Stigma

Stigma is still pervasive in attitudes surrounding those with mental illness. In fact, nearly two-thirds of people with diagnosable mental health disorders do not seek treatment due to the stigma of mental illness (Hegner, 2000). Self-stigma, public stigma, and institutional stigma each affect people in the way they seek treatment and look at themselves in relation to the world around them and influence their ability to function on a daily basis. Prejudice and discrimination can cause barriers to accessing health care, finding safe and affordable living, getting a job, maintaining social relationships, and feeling like a contributing part of society.

Nurses can model acceptance in the care they provide. They can also educate individuals, families, caregivers, and communities about the detrimental effects of stigma and ways to increase positive awareness. Nurses should also take the time to perform self-care because without taking care of themselves, they will not be able to provide the best care for others.

1.4 Mental Health Recovery and Wellness

Recovery is an overarching term that covers both physical and mental health. It is continuous but nonlinear in nature. The steps in the recovery process assist the client in making choices to determine their own life course. Acceptance, hope, insight, and taking action have a positive effect on increasing one's self-esteem. The higher the self-esteem, the healthier a person can become. Learning to rebuild relationships, set boundaries, have gratitude, and focus on the positives all help to maintain wellness through and beyond the recovery journey.

1.5 Integration of Research- and Evidence-Based Standards

Research is an important nursing role and tool that provides the foundation for evidence-based practice. The main types of empirical research performed are qualitative, quantitative, and sometimes a mixed method. It is imperative to use credible databases and websites to gather the information for a literature search based upon the evidence pyramid. Although evidence-based practice is the basis of good nursing practice, the nurse must evaluate how evidence-based interventions work with specific clients. If the evidence is not applicable to the client being served, it will diminish the chance of a positive outcome. There are several levels of nursing expertise and each one takes on a different kind of research—PICOT, QI, and new research—that lends knowledge to evidence-based practice.

Key Terms

discrimination actions or behaviors taken against a group of people because of prejudice

dysfunctional relationship relationship in which unhealthy behavior patterns exist among members of a group
empirical research scholarly work from observation and measurement of experience, in contrast to theory
explicit bias attitudes people are aware of, endorse, and communicate
implicit bias prejudice evidenced in attitudes beyond consciousness or control
mental health state of well-being in which individuals realize their own abilities, cope with the normal stresses of life, work productively, and contribute to their community
mental illness health condition involving changes in emotion, thinking, or behavior (or a combination of these) associated with emotional distress and problems functioning in social, work, or family activities
prejudice beliefs, thoughts, feelings, and attitudes someone holds about a group, not based on personal experience
professional intimacy nurse gains an understanding of the client through acceptance, respect, empathy, recognition, and compassion
psychosocial rehabilitation helps individuals develop the social, emotional, and intellectual skills needed to live happily with the smallest amount of professional assistance manageable
quality improvement (QI) process involves looking at a problem; utilizing data, decision-making tools, and testing; and making an improvement
risk factor any number of things that increase the chances of developing a mental illness
stereotyping when someone has a generalized and prejudiced opinion about members of a particular group of people
stigma cluster of negative attitudes and beliefs that motivates the general public to fear, reject, avoid, and discriminate against a group of people
traumatic brain injury (TBI) brain injury that can cause short- or long-term problems with a person being unable able to think, function, move, and communicate normally

Assessments

Review Questions

1. Nurse Jon is caring for a client with severe anxiety. Their anxiety has recently increased so much that the client is unable to go to work. Identify the category of the continuum of mental health to mental wellness that applies to Nurse Jon's client.
   a. emotional problems or concerns
   b. well-being
   c. mental illness
   d. between well-being and emotional problems

2. Student nurse DeShawna just began clinical on a behavioral health unit. What is an example of a statement DeShawna may make that demonstrates her need for assistance?
   a. “I have completed all parts of the nursing assessment.”
   b. “This client seems fine so I did not complete a mental status exam.”
   c. “I have gathered the names of all the medications this client takes.”
   d. “I have assessed for suicidal ideation.”

3. What is the scope of psychiatric-mental health nursing practice?
   a. assessment, education, medication administration, and screening for suicide risk
   b. assessment, medical diagnosis, giving orders, writing prescriptions, admitting, and discharging
   c. assisting providers, assisting with ADLs, monitoring clients, offering support, promoting safety
   d. assessment, counseling, teaching coping skills, giving advice, listening

4. A psychiatric nurse is working in a community mental health center. They are completing an assessment on a 32-year-old pregnant female presenting with depression. They note that the client has not answered the questions about alcohol and tobacco use. Why is it important to gather this information?
   a. This information is not a pertinent part of the assessment process for a community mental health client.
   b. This information will help the health-care team in all aspects of caring for the client, especially since

she is pregnant.
c. This information is not important as it will have no long-term effects on the client's unborn child.
d. This information is optional in relation to mental health care.

5. A client of the local mental health clinic arrives for their appointment out of breath, hair a mess, and clothing askew. The receptionist tells the client, "You are fifteen minutes late. I will have to see if the doctor can still see you." The client responds, "I know I am late. I can explain, my mother-in-law had a bad night. She lives with my husband and me. I am just so tired of taking care of her." This example falls under what category of risk factors?
a. genetic comorbidities
b. psychological factors
c. social factors
d. victimization

6. Nurse Simon has just completed a psychosocial assessment of his client Juan. During the assessment, Nurse Simon listens to Juan and tries to make Juan feel respected by showing compassion and empathy. What method is Nurse Simon using?
a. the therapeutic relationship
b. risk assessment
c. spiritual awareness
d. resilience strategy

7. To keep the plan of care client-centered, what important assessment should the nurse do after identifying several risk factors for substance misuse in a client?
a. contact a rehab center for an intake assessment
b. perform a client strengths assessment
c. ask the psychiatrist to screen for depression
d. complete a health assessment

8. A nurse is teaching a therapeutic group about reducing the stigma of taking psychiatric medications. One of the participants raises his hand and states, "I don't want to take medication because I am afraid what other people will think of me." What is an appropriate response by the nurse?
a. "Why do you care what other people think?"
b. "You don't need to tell anyone you are taking medication."
c. "Medication to help your brain is just as important as it is for any other body part."
d. "People can be really mean sometimes, can't they?"

9. A person with mental illness does not want to seek care because of the shame they feel for being sick. What type of stigma is this related to?
a. self-stigma
b. caregiver stigma
c. institutional stigma
d. public stigma

10. A 45-year-old male with schizophrenia has been denied the rental of an apartment due to his mental health. Besides being illegal, what is this most closely related to?
a. stigma
b. prejudice
c. discrimination
d. hate crimes

11. A student nurse is studying for an exam on the recovery process. What is an example of a statement that demonstrates their understanding to their study group?

a. "The majority of people with mental illness or substance use do not recover."
b. "The recovery process is dictated by the health-care team."
c. "Recovery is a nonlinear process based on instilling hope."
d. "In recovery, a client needs to advocate for themselves right from the start."

12. Maria is trying to create a psychiatric-mental health wellness routine. She has just seen her therapist and is writing notes from their session about wellness. What is an example from her notes that would demonstrate her understanding?
a. exercising sixty minutes three to five days per week
b. exercising thirty minutes three to five days per week
c. exercising forty-five minutes three to five days per week
d. exercising sixty minutes seven days per week

13. What should the psychiatric nurse do to assist individuals and families to understand the recovery process and the resources available to them?
a. psychoeducation
b. create a care plan for them
c. refer them to a psychiatrist
d. refer them to a website to read on their own

14. A nurse wants to head a project to improve medication administration on their unit. They work with other nurses on the unit to find evidence-based practice. What type of a research project is this?
a. qualitative
b. PICOT
c. mixed methods
d. QI

15. Nurse Sheila makes adjustments to the client's plan of care after talking with the client. This is most likely an example of what component of the EBP model?
a. best available research
b. client preferences
c. nursing expertise
d. review of evidence

16. A community psychiatric nurse is reviewing data to find gaps in the local health-care system. What type of service yields the best outcomes for the acutely ill client?
a. wraparound services
b. community health services
c. facility mental health services
d. individual therapy services

17. What should the nurse do to locate credible sources of research in order to practice evidence-based interventions?
a. The nurse should ask a supervisor for help locating credible sources.
b. The nurse should access CINAHL or another professional database.
c. The nurse should perform a Wikipedia search.
d. The nurse should ask a librarian to gather information for them.

Check Your Understanding Questions

1. Define psychiatric-mental health.

2. What are some common physical responses related to stress?

3. Why do nurses complete a spiritual assessment as part of the psychosocial assessment?

4. Describe barriers to getting mental health treatment.
5. Identify the five stages of psychiatric-mental health recovery.

Reflection Questions

1. What is an example of therapeutic communication that might take place during the nursing assessment?
2. As a nurse, what ways could you educate people to help decrease the stigma surrounding mental health?
3. In what ways can nurses help their clients who have the potential for or are experiencing a mental illness or substance misuse?
4. Using the chart in this chapter describing the levels of evidence, what are two examples of a high- and a low-level source?
5. Which level do you think you would use if you wanted to make a hospital unit's admission procedures more effective?
6. If your clinical question was: "Would the addition of a checklist for unit admissions result in more relevant data being obtained over six months?" What would your PICOT format look like?

What Should the Nurse Do?

1. An experienced psychiatric RN is caring for a 60-year-old male client without a home who just arrived on a hospital behavioral health unit. The nurse has asked the client to describe in his own words his reason for seeking care. The client has shared that he is often bullied on the streets due to his unkempt appearance. The nurse notes that in addition to body odor, the client smells of alcohol and urine. The client relates that he wasn't always homeless; he used to have a good job, a house, and was married. He lost his job due to a layoff, and then everything else seemed to fall apart. His wife left him after the bank took the house when he could no longer make the payments. He did not have any close friends or family who he could stay with long-term. He found that he quickly wore out his welcome of sleeping on their couches. He tells the nurse he began drinking alcohol to cope with his losses. He cannot give the nurse an exact number of drinks that he takes per day.
   What additional aspects of the psychosocial assessment should the nurse explore?

Competency-Based Assessments

1. Look at the mental health continuum and give examples for each level of functioning.
2. View the video Why Students Should Have Mental Health Days (https://openstax.org/r/77mentalhealthdays). Write two paragraphs connecting this video's main focus on overall health (that includes taking time to protect your own mental health) to what you could teach a client about taking care of their mental health.
3. Search the internet and find two local resources that you could share with a client who needs a safe place to receive mental health care.

References

Abderholden, S. (2019, March 7). *It's not stigma, it's discrimination* [Blog]. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/March-2019/It-s-Not-Stigma-It-s-Discrimination

Administration for Children & Families. (2021). *Child maltreatment 2019.* [Report]. U.S. Department of Health & Human Services. https://www.acf.hhs.gov/cb/report/child-maltreatment-2019

American Mental Health Association. (2023). Risk and protective factors. https://www.americanmentalwellness.org/prevention/risk-and-protective-factors/

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

American Psychiatric Association. (2022). What is mental illness? https://www.psychiatry.org/clients-families/what-is-mental-illness

American Psychiatric Association. (2023). *Stigma, prejudice and discrimination against people with mental illness.* https://www.psychiatry.org/clients-families/stigma-and-discrimination

American Psychiatric Nurses Association. (2022). *Psychiatric-mental health nursing: Scope and standards of practice* (3rd ed.). APNA. https://www.nxtbook.com/apna/apna/psychiatric_mentalhealthnursing_3/index.php#/p/ii

American Psychological Association (APA). (2020). Abstract and key words guide. *Publication manual of the American Psychological Association* (7th ed.). https://doi.org/10.1037/0000165-000

American Psychological Association. (2012, January 1). Recovery principles. *Monitor on Psychology*, *43*(1). https://www.apa.org/monitor/2012/01/recovery-principles

André, N., & Baumeister, R. F. (2023). Three pathways into chronic lack of energy as a mental health complaint. *European Journal of Health Psychology*, *30*(2), 87–101. https://doi-org.easydb.angelo.edu/10.1027/2512-8442/a000123

Atunah-Jay, S. J., Basappa, S. N., Fischer, K., Taylor-Desir, M., & Phelan, S. M. (2022). The interplay between group identity, suicidality, and bullying in midwestern middle school youth. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, *29*(3), 18–42. https://doi-org.easydb.angelo.edu/10.5820/aian.2903.2022.18

Ayhan, F., & Üstün, B. (2021). Examination of risk assessment tools developed to evaluate risks in mental health areas: A systematic review. *Nursing Forum, 56*, 330–340. https://doi-org.easydb.angelo.edu/10.1111/nuf.12557

Bermudez, N. (2021). Formulating well-written clinical practice questions and research questions. *Nursing & Health Sciences Research Journal, 4*(1), 70–82. https://scholarlycommons.baptisthealth.net/cgi/viewcontent.cgi?article=1113&context=nhsrj

Bring Change to Mind (2023). Public service announcements. https://bringchange2mind.org/learn/psas/

Britannica Dictionary. (2023). Stigma. In *Britannica Dictionary*. Retrieved June 10, 2023, from https://www.britannica.com/dictionary/stigma

Brown, A., & Hardey, S. (2023). Stigma impacts substance abuse and mental health care in veterans. https://americanaddictioncenters.org/veterans/stigma-impacts

Center for Substance Abuse Treatment (US). (2014). *Trauma-informed care in behavioral health services.* https://www.ncbi.nlm.nih.gov/books/NBK207201/

Centers for Disease Control and Prevention. (2021a). *Mental health.* https://www.cdc.gov/mentalhealth/index.htm

Centers for Disease Control and Prevention. (2021b). *Preventing elder abuse.* https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

Centers for Disease Control and Prevention. (2022). Get the facts about TBI. https://www.cdc.gov/traumaticbraininjury/get_the_facts.html

Central Michigan Libraries. (2022) Website research: URLs. Retrieved April 23, 2023, from https://libguides.cmich.edu/web_research/urls.

Cherry, K. (2023). How does implicit bias influence behavior? *Verywell Mind.* https://www.verywellmind.com/implicit-bias-overview-4178401

Chisholm, J., & Petrakis, M. (2022). Clinician perspectives and sense of efficacy about the implementation of recovery-oriented practice in mental health. *British Journal of Social Work*, *52*(3), 1380–1397. https://doi-org.easydb.angelo.edu/10.1093/bjsw/bcab125

Cleveland Clinic. (2023). Endorphins. https://my.clevelandclinic.org/health/body/23040-endorphins

Connect Online. (n.d.). Risk factors, protective factors, & warning signs. In NAMI New Hampshire. Retrieved April 15, 2023 from https://theconnectprogram.org/resources/risk-protective-factors/

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 1*(1), 16–20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/

Coveney, S. (2023). The gender gap in mental health. *News Medical Life Sciences*. https://www.news-medical.net/health/The-Gender-Gap-in-Mental-Health.aspx

Dalcin, L. R., Ferreira Neto, J. L., & dos S. Guzella, M. (2022). Vulnerability factors for psychological suffering during social distancing. *Psicologia: Teoria e Prática*, *24*(3), 1–16. https://doi-org.easydb.angelo.edu/10.5935/1980-6906/ePTPCP14194.en

Dalum, H.S., Pedersen, I. K., Cunningham, H., & Eplov, L. F. (2015). From recovery programs to recovery-oriented practice? A qualitative study of mental health professionals' experiences when facilitating a recovery-oriented rehabilitation program. *Archives of Psychiatric Nursing, 29*, 419–425, http://dx.doi.org/10.1016/j.apnu.2015.06.013.

Dell, N. A., Long, C., & Mancini, M. A. (2021). Models of mental health recovery: An overview of systematic reviews and qualitative meta-syntheses. *Psychiatric Rehabilitation Journal*, *44*(3), 238–253. https://doi-org.easydb.angelo.edu/10.1037/prj0000444

Family Addiction Specialist. (2023). 10 lessons of addiction recovery that are rooted in psychology. Retrieved April 20 2023, from https://www.familyaddictionspecialist.com/blog/10-lessons-of-addiction-recovery-that-are-rooted-in-psychology

Fei, S. et al. (2021). Attachment, self-esteem, and psychological distress: A multiple-mediator model in *The Professional Counselor*, *11*(2), 129–142. https://files.eric.ed.gov/fulltext/EJ1300191.pdf

Ferro, A. L., & Yoder, L. H. (2023). A scoping review of graduate nurses' education and use of QSEN Competencies. *Military Medicine, 189*(suppl 1), 45–50.

FRIENDS National Center. (2023). Protective Factors. https://friendsnrc.org/prevention/protective-factors/

Galimidi, N., & Shamai, M. (2022). Interactions between mental illness recovery processes in the family. *Family Relations*, *71*(1), 408–425. https://doi-org.easydb.angelo.edu/10.1111/fare.12594

Garza Varela, J. P., de la Cruz-de la Cruz, C., Leija Guerrero, J. G., Sánchez Rodríguez, K. E., & Kawas Valle, O. (2021). Positive reappraisal as a stress coping strategy during the COVID-19 pandemic. *Salud Mental*, *44*(4), 177–184. https://doi-org.easydb.angelo.edu/10.17711/SM.0185-3325.2021.023

Georgetown Behavioral Health Hospital (2023, June 3). What are the 5 stages of recovery for mental health? https://www.gbhoh.com/what-are-the-5-stages-of-recovery-for-mental-health/

Glasner, J., Baltag, V., & Ambresin, A. E. (2021). Previsit multidomain psychosocial screening tools for adolescents and young adults: A system review. *Journal of Adolescent Health*, 68, 449–459. https://www.jahonline.org/article/S1054-139X(20)30600-5/pd

Gold, A. (2016, July 12). Why self-esteem is important for mental health. National Alliance on Mental Illness (NAMI). https://www.nami.org/Blogs/NAMI-Blog/July-2016/Why-Self-Esteem-Is-Important-for-Mental-Health

Grys, C. (2022). Evidence-based practice, quality improvement, and research: A visual model. *Nursing, 52*(11), 47–49.

GW School of Medicine & Health Sciences. (n.d.). Clinical FICA tool. https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool

Haber, J. (2000). Hildegard Peplau: The psychiatric nursing legacy of a legend. *Journal of American Psychiatric Nurses Association, 6*(2), 56–62. https://journals-sagepub-com.easydb.angelo.edu/doi/epdf/10.1067/mpn.2000.104556

Happell, B., Waks, S., Bocking, J., Horgan, A., Manning, F., Greaney, S., Goodwin, J., Scholz, B., van der Vaart, K. J., Allon, J., Hals, E., Granerud, A., Doody, R., Chan, S. W. C., Lahti, M., Ellilä, H., Pulli, J., Vatula, A., Platania-Phung, C., & Browne, G. (2021). "But I'm not going to be a mental health nurse": Nursing students' perceptions of the

influence of experts by experience on their attitudes to mental health nursing. *Journal of Mental Health*, *30*(5), 556–563. https://doi-org.easydb.angelo.edu/10.1080/09638237.2019.1677872

Harold, L. (2023, January 3). What is dysfunctional behavior in families? *Verywell mind*. https://www.verywellmind.com/dysfunctional-defined-2610364

Harvard Health Publishing. (2020, July 6). Understanding the stress response. Retrieved April 16, 2023, from https://www.health.harvard.edu/staying-healthy/understanding-the-stress-response

Hasani, S., Aung, E. & Mirghafourvand, M. (2021). Low self-esteem is related to depression and anxiety during recovery from an ectopic pregnancy. *BMC Women's Health*, *21*(1), 1–8. https://doi-org.easydb.angelo.edu/10.1186/s12905-021-01467-2

Heath, S. (2017). Understanding stigma as a healthcare barrier. *TechTarget*. https://clientengagementhit.com/news/understanding-stigma-as-a-mental-healthcare-barrier?utm_content=b1281c3eaa9e820f79ecee0fe1311937&utm_campaign=MHD%25206%252F8%252F17&utm_source=Robly.com&utm_medi

Hegner, R. E. (2000). Dispelling the myths and stigma of mental illness: The surgeon general's report on mental health. *Issue Brief*, 754. https://www.ncbi.nlm.nih.gov/books/NBK559750/

Higgins, A. Morrissey, J. Doyle, L. Bailey, J. Gill, A. (2015). Best practice principles for risk assessment and safety planning for nurses working in mental health services. Dublin: Health Service Executive. *Office of the Nursing & Midwifery Service Directory*. 1–25. http://hdl.handle.net/10147/559255. Retrieved April 15, 2023, from https://www.lenus.ie/bitstream/handle/10147/559255/Best+Principles+Risk+Assessment.pdf?sequence=1

Holt, D. J., & DeTore, N. R. (2021). Prevention of psychiatric illness in the community: Seeds of change. *Psychiatric Annals*, *51*(6), 255+. https://link-gale-com.easydb.angelo.edu/apps/doc/A679578458/AONE?u=txshracd2485&sid=ebsco&xid=ee232fad https://doi.org/10.1016/j.drugpo.2020.103063

Illingworth, P. (2021). How do we engage global communities in the de-stigmatisation of mental illness? *British Journal of Nursing*, *30*(3), 184–187. https://doi-org.easydb.angelo.edu/10.12968/bjon.2021.30.3.184

Jessell L. & Stanhope, V. (2022). "How do you try to have anyone comply or at least be pliable with you if that person's not even medicated?": Perspectives on the use of psychiatric medication within recovery-oriented practice. Psychiatric Rehabilitation Journal, *45*(2), 153–159. ISSN: 1095-158X https://doi.org/10.1037/prj0000493

John Hopkins Medicine. (2023). Evidence-based practice. Retrieved April 22, 2023, from https://www.hopkinsmedicine.org/nursing/center-nursing-inquiry/nursing-inquiry/evidence-based-practice.html

Joint Commission. (2024). *Hospital: 2024 National Patient Safety Goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-national-patient-safety-goals/

Kaggwa, M. M., Najjuka, S. M., Mamun, M. A., Griffiths, M. D., Nyemara, N., & Ashaba, S. (2023). Involvement and burden of informal caregivers of clients with mental illness: the mediating role of affiliated stigma. *BMC Psychiatry*, *23*(1), 1–9. https://doi-org.easydb.angelo.edu/10.1186/s12888-023-04553-x

Kesavayuth, D., Shangkhum, P., & Zikos, V. (2022). Building physical health: What is the role of mental health? *Bulletin of Economic Research, 74*(2), 457–483. https://doi-org.easydb.angelo.edu/10.1111/boer.12304

Kraybill, O. (2019, May 31). Inflammation and mental health symptoms. *Psychology Today*. https://www.psychologytoday.com/us/blog/expressive-trauma-integration/201905/inflammation-and-mental-health-symptoms

Linney, S. (2022, September 13). Why acceptance is an essential part of recovery. American Addiction Centers. Retrieved April 20, 2023, from https://americanaddictioncenters.org/blog/acceptance-is-part-of-recovery

Ma, Z., & Nan, X. (2018). Role of narratives in promoting mental illnesses acceptance. *Atlantic Journal of Communication*, *26*(3), 196–209. https://doi-org.easydb.angelo.edu/10.1080/15456870.2018.1471925

Macfarlane A. (2018). Gangs and adolescent mental health: A narrative review. *Journal of Child & Adolescent*

Trauma, *12*(3), 411–420. https://doi.org/10.1007/s40653-018-0231-y

Martin, S. (2018, June 29). Dysfunctional family dynamics: Don't talk, don't trust, don't feel. *PsychCentral*. https://psychcentral.com/blog/imperfect/2018/06/dysfunctional-family-dynamics-dont-talk-dont-trust-dont-feel#What-is-a-dysfunctional-family?

Mayo Clinic. (2023). Mental health: Overcoming the stigma of mental illness. https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477

McCusker, K., & Gunaydin, S. (2015). Research using qualitative, quantitative or mixed methods and choice based on the research. *Perfusion*, *30*(7), 537–542. https://doi-org.easydb.angelo.edu/10.1177/0267659114559116

Medline Plus. (2019). Dual diagnosis. *NIH National Library of Medicine*. https://medlineplus.gov/dualdiagnosis.html

Mental Health America. (2023). The state of mental health in America. Retrieved April 21, 2023, from https://mhanational.org/issues/state-mental-health-america

Mental Health First Aid USA. (2019, July 11). Four ways culture impacts mental health. National Council for Mental Wellbeing. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

Mental Health First Aid. (2022, January 18). How protective factors can promote resilience. National Council for Mental Wellbeing, https://www.mentalhealthfirstaid.org/2022/01/how-protective-factors-can-promote-resilience/

Mizock, L., & Russinova, Z. (2013). Racial and ethnic cultural factors in the process of acceptance of mental illness. *Rehabilitation Counseling Bulletin, 56*(4), 229–239. https://journals-sagepub-com.easydb.angelo.edu/doi/pdf/10.1177/0034355213475823

Morant, N. (2006). Social representations and professional knowledge: The representation of mental illness among mental health practitioners. *British Journal of Social Psychology*, *45*(4), 817–838. https://doi-org.easydb.angelo.edu/10.1348/014466605X81036

National Alliance on Mental Illness (NAMI). (n.d.-a) Stigma free. Retrieved April 17, 2023, from https://www.nami.org/Get-Involved/Pledge-to-Be-StigmaFree

National Alliance on Mental Illness (NAMI). (n.d.-b). Psychosocial Treatments. Retrieved April 20, 2023, from https://www.nami.org/About-Mental-Illness/Treatments/Psychosocial-Treatments.

National Center for Injury Prevention and Control, Division of Violence Prevention. (2022, April 6). Fast facts: Preventing adverse childhood experiences. https://www.cdc.gov/violenceprevention/aces/fastfact.html

National Council of State Boards of Nursing (NCSBN). (2023). *Next Generation NCLEX: NCLEX-RN Test Plan.* Chicago: NCSBN.

National Institute on Neurological Disorders and Stroke. (n.d.). Traumatic brain injury. https://www.ninds.nih.gov/health-information/disorders/traumatic-brain-injury-tbi

Office of Federal Contract Compliance Programs. (2009, January 1). *ADA Amendments Act of 2008 frequently asked questions.* U.S. Department of Labor. https://www.dol.gov/agencies/ofccp/faqs/americans-with-disabilities-act-amendments

Petros, R. & Solomon, P. (2021). How adults with serious mental illness learn and use wellness recovery action plan's recovery framework. *Qualitative Health Research, 31*(4), 631–642. https://journals.sagepub.com/doi/abs/10.1177/1049732320975729?journalCode=qhra

Prakash, J., Chatterjee, K., Srivastava, K., Chauhan, V., & Chail, A. (2020). Role of various lifestyle and behavioral strategies in positive mental health across a preventive to therapeutic continuum. *Industrial Psychiatry Journal*, *29*(2), 185–190. https://doi-org.easydb.angelo.edu/10.4103/ipj.ipj_126_20

Prevention United. (n.d.) Risk and resilience. Retrieved April 15, 2023, from https://preventionunited.org.au/how-prevention-works/risk-and-resilience/

Quality and Safety Education for Nurses (QSEN) Institute. (2022). QSEN Competencies. https://www.qsen.org/

competencies-pre-licensure-ksas

Rakitzi, S., Georgila, P., & Becker-Woitag, A. P. (2021). The recovery process for individuals with schizophrenia in the context of evidence-based psychotherapy and rehabilitation: A systematic review. *European Psychologist, 26*(2), 96–111. https://doi.org/10.1027/1016-9040/a000400

Regis College. (2023, January 30). *Self-care for nurses:6 tips and strategies*. Retrieved April 18, 2023, from https://online.regiscollege.edu/blog/self-care-for-nurses/

Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558–567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

Ross, E. J., Graham, D. L., Money, K. M., & Stanwood, G. D. (2015). Developmental consequences of fetal exposure to drugs: What we know and what we still must learn. *Neuropsychopharmacology: Official Publication of the American College of Neuropsychopharmacology*, *40*(1), 61–87. https://doi.org/10.1038/npp.2014.147

Sandy Hook Promise. (2023). Know the signs. Save lives. https://www.sandyhookpromise.org/our-programs/program-overview/

Solomon, B., Sutton, D., & McKenna, B. (2021). The experience and meaning of recovery-oriented practice for nurses working in acute mental health services. *International Journal of Mental Health Nursing,* 30, 963–974 doi: 10.1111/inm.12851

Spector, H. (2016, October 5). Client or Client? Using the right lingo in your practice. *Simple Practice*. Retrieved April 16, 2023, from https://www.simplepractice.com/blog/client-client-using-right-lingo-practice/

Stanley, J., Gale, B. M., & Mossburg, S. E. (2023). The role of undergraduate nursing education in patient safety. *PSNet*. https://psnet.ahrq.gov/perspective/role-undergraduate-nursing-education-patient-safety

Stull, L. G., McGrew, J. H., Salyers, M. P., & Ashburn-Nardo, L. (2013). Implicit and explicit stigma of mental illness: attitudes in an evidence-based practice. *The Journal of Nervous and Mental Disease*, *201*(12), 1072–1079. https://doi.org/10.1097/NMD.0000000000000056

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *SAMHSA's working definition of recovery*, https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). Psychosocial interventions for older adults with serious mental illness. Retrieved April 15, 2023 from https://store.samhsa.gov/sites/default/files/pep21-06-05-001.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *Recovery and recovery support*. Retrieved April 18, 2023, from https://www.samhsa.gov/find-help/recovery

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.-a). Risk and protective factors. Retrieved April 15, 2023, from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.-b) School materials for a mental health friendly classroom: training package https://www.prevention.org/Resources/2e2ba6ce-1e47-40ec-b49d-f7952b1f95a1/School%20Materials%20for%20a%20Mental%20Health%20Friendly%20Classroom.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.-c). Evidence-based practices resource center. https://www.samhsa.gov/resource-search/ebp

Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health.* United States Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK424857/

Tsur, N., & Haller, C.S. (2020). Physical and mental health and functioning among traumatic brain injury close relatives: The role of posttraumatic stress symptoms, *Family Process, 59*(2), 666–680, Family Process Institute doi: 10.1111/famp.12454

U.S. Department of Health & Human Services. (2020, January 24). Strategic goal 3: Strengthen the economic and social well-being of Americans across the lifespan. https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.htm

University of Michigan Human Resources. (2024). *Section 1: What you need to know about mental health problems and substance misuse.* https://hr.umich.edu/benefits-wellness/health-well-being/mhealthy/faculty-staff-well-being/mental-emotional-health/mental-emotional-health-classes-training-events/online-tutorial-supervisors/section-1-what-you-need-know-about-mental-health-problems-substance-misuse

Vela, M.B., et al. (2022). Eliminating explicit and implicit biases in health care: Evidence and research needs. *Annu Rev Public Health*. Apr 5;43:477–501. doi: 10.1146/annurev-publhealth-052620-103528. Epub 2022 Jan 12. PMID: 35020445; PMCID: PMC9172268. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9172268

Vita, A., & Barlati, S. (2018). Recovery from schizophrenia: Is it possible? *Current Opinion in Psychiatry, 31*(3), 246–255. https://doi.org/10.1097/YCO.0000000000000407

Walters, K., & Benjamins, M. R. (2022). Religious beliefs about health and the body and their association with subjective health. *Journal of Religion & Health, 61*(6), 4450–4465. https://doi-org.easydb.angelo.edu/10.1007/s10943-020-01178-2

Ward, T., Haig, B. & McDonald, M. (2022). Translating science into practice in clinical psychology: A reformulation of the evidence-based practice inquiry model. *Theory & Psychology, 32*(3) 401–422. DOI: 10.1177/09593543211059816

Warner, C. H., Appenzeller, G. N., Greiger, T., Belenkiy, S., Breitbach, J., Parker, J., Warner, C. M., & Hoge, C. (2011). Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. *Arch Gen Psychiatry.* 2011;68(10):1065–1071. doi:10.1001/archgenpsychiatry.2011.112. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1107428?resultClick=1

White House. (2023). White House report on mental health research priorities. https://www.whitehouse.gov/wp-content/uploads/2023/02/White-House-Report-on-Mental-Health-Research-Priorities.pdf

Wisconsin Department of Health Services. (2018, November 13). *Adult protective services: Definitions.* https://www.dhs.wisconsin.gov/aps/definitions.htm#Abuse

Witt, W., Wisk, L., Cheng, E., Hampton, J., & Hagen, E. (2012). Preconception mental health predicts pregnancy complications and adverse birth outcomes: A national population-based study. *Maternal & Child Health Journal*, *16*(7), 1525–1541. https://doi-org.easydb.angelo.edu/10.1007/s10995-011-0916-4

World Health Organization. (2016). mhGAP Intervention Guide: Version 2.0. https://www.who.int/publications/i/item/9789241549790

World Health Organization. (2018, March 30). Mental health: Strengthening our response. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Yang, J., & Giummarra, M. (2021). Compulsory and voluntary drug treatment models in China: A need for improved evidence-based policy and practice to reduce the loaded burden of substance use disorders. *International Journal of Drug Policy,* Vol 92, 103063, ISSN 0955-3959.

CHAPTER 2
Fundamentals of Theories and Therapies

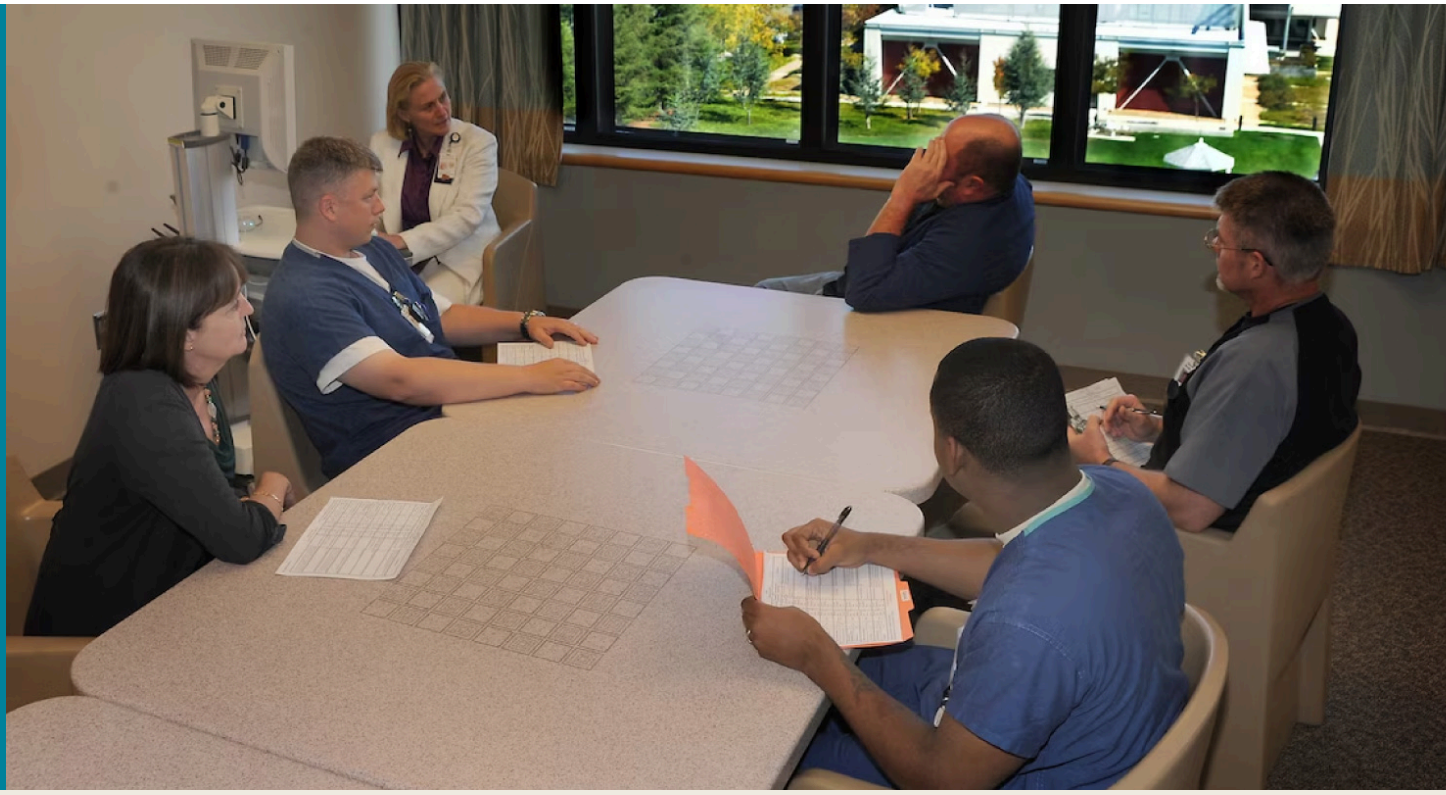


FIGURE 2.1 Psychiatric-mental health nurses are important members of an interdisciplinary team that collaborates to evaluate and treat clients. (credit: U.S. Air Force photo/Staff Sgt. Lillian Moreno, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Clinical professions are evidence-based and founded in theory. The professional specialty of psychiatric-mental health (PMH) nursing addresses brain-based behaviors. Therefore, it seeks theoretical foundations in biological and psychosocial theories. Psychiatric-mental health nursing follows established guidelines based upon the client's state of health. Multiple theories have been developed to account for how the client comes to be in that state. Nurses must understand the different theoretical concepts and interventions to apply in care of the client experiencing mental health alterations. Comprehension of classic and established theories and therapies relevant to psychiatric-mental health nursing provide a foundation for professional nursing practice. Further, this understanding develops the nurse's ability to plan client care that is person-centered. Nurses also benefit from self-awareness, which can come with understanding the impact of psychosocial factors on health, illness, and recovery.

2.1 Psychoanalytic Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define psychoanalytic theories and therapies
- Identify nursing applications of psychoanalytic theories and therapies

Dr. Sigmund Freud (1856–1939) was the founder of psychoanalysis and noted for his theory that provides explanation of mental health, associated influences, and treatments (Mcleod, 2024b). Freud's work on the ego defense mechanisms contributed significantly to the nurse's work in therapeutic communication with clients.

Definitions

Freud's psychoanalytic theory reaches into several areas of mental health and illness. Each area influences the client's experience and leads the practitioner to investigate or assess the areas where distress originates, such as components of the personality and levels of consciousness. The nurse's understanding of personality development can bring insight to nursing approaches and provide the basis for person-centered care.

Personality Development and Levels of Consciousness

Freud theorized that personality develops between the first and fifth years of life and believed that the person's manner of being was set by this age. Freud thought the personality was controlled by the mind and that the mind had a structure that included three elements: the id, the ego, and the superego. Each element has a specific function.

Freud often used the description of an iceberg to visualize the mind; only a tenth of the mind is conscious, while the other 90 percent of the mind is unconscious. The awareness of one's own existence, sensations, thoughts, and surroundings is **consciousness**. It is the part of the mind comprising psychic material of which the individual is aware. Whereas, **unconsciousness** is all the repressed memories, thoughts, and unacceptable feelings a person may have. The unconscious cannot be recalled without a trained therapist. Between these areas, Freud conceptualized the **preconscious** mind where thoughts and feelings are available to the conscious mind though not currently being applied (Mcleod, 2024b).

Id

The **id** is the part of the personality that is the most primitive and exists in infants. The id drives the instincts, reflexes, and needs. It lacks logic and cannot solve problems. It is often manifested by instinctive behaviors that all humans have to communicate and relieve stress and discomfort. Examples are crying, gagging, laughing, and coughing. The id strives to have all needs in check or to reach a sense of pleasure. Once the needs are met, the id-driven behaviors cease. There are other tensions or stresses that cannot be satisfied by these instinctive measures, such as anxiety. At the point of personality development, around the age of two, the ego takes over (Erwin, 2002).

Ego

The **ego** is both physiological and psychological and maturity often emerges around the fourth or fifth year of development. The ego is the part of the personality that experiences, reacts to, and negotiates with the outside world and thus mediates between the primitive drives of the id and the demands of the social and physical environment. Freud labeled this process that the ego goes through **reality testing**, meaning that it satisfies the id through manners that are appropriate and it weighs the positives and negatives of an id demand before reacting.

When the id surfaces that a person is hungry, for example, and wants to be fed to satisfaction, their ego enters and staves off the id with delayed gratification. The ego then synchronizes the id, reality, and the superego to manifest behaviors that are expressive. The ego therefore negotiates with the id to please the superego and is a learned component of the personality that contributes social expectations to meeting demands of reality.

Superego

The superego is the moral compass for the personality, the conscience of the person. The **superego** is the part of the personality representing the conscience, formed in early life by internalization of the standards of parents and other models of behavior. It echoes the good and bad learned from the primary caregiver from birth on. The problem with the superego is that it projects the ideal, not the realistic, striving for perfection in modeling learned responses. If a person has a strong superego, they may exhibit this through perfectionistic tendencies by being critical of

themselves and others, and suffering from feelings of inferiority. Figure 2.2 and Figure 2.3 show how the id, ego, and superego relate to each other.

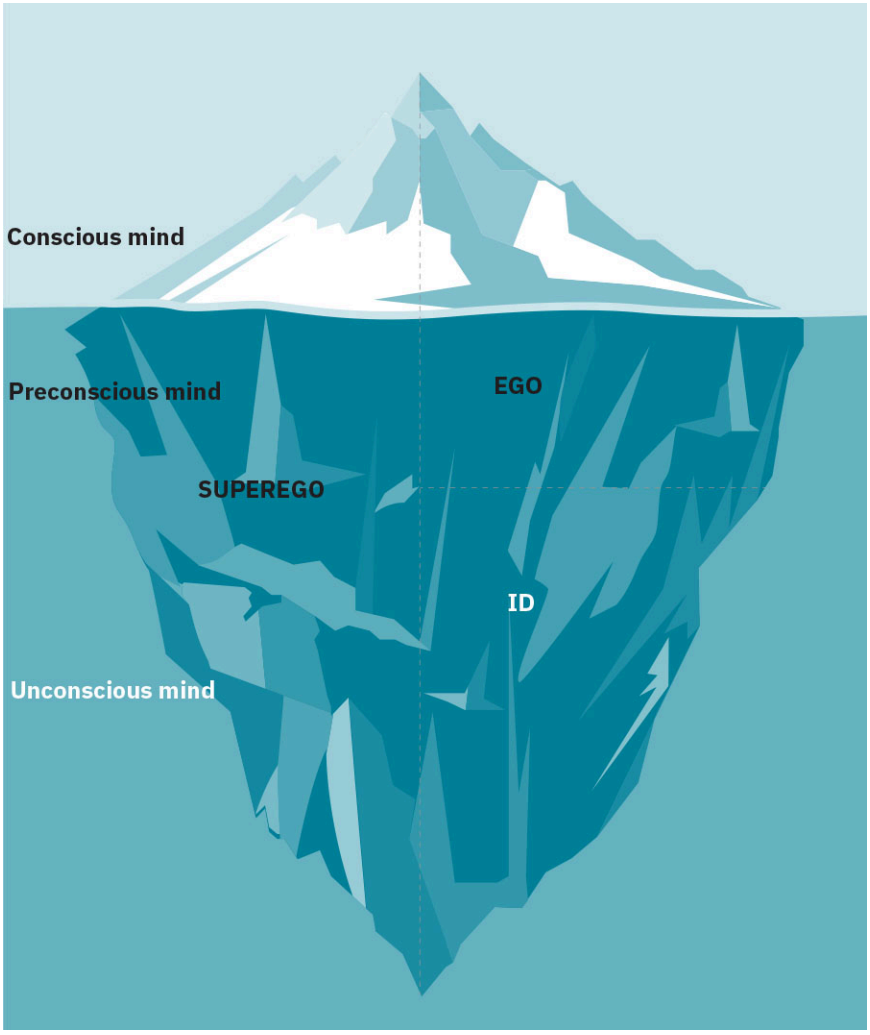


FIGURE 2.2 Freud theorized that awareness of the personality components exists at differing levels of consciousness. The id exists in the unconscious mind. The ego and superego exist in both the conscious and unconscious areas of the mind. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

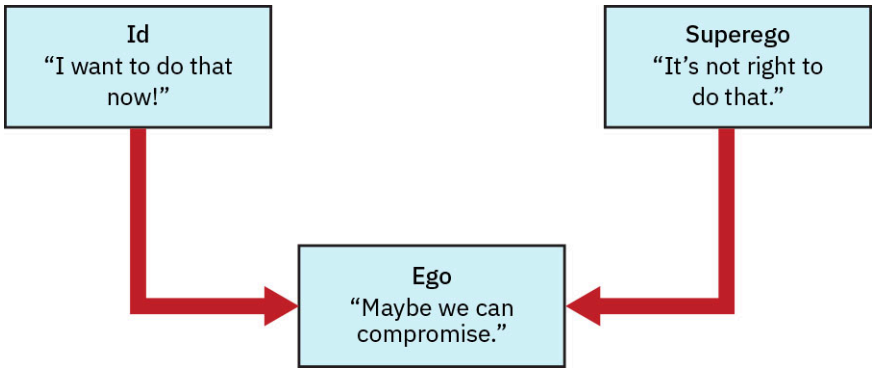


FIGURE 2.3 While the id seeks pleasurable and immediate resolution to needs, the ego attempts to negotiate these impulsive drives with the learned morality of the superego. (modification of work from *Psychology, 2e*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Another area of Freud's theory is the **psychosexual stages of development**, which proposes that childhood experiences shape the adult personality and can underlie mental health problems. Freud created these stages and believed every human developed through these stages. It is important to understand these stages as nurses care for children and adults to assess development. The stages of psychosexual development are summarized in Table 2.1.

Stage	Age (Years)	Erogenous Zone	Major Conflict	Adult Fixation Example
Oral	0–1	Mouth	Weaning off breast or bottle	Smoking, overeating
Anal	1–3	Anus	Toilet training	Neatness, messiness
Phallic	3–6	Genitals	Oedipus/Electra complex; identify with gender role	Vanity, overambition Difficulty with relationships
Latency	6–12	None	Social interaction	None
Genital	12+	Genitals	Intimate relationships	None

TABLE 2.1 Freud's Stages of Psychosexual Development (Cherry, 2023)

Psychoanalytic Theories Related to Stress Response

In Freudian theory, **a defense mechanism**—a thought, words, or a behavior prompted by the unconscious mind—surface when demands of reality cannot be met by the person. Defense mechanisms are essentially stress responses. In the short-term, defense mechanisms reduce anxiety and provide a buffer to stressful situations. If relied upon longer term, however, defense mechanisms can result in ineffective coping and contribute to mental illness (Ito & Matsushima, 2017).

Freud believed that all defense mechanisms were rooted in anxiety. The environments in which all humans live have stressors that threaten, create pain, or create tension. The defense mechanism seeks to decrease the threat, stress, pain, or tension. Defense mechanisms like denial or distortion of reality keep reality less threatening. While some defense mechanisms are necessary to live in a healthy emotional manner, too many can cause problems with healthy adjustments and personal growth. Table 2.2 summarizes common ego defense mechanisms.

Mechanism	Rationale	Example
Displacement	Transferring unacceptable feelings to another situation or person	A client criticizes the nurse after becoming angry with the physician.
Reaction formation	Exhibiting opposite behavior to disguise underlying feelings	A person who worries about their own alcohol use offers to speak against drinking at a school.
Undoing	Acting in a way that cancels or makes up for another behavior	A person brings their partner a gift after having an argument.
Projection	Assigning blame or responsibility to others for thoughts/behaviors unacceptable to self	A teenager states he would not have used tobacco if his brother did not bring it into the home.
Denial	Rejecting the truth to delay acceptance of reality	Someone receives news of a loved one involved in a traffic accident and exclaims, "Oh no! That can't be true!"
Regression	Exhibiting behaviors usually seen at an earlier stage of development when the current problem did not exist	A preschool-aged child begs for a bottle when the parents are absent.

TABLE 2.2 Commonly Seen Ego Defense Mechanisms (Mcleod, 2024a)

Two other areas of Freud's psychoanalytic theory that are helpful to nursing are the concepts of transference and countertransference. An unconscious feeling the client has toward another (such as a health-care worker) that is originally based on a childhood experience with an important person in their life is **transference**. For example, the nurse's mannerisms may prompt unconscious recall for the client of positive or negative experiences from a past relationship, which influences the client's response to the nurse. In nursing practice, the nurse should consider the concept of transference when recognizing and analyzing cues during client interaction. Whereas **countertransference** is the unconscious feeling the health-care worker has toward the client. If the client reminds the health-care worker negatively of someone they know, this can cause a problem with therapeutic communication and relationship. The nurse may also feel protective or affectionate toward the client, based on unconscious feelings from a past relationship. Feedback from nursing peers and mentors is very important, as is the nurse's need for self-reflection and supervisory assistance so that the therapeutic relationship remains strong and client care is optimal. In all nurse-client interactions, nurses should strive to avoid personalizing clients' behaviors and remarks.

Nursing Application of Psychoanalytic Theories

Because Freud's theory discusses the complex human personality and how it is influenced by past events, it is helpful in nursing practice. It can provide a more in-depth comprehension of client behavior, emotions, development throughout stages of life, and motivations, which will improve the therapeutic relationship and enhance provision of care. By delving into unconscious processes, nurses are able to be more at one with clients, better understand their nonverbal behaviors, and clue into foundational mental health challenges. The theory reinforces the notion that humans and their environments are intermingled and that nurses should look at their clients in that broader context. The theory also emphasizes the need for focused listening, which can help nurses recognize the use of defense mechanisms as cues to the client's feelings. The nurse can then reflect on what the client is saying to help them process their thoughts and emotions. Nurses also benefit from awareness of transference and countertransference in their interactions with clients, which improves nursing practice.

2.2 Interpersonal Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define interpersonal theories and therapies
- Identify nursing application of interpersonal theories and therapies

Interpersonal theory, first described by Harry Stack Sullivan (1892–1949), holds that human behaviors can be explained through relationships with others. Influences from these relationships shape personality, ability to cope with stressors, and, ultimately, survival. Interpersonal theory is substantiated by data obtained through observation and investigation.

These theories enable the nurse to develop person-centered care, become aware of reasons behind client responses, interpret behaviors, avoid judgment, and, ultimately, teach clients self-awareness. This section will explore interpersonal theories of Harry Stack Sullivan, Hildegard Peplau, and Erik Erikson.

Definitions

Interpersonal theories posit that personality development and mental health depend upon relationships between people. With the therapeutic relationship between nurse and client being so foundational to nursing practice, these theories resonate when nurses interact with clients. In fact, many interventions have been created based on interpersonal theory. More specifically, interpersonal theories focus on how to assess, interact, and intervene with clients who may be struggling to communicate when dealing with mental health issues.

Interpersonal theory was originally created by Harry Stack Sullivan. He developed a theory founded on the belief that interpersonal interaction is the basis for the person's behaviors and sense of self. The main mental health problem identified by Sullivan was anxiety. He believed that human anxiety was fueled by the need for human interaction. He coined the term **significant other**, as the main person, or a parent, from which humans have their first interpersonal interaction. He believed that this relationship was crucial for healthy emotional development.

Hildegard Peplau (1909–1999) was influenced by Sullivan's interpersonal theory and extended it to nursing practice, thereby developing the first systematic theoretical framework for psychiatric nursing in her book,

Interpersonal Relations in Nursing (1952). Peplau was the first to create and define the nurse's interpersonal relationship with the client as the foundation for nursing practice. She changed the mindset of nursing practice from what nurses do *to* clients to what they do *with* clients. Her theory speaks to helping clients make positive changes in their health care and wellness through education. She believed that illness presents an opportunity for learning, growth, and coping, and that self-awareness/reflection and the environment are keys. The **nurse-client relationship** is broken down in stages in her theory: pre-orientation, orientation, working, and mutual termination. The nurse and client move through these phases in an interwoven manner over time during which the nurse encourages the client's process of thoughts and feelings. The client's self-awareness is increased during these interactions (Hagerty et al., 2017).

Erik Erikson (1902–1994) was an American psychoanalyst and follower of Freud's theories. Erikson believed that a human's personality is developed throughout their life span and created a developmental model to reflect this. Erikson's theory described eight stages of human development, conflicts through which people negotiate individual needs against needs and demands of society in order to grow. Many of the stages involve interpersonal relations. Erikson's work is referenced by other studies of human development in mental health, aging, and child development (Orenstein, 2022). For example, according to Orenstein (2022), the recovery stage of mental illness involves trusting the possibility of regaining health; therefore, this represents a resolution of Erikson's stage of trust versus mistrust.

Nursing Application of Interpersonal Theories

Peplau's most lauded contribution to nursing is the application of interpersonal theory to anxiety. She described levels of anxiety as mild, moderate, severe, and panic on perception of learning (Table 2.3). She promoted and taught different strategies to lower anxiety to a level where the client could learn and cope with life's stresses.

Level	Perception	Signs/Symptoms	Helpful or a Hindrance	Nursing Interventions
Mild	Normal experiences of everyday life, with perceived reality in sharp focus.	Slight discomfort, restlessness, irritability, mild tensions, relieving behaviors such as nail biting, foot/finger tapping, or fidgeting.	Can be constructive for the person, as this may be a signal that something needs attention or is dangerous for them. The person can ask for help.	Emotional support; encouraging communication; family /significant other support.
Moderate	Perceptual field narrows, details are missing. The ability to think clearly is hampered; however, learning and problem-solving can still occur, but not at the optimal level.	Tension, pounding heart, increased pulse and respiratory rate, perspiration, gastric discomfort, headache, and urinary urgency. Voice tremors and visible; shaky hands are possible.	Can be constructive for the person, as this may be a signal that something needs attention or is dangerous for them. Can also be a hindrance to a person because they are unable to focus as sharply on details outside of the anxious thoughts.	Sitting with the client, speaking slowly and calmly, using short simple sentences. Assure client that the nurse is available, and they can ask for help if needed. Provide a quiet environment with decreased stimuli. Encourage the client to talk about their feelings and what happened prior to the symptoms/signs occurring. Ask the client, "What evidence do you have?" "Think a minute, are you basing this conclusion on fact or feeling?" Offer antianxiety medication as ordered. Help the client to problem-solve.

TABLE 2.3 **Peplau's Levels of Anxiety**

Level	Perception	Signs/Symptoms	Helpful or a Hindrance	Nursing Interventions
Severe	Perceptual field is greatly reduced. The person may focus only on one detail or many scattered details, but have trouble discerning what is happening in the environment, even when another person shows them. Possible confusion and may be dazed by the reality. Behavior is automatic and its purpose is to relieve anxiety.	Headache, nausea, dizziness, insomnia may increase. Trembling and experiencing a pounding heart are common. Hyperventilation and a sense of impending doom may occur.	The person needs to have intervention with this level of anxiety. They are unable to make safe or logical decisions.	Remove the client from the stimuli if possible. Stay with the client. Ask the client to discuss their feelings and what happened for the anxiety to accelerate, if possible. Same interventions as moderate anxiety. Offer antianxiety medication as ordered.
Panic	Unable to process what is happening and may lose touch with reality. Dysregulated behavior results. Pacing, running, shouting, screaming, or withdrawal may result. The person may experience hallucinations, or false sensory perceptions, such as seeing people or objects not seen by others.	Immobility, or severe hyperactivity, garbled speech, or inability to speak, numbness, tingling, shortness of breath, dizziness, chest pain, nausea, trembling, chills, flushing skin, palpitations.	This person needs immediate attention. They may need to be removed from the situation or stimuli. They may need to be placed in an environment where they cannot hurt themselves or others.	Help the client to move to safe space. Allow client to pace, or withdraw; however, keep the client within eyesight. Stay with the client. Help and keep client safe from injury. All interventions with severe anxiety and offer medication as needed and ordered. Once the incident is over, debrief with the client about what happened and assist the client in reframing the issues. Provide honest praise for the client's ability to recover.

TABLE 2.3 **Peplau's Levels of Anxiety**

Peplau also defined the nurse-client relationship as the connection between the professional nurse and those seeking health services (Hagerty et al., 2017). This connection is accomplished through application of the therapeutic relationship, which contains specific phases. The phases of this relationship are denoted in Figure 2.4.

FIGURE 2.4 Peplau's phases of the nurse-client relationship describe the evolving therapeutic relationship. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

These phases are interwoven and overlap as the client and nurse develop **rapport**, which is the process during which the nurse creates an atmosphere of safety, trust, and understanding. During this process, the nurse should use the attributes of empathy, transparency, and positive regard. The nurse assists the client with problem-solving in a practical, emotional, and situational manner. When used in a nursing context, **empathy** involves the nurse placing themselves in the client's shoes, through compassion, understanding, and identification. The **interpersonal process** is a process where the nurse and client communicate to develop an understanding of their roles and responsibilities in the therapeutic relationship. This is often during the orientation phase of the nurse-client relationship.

Erik Erikson's developmental theory has implications for nursing practice and development of the therapeutic relationship as well. Nurses use this theory, for instance, during the assessment of the client. Review of the client's behavioral patterns can help identify age-appropriate, or delayed, development of interpersonal skills. Delays can hinder normal development and result in a diminished sense of self. Understanding the stages of emotional development of the client allows the nurse to interact with and assess the client in the most age-appropriate manner. Table 2.4 lists Erikson's stages of development.

Stage	Age (Years)	Developmental Task	Description
1	0–1	Trust vs. mistrust	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
2	1–3	Autonomy vs. shame/doubt	Sense of independence in many tasks develops
3	3–6	Initiative vs. guilt	Take initiative on some activities, may develop guilt when success not met or boundaries overstepped
4	7–11	Industry vs. inferiority	Develop self-confidence in abilities when competent or sense of inferiority when not
5	12–18	Identity vs. confusion	Experiment with and develop identity and roles
6	19–29	Intimacy vs. isolation	Establish intimacy and relationships with others
7	30–64	Generativity vs. stagnation	Contribute to society and be part of a family
8	65–	Integrity vs. despair	Assess and make sense of life and meaning of contributions

TABLE 2.4 **Erikson's Eight Stages of Development** (Orenstein, 2022)

2.3 Cognitive Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define behavioral and cognitive behavioral theories and therapies
- Identify nursing application of behavioral and cognitive behavioral theories and therapies

Behavioral theory states that human responses can be retrained. Behavior therapies, in general, provide techniques for people to learn how to control or modify negative behaviors. Primary behavior therapy seeks to change the person's responses to the environment, usually with reward systems.

Cognitive behavioral theory, one major type of behavioral therapy commonly practiced today, is based on the belief that human thinking drives human behaviors. Cognitive therapy brings behavioral change through identification of negative emotions and reframing the personal script. Examples of this technique include modeling, cognitive, exposure, and acceptance or commitment therapy. The goal for behavioral techniques is to modify or change negative emotions or anger-based behavior associated with identified situations. Cognitive behavioral techniques can assist the person to be more effective at managing or coping with negative emotions (Horiuchi et al., 2018).

Definitions

The form of psychotherapy that is used to change the way a person feels about or perceives an experience is called **cognitive behavioral therapy (CBT)**. It is effective for a range of problems, including depression, anxiety disorders, alcohol and drug use problems, marital conflict, eating disorders, and severe mental illness. CBT helps a person to recognize distorted/negative thinking with the goal of changing thoughts and behaviors to respond to changes in a more positive manner. Numerous research studies suggest that CBT leads to significant improvement in functioning and quality of life. Studies show that CBT has been demonstrated to be as effective as, or more effective than, other forms of psychological therapy or psychiatric medications (American Psychological Association, 2017).

CBT treatment usually involves efforts to change behavioral patterns. Strategies to achieve these goals might include facing one's fears instead of avoiding them, using role-play to prepare for potentially problematic interactions with others, and learning to calm one's mind and relax one's body. CBT aims to help develop skills to manage feelings in healthy ways. Through in-session exercises and "homework" between sessions, people develop coping skills, whereby they learn ways to change their own thinking and behavior, ultimately changing how they feel. For example, through journaling and reflection on feelings versus behaviors, a client will be developing coping strategies to employ the next time they are exposed to the same situation. CBT clinicians focus on current situations, thought patterns, and behaviors rather than past events. A certain amount of information about one's history is needed, but the focus is primarily on developing more effective ways of coping with life moving forward.

LINK TO LEARNING

This fact sheet describes the core principles of CBT (https://openstax.org/r/77CBT) and outlines treatment strategies.

Essential Elements of Cognitive Behavioral Therapy

CBT is based on the principle that how a person perceives life experiences or interprets events determines how they will feel, behave, or respond. The essential function of CBT is to assist in changing the way a person thinks or perceives an experience to improve the emotion or behavior associated with the event.

CBT has three main core principles, shown in Table 2.5. One principle is that emotional upsets become *thoughts* that obstruct ways of analyzing situations. A second principle is that emotional upsets are learned *behaviors* or patterns of thinking. A third principle is that one's quality of life can be enhanced through better ways of *coping with emotions*. Treatment with CBT utilizes the influential relationships between these three principles and assists the person to understand their own way of thinking.

Principle	Strategy	Rationale
Thoughts	Learning how to recognize thought-process distortions that are causing emotional upsets, then reevaluating and applying to reality	What we think affects how we feel and act.
Behavior	Understanding the behaviors and motivations of others in similar situations	How we behave affects how we think and feel.
Emotion	Learning new coping techniques to apply in difficult situations; application of problem-solving skills to determine which coping technique to use	What we feel affects how we think and act.

TABLE 2.5 **Cognitive Behavioral Therapy Strategies** (Acha, 2017)

Specific techniques taught to manage one's thoughts and emotions include **mindfulness-based cognitive therapy (MBCT)**, where behavioral therapy is combined with meditation, and **dialectical behavior therapy (DBT)**, which focuses on problem-solving skills and the ability to find and seek acceptance of negative emotions while tolerating stressors. MBCT has been effective in helping clients cope with anxiety, depression, and bipolar disorders, while DBT has proven effective in helping clients cope with personality disorders, substance misuse, and eating disorders (Good Therapy, 2018).

PSYCHOSOCIAL CONSIDERATIONS

Milieu Therapy

The concept of a therapeutic community is a critical component in mental health care, particularly with behavioral therapy. A therapeutic, controlled, and supportive environment that provides safety and structure while one seeks treatment and works on changing negative behavior is called a **milieu**. The origin of the word *milieu* is French for *middle place*, the safest place in a group, a sanctuary.

Milieu therapy permits health-care clinicians to assess the client while they are exposed to different relationships and behaviors. Allowing clients to function within a milieu community provides a sense of civility, belonging, and accountability. The controlled environment provides consistent routine, which fosters predictability and trust. This allows the client to learn how to respond to stressors through staff and community member feedback and modeled behavior. As described by Belsiyal et al. (2022), the goals of milieu therapy are behavior change through the client's autonomy and supported decision-making, therapeutic communication directed toward increasing the client's self-esteem, and overall respect practiced by all participants.

Another CBT-based technique is called **acceptance and commitment therapy (ACT)**, which relies on positive reinforcement (providing a reward for desired behavior, i.e., praise or material incentive) and counterconditioning. Counterconditioning means becoming deconditioned to the negative stimulus. This can be accomplished through brief exposures while being supported until tolerance is built, or by learning a relaxation technique to mitigate the stress of the exposure. ACT has been shown to help people cope with anxiety, stress, psychosis, OCD, substance use, eating disorders, and depression (Glasofer, 2024).

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Teamwork and Collaboration

The role of the nurse in caring for clients experiencing emotional stressors is related to primary nursing care, but in collaboration with interprofessional team members. As an interprofessional team member, the nurse may consult with psychiatrists, psychologists, licensed social workers, and other health-care providers. The scope and practice of each team member is clearly defined within their professional licensure.

Nurses play a vital role in behavioral therapy as interprofessional team members modeling and teaching desired

behaviors. The nurse, as the coordinator of care, spends the most time observing and interacting with the client. The nurse's assessment plays a crucial role in understanding and treating the client's behavior, which allows for a more successful treatment plan.

Behavioral Therapy in Groups

The treatment of several clients together by one or more group facilitators addressing traumatic or stress disorders, depression, learning differences, or other conditions likely to benefit from the interaction is group therapy (Malhotra & Baker, 2022). Group therapy provides opportunities for supportive exchange within the group of individuals who have similar challenges. The professionals who facilitate group therapy may explore emotional, cognitive, and spiritual struggles. Before group therapy begins, the organizer determines group goals, size, duration of meetings, facilitator, and member characteristics. Group therapy can have a fixed life or be ongoing with members leaving and being replaced over time. The group usually has a set of agreed rules, such as the role of members in the group, contribution expected from members, the role of the leader in the group, dealing with inappropriate behavior, etiquette regarding starting and finishing the group as well as when members can leave the room. Group therapy can be in treatment settings or in the community and can take place face-to-face or in virtual sessions.

Group behavioral (and interpersonal) therapy has been proven to be effective in managing substance use disorders, such as addictions, and promoting supportive relationships. Group therapy can be a powerful motivator for change when members are stimulated with new thought processes, develop bonds with other members, and experience adjustments to negative behavior. In group CBT, for instance, the group leader helps group members become aware of negative thought patterns that influence their actions and emotions. CBT groups enable members together to discover ways to refashion their behaviors and interpretations of situations by determining the foundations of their thoughts.

A form of group therapy wherein all the participants of the group are related, as defined by the family members is **family behavioral therapy (FBT)**. FBT can address substance misuse and other addictions, and also assists with managing secondary co-occurring problems within the family unit. Addictions can negatively affect the whole family and can cause secondary problems, such as abuse or conflict, mistreatment of children, and unemployment. In family therapy, the family members try to resolve negative behavior and interactions through learning new coping skills. Then, participants apply these strategies to improve the situation at home.

CULTURAL CONTEXT

Adapted Cultural Formulation Interview for Children and Adolescents

The Cultural Formulation Interview (CFI) is a structured tool in the DSM-5, adaptable to the setting, and used to assess the influence of culture on a client's experience of distress (Jarvis et al., 2020). The following is an adapted version of the CFI tool for children and adolescents that may be used in family therapy.

- Suggested introduction to the child or adolescent: We have talked about the concerns of your family. Now I would like to know how you are feeling about being [age] years old.
- Feelings of age appropriateness in different settings: Do you feel you are like other people your age? In what way? Do you sometimes feel different from other people your age? In what way?
    - If they acknowledge sometimes feeling different: Does this feeling of being different happen more at home, at school, at work, and/or at some other place? Do you feel your family is different from other families? Does your name have special meaning for you? Is there something special about you that you like or are proud of?
- Age-related stressors and supports: What do you like about being at home? At school? With friends? What don't you like at home? At school? With friends? Who is there to support you when you feel you need it? At home? At school? Among your friends?
- Age-related expectations: What do your parents or grandparents expect from a person your age in terms of chores, schoolwork, play, or religion? What do your teachers expect from a person your age? What do other people your age expect from a person your age? (If they have siblings, what do your siblings expect from a person your age?)

- Transition to adulthood (for adolescents): Are there any important celebrations or events in your community that recognize reaching a certain age or growing up? When is a youth considered ready to become an adult in your family or community? What is good about becoming an adult in your family? In school? In your community? How do you feel about "growing up"? In what ways are your life and responsibilities different from your parents' life and responsibilities?

(American Psychiatric Association, 2013)

Nursing Applications of Behavioral Therapies

Nurses use behavioral therapy treatments and techniques to help clients alter their maladaptive responses to certain scenarios. Altering these responses can often ameliorate psychological distress and mental health challenges. Nurses can use CBT practices, for instance, to assist clients in lessening psychological distress and in building up coping tools to enhance their mental health. Nurses assess and evaluate, on an ongoing basis, clients with mental health challenges to recognize behavioral changes and developments. As educators, nurses teach clients about the effects of thoughts and feelings on behavior. Nurses are support persons and coaches when clients are in counterconditioning, for example, and can provide honest praise for the client's accomplishments. Further, nurses facilitate collaborative care when working with therapists and other providers.

In group therapy, nurses can play a vital role in leading or facilitating the group to achieve desired outcomes and providing feedback to group members. In family therapy, nurses can teach the family unit new coping strategies that reduce negative behavior and reinforce adaptation to common stressors. Interventions, such as education related to healthy lifestyle, can be effective for stress reduction and for family unity.

LINK TO LEARNING

The Patient Health Questionnaire-9 (https://openstax.org/r/77healques) is a quick screening tool with nine criteria for assessing a client's risk of depression. It can be used during CBT to assess the client's risk of depression related to inability to cope with life stressors.

2.4 Humanistic Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define humanistic theories and therapies
- Identify nursing application of humanistic theories and therapies

Humanistic theory emerged after the concepts of psychoanalytic and behavioral theories. Humanistic theory states that persons must be viewed as holistic beings with free will and choice, as continually moving toward **self-actualization**, which is the realization of full potential or inner fulfillment considered as a drive or need present in everyone.

Humanistic theory places the person at the center of mental health care where they are supported to identify personal strengths and discover their own perspectives. Humanistic theory has a wellness focus and acknowledges environmental effects on health (Sussex Publishers, 2022). Two humanistic theorists are discussed here: Abraham Maslow and Carl Rogers.

Definitions

The humanistic theory is based on identification of holistic human needs. When these needs are met, persons can grow and achieve their goals in life. When needs go unmet, persons may struggle to move to next levels in life. In therapy utilizing these guidelines, the therapist and client work together to determine the client's life accomplishments and where assistance is needed for growth.

Abraham Maslow

Abraham Maslow (1908–1970) believed humans were motivated by unmet needs. Maslow created a model that

started with the most basic needs of all human beings and worked into the most esoteric and abstract human needs (Figure 2.5). These needs were incremental and necessary for a client to become a fully functioning whole person. He initially had five levels of needs: physiological, safety/security, belonging and love/social, esteem, and self-actualization. Later, he added cognitive and aesthetic needs (placed between esteem and actualization). These additions represented the need to obtain and understand knowledge and the need for beauty and symmetry (McLeod, 2018).

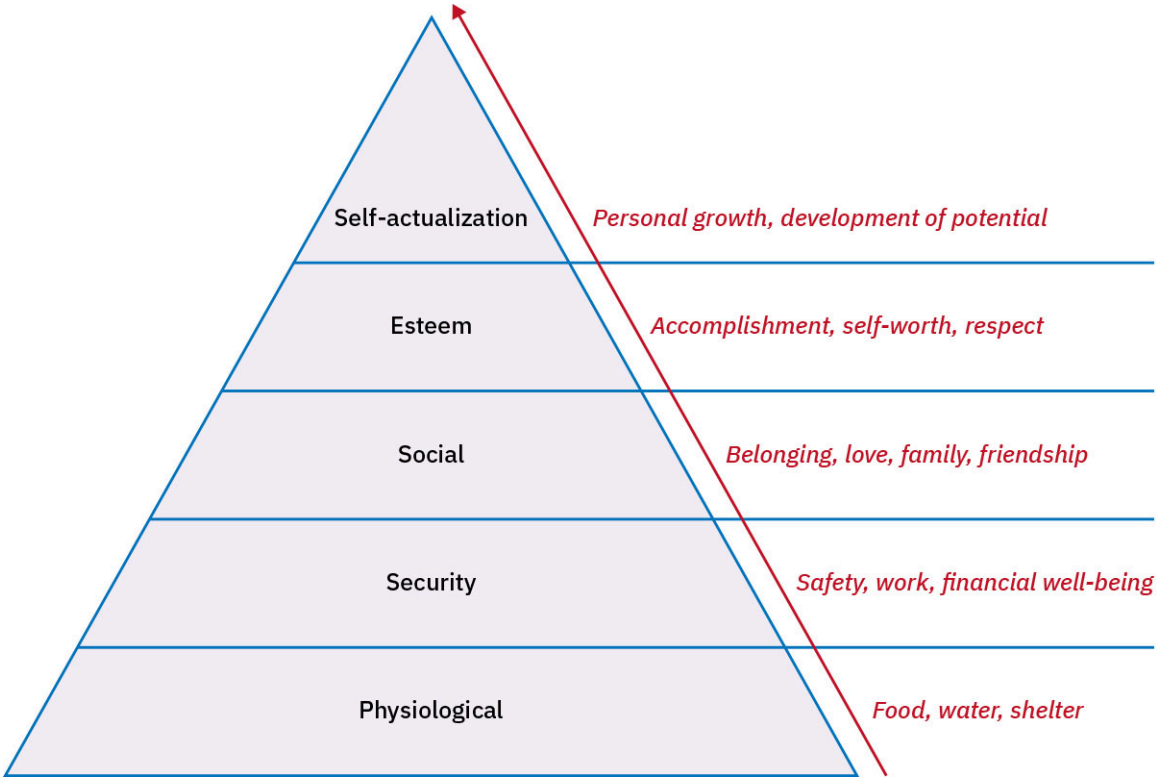


FIGURE 2.5 Maslow's hierarchy of needs identifies the levels of needs humans need to feel fulfilled. (modification of work from *Clinical Nursing Skills*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Carl Rogers

Psychologist Carl Rogers (1902–1987) is known for his humanistic theory and person-centered approach to therapy. He said that an individual's actions are motivated by the potential of self-actualization, by the possibility of achieving their best self, their highest potential. He based his theory on the idea of self-concept, which is a person's awareness of who they are. Self-concept has three components, according to Rogers: self-image, self-esteem, and the ideal self. He believed that humans have the ability to be self-aware, to evolve, and to recover with the person-centered therapist offering unconditional positive regard, empathy, and congruence. This supportive process allows the person to work toward their chosen goals in their own way (Millacci, 2022).

Humanistic Therapies Applications in Mental Health Nursing

Maslow's theory has had a profound effect on nursing. Understanding the humanistic model demonstrates to the nurse what the priority client needs are. The nurse must be able to understand that physiological needs must be met before higher-level needs, such as safety or love and belonging. It is important for the nurse to know this in the assessment phase of the interaction with the client, when recognizing and analyzing cues. It is important that the nurse prioritize and personalize the care of every client.

Maslow's hierarchy of needs theory is a major foundation of nursing practice as is Carl Rogers's theory. His belief was that client care should be done with empathy and should encourage clients to voice their emotions and form trusting relationships with the nurse that provide a foundation for client self-awareness and self-care. Nurses should respect clients, their autonomy, and treat them with genuine empathy and understanding in order for clients to reach their potential.

Because humanistic therapy is a holistic approach, aspects of care focus on the client's personal development and recovery. Strength identification is part of this process, and feedback from the nurse is meaningful. Also significant to nursing practice are the concepts of person-centered care and therapeutic communication wherein nurses establish rapport with clients by focusing on them as individuals. As the person reacts to others and to different situations, the nurse can assist the client to find relevance and plan their own success. This nursing focus on the client as an individual encourages trust and transparency in the process.

CLINICAL JUDGMENT MEASUREMENT MODEL

Humanistic Approach to Client Care Scenario

Layer 4 of the CJMM provides contextual elements of clinical decision-making in the form of realistic client-care environmental factors. Consider the following example:

- Environmental cues: secure psychiatric hospital unit
- Client observation cues: young adult, panic anxiety
- Medical record cues: history of bipolar mood disorder
- Time pressure cues: client rapidly losing personal control

To analyze these cues, nurses must interpret the information. This client has a safety need. The nurse assures the client as to safety and the availability of nursing staff to assist the client. The nurse says, "You can tell us how you are feeling." The nurse reminds the client of their prior success in self-management and assures the client of the staff's interest in returning the client to self-care, thereby establishing trust and person-centered care.

2.5 Biological Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define biological theories and therapies
- Identify nursing application of biological theories and therapies

From a biological perspective, psychiatric-mental health conditions are considered physiological disorders with a focus on the neurological and immune systems of the body, as well as genetic components of health. Trauma and injury are also considered with diagnoses and treatment of mental illness (Schwartz & Corcoran, 2017). Magnetic and computerized imaging are used to study the brain and detect areas of damage or change. The premise is to find where the problem is in the brain and target that area with medications, diet, surgery, or other therapies, such as brain stimulation.

Definitions

Biological theory centers on an actual physical reason for psychiatric problems and, in effect, has decreased the stigma long associated with mental illness. For instance, when a person is diagnosed with schizophrenia, under this theory it has a physical root cause, which displaces blame.

Medication Therapy

Biological therapy provides remedies for mental health disorders by physically treating the brain. Medical understanding of the action of neurotransmitters in the brain provides the rationale for pharmacological approaches. Intended to restore balance in this chemical process, medication therapy is a commonly utilized method to treat mental health disorders.

Using chemicals to adjust the brain chemistry to assist the client with a mental health disorder is **psychopharmacology**. With the inception of **chlorpromazine**, also known as Thorazine, a strong antipsychotic medication, many psychiatric clients were able to move from a state of psychosis to a manageable lifestyle (Lindamood, 2005). Medications that target neurotransmitters help restore brain function by regulating these neurotransmitters. Clients report having less emotional distress and greater satisfaction with their lives, due to taking these medications. Clinicians began to understand the vital role these chemicals provided as a new way to treat psychiatric disorders, other than psychoanalysis and behavioral therapy. Many medications have proven

effective to treat and/or control psychosis, mania, depression, and anxiety. These medications have decreased lengths of hospitalization and helped clients have more productive lives.

Diet

Healthy lifestyles include healthy diets. Research has found evidence of dietary influence on mental health. Grajek et al. (2022) reviewed possible connections between nutrition and mental health. Nutrition may be able to reduce inflammatory processes in the body and promote optimal circulatory and cellular health. Studies reviewed by Grajek et al. (2022) found that complex carbohydrates, antioxidants, vitamins B9, D, E, C, carotenoids, tryptophan, alpha-lipoic acid, and soluble fiber could have these therapeutic effects. Recent research describes new disciplines of psychodietetics and nutritional psychiatry (Grajek et al., 2022).

Psychosurgery

Neurosurgery intended to alter psychological responses is called psychosurgery (De Jesus et al., 2023). It can be used for a select group of clients who have not experienced successful treatment for anxiety disorders and obsessive-compulsive disorders. Psychosurgery alters small portions of brain tissue in specific areas that control certain behaviors. Changes are made by thermal, radiation, or surgical methods without damage to the person's general function. Drastic surgeries such as frontal lobotomy are no longer performed due to disabling effects.

Brain Stimulation

Brain stimulation therapies are those that stimulate the brain through neurochemicals, electricity, and nerve action (National Alliance on Mental Illness [NAMI], 2023). There is traditional electroconvulsive therapy (ECT), which uses electricity to stimulate targeted areas of the brain by creating a controlled seizure, most commonly used to treat major depression. Now other brain stimulation therapies, such as transcranial magnetic stimulation (TMS), aim to target specific brain areas to treat the problem. These therapies also treat other disorders, such as epilepsy, Parkinson disease, and several chronic pain disorders.

Nursing Application of Biological Theory

The major concepts of the biological theory related to nursing are basic care of the client, through monitoring and supporting their physical needs. Nurses are responsible for overseeing sleep, activity, nutrition, hydration, elimination, and other functions for the client. The nurse is responsible for administering medications and preparing the client for procedures. The nurse also monitors drug-level laboratory reports and ensures the client's therapeutic level is met. This physical care of the psychiatric client is part of the holistic approach nursing is known for.

For clients in treatment with biological therapies, teaching is a nursing intervention that promotes health, prevents harm, and empowers the client through partnership with the health-care team. Specific to medication teaching, clients must be made aware of the indications and effects of all medications prescribed, including drug-food interactions. Nurses also conduct preoperative or pre-procedure teaching and witness the surgical or procedural written consent. This education contributes to the effectiveness of the plan of care.

In dietary education, nurses can teach how stress can result in food choices detrimental to overall health and educate clients on the aspects of emotional eating, where food becomes a substitute for addressing feelings. Nurses can counsel on grocery shopping and meal preparation.

LINK TO LEARNING

This article from Sutter Health discusses how proper nutrition can enhance mental health (https://openstax.org/r/77nutrition), and poor nutrition can negatively affect thinking and energy level.

Nurses also play a supportive role as advocates for the expressed preferences of the client in treatment with biological therapies. The client's beliefs and values must be considered and explored. Open exchange of this information contributes to best outcomes of care. Clients and families must be informed of aspects of all biological therapies.

LINK TO LEARNING

The Use of Theories in Psychiatric Nursing-II (https://openstax.org/r/77theories) discusses all the major theories reviewed in this chapter and how nurses can use them in practice.

2.6 Developmental Theories and Therapies

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define developmental theories and therapies
- Identify nursing application of developmental theories and therapies

Psychiatric-mental health nurses can utilize concepts from developmental theories to enhance their awareness of the client's experience. This knowledge informs client education as well. Nurses may apply cognitive development theory when observing the client's interactions with the environment, whether in treatment or in the community. The theory of object relations empowers nurses to recognize and analyze cues in the client's presentation and expressed needs, which leads to focused care planning. Moral development theory informs nurses when ethical questions arise. All theory application contributes to the nurse's self-awareness and effectiveness in client care. This section covers theories of Jean Piaget, Margaret Mahler, and Lawrence Kohlberg.

Definitions

Developmental theories seek to explain the process of a child's understanding. This process is investigated as occurring in steps or stages, or in a continual way through the life span.

Jean Piaget

Jean Piaget (1896–1980) was a Swiss psychologist and researcher. Piaget worked in a boys' school and scored the intelligence exams given to the boys, noting that younger children would consistently give incorrect answers to the same questions the older children would answer correctly. This brought him to conclude that **cognitive development** was a dynamic process with primitive awareness and recognition to a more complex manner of thinking. He found that the mental representation of the world or process of information depended on the cognitive stage humans reached and mastered (Scott & Cogburn, 2023). The theory had four stages of development: sensorimotor, preoperational, concrete operational, and formal operational. Table 2.6 describes these stages.

Stage	Ages	Description
Sensorimotor	Birth to 2 years	Basic reflexes through purposeful movement, spatial abilities, and hand-eye coordination. The physical interaction provides the child with understanding of the environment. Around nine months, the concept of object permanence is mastered. This means the child is able to believe an object exists after the first encounter.
Preoperational	2–7 years	Egocentric thinking where the child thinks in concrete terms, not in the abstract. They expect others to see the world as they do. They cannot conceptualize qualities without specific objects to show this. They are unable to comprehend, for instance, that the same amount of (mass, volume, or number) liquid can be stored in a tall, thin glass as a short, wide glass.

TABLE 2.6 **Piaget's Cognitive Development Stages** (Scott & Cogburn, 2023)

Stage	Ages	Description
Concrete Operational	7–11 years	Logical thinking starts and abstract thinking is possible. Diversity of thought is possible, and the child can see multiple ways to solve problems. The ability to understand classification, sorting with distinct differences, creating patterns, and the concept of reversibility.
Formal Operational	11 years to adulthood	Conceptual reasoning starts at the same time as puberty. Problem-solving and abstract thinking are the same abilities as an adult.

TABLE 2.6 Piaget's Cognitive Development Stages (Scott & Cogburn, 2023)

Piaget's concepts are utilized in therapies in educational settings, especially with children.

Margaret Mahler

The **theory of object relations**, according to theorist Margaret Mahler (1897–1985), is how a person relates to the world according to their past relationships. Specifically for the infant, the mother or significant other becomes one with the child. The infant cannot conceptualize the mother's permanence when the two are apart, which is known as the concept of *object constancy*. Therefore, in the infant's understanding, the mother does not exist when not physically present. A variation of other theories, Mahler places less emphasis on primitive human drives and more importance on consistent relationship patterns.

Mahler believed that psychological problems were related to the disruption in separation from the object (Blom, 2018). She studied the process of how infants move from total self-interest to struggle with separation from the mother, to becoming a physically and psychologically differentiated toddler (Table 2.7). This natural healthy process is developed by the object, that is, the parent/significant person, allowing the child to wander off in a safe environment while staying close by so the child is assured the parent is still present. Over time and over exposure to this type of experience, the child begins to trust the process and become an individual. Another important piece of exposure is to reward the child when they return to the mother. This reward is a verbal or other sensory affirmation that reinforces the action was good. Mahler also believed that "perfect parenting" was not necessary for this transitional trust to develop.

Mahler's concepts are utilized in therapies by recognizing that individuation is a complex process (Blom, 2018). Treatment approaches factor into therapy with families who experience periods of transition such as a new baby, a child beginning school, or a young adult leaving home. Mahler's framework guides assessment of individual growth. Couples therapy explores separation-individuation, recognizing that personality development occurs throughout the life span.

Stages of Development	Infant's Behaviors
Autistic stage: (0–1 month)	Infant's focus is self Mother/caregiver is one with the infant, not existing separately
Symbiotic stage: (1–5 months)	Infant begins to realize mother/caregiver's separate existence and main source of support
Separation-individuation stage: (5–24 months)	Infant's focus shifts to difference between self and mother/caregiver Motor skills develop, allowing physical separation Infant explores environment, though remains dependent on mother/caregiver Infant begins to fear loss of mother/caregiver and must learn to balance dependence with independence, i.e., "terrible two's" as infant tests new behaviors, resulting in development of self-concept

TABLE 2.7 Mahler's Stages of Child Development (Grace, 2019)

LINK TO LEARNING

In the article "An Object Relations Approach to Cult Membership" (https://openstax.org/r/77psytherapy), the authors apply the theories of object relations to interactions throughout life that are guided by the earliest relationships.

Lawrence Kohlberg

Psychologist Lawrence Kohlberg (1927–1987) expanded upon Piaget's cognitive stages by establishing moral stages. His theory of **moral development** provides a framework of three levels and six stages for understanding the progression a child develops when learning right from wrong (Smith, 2023).

The first level, preconventional, has two stages. This level is distinguished by rules and listening to authority. During the first stage, punishment and obedience, the child learns obedience is the way to avoid punishment. The second stage is instrumental purpose orientation. In this stage, the child sees that others look at rules differently and if they choose to not follow the rules, they risk punishment.

The second level, conventional, has stages three and four. The third stage is good interpersonal relationships. In this stage, the child begins to start using motivation and personality as reason for following or not following the rules. The child thinks in terms of "good and bad" as a person who gets along with others. Stage four is maintaining the social order. The person becomes aware of the fact "rules are rules." People all must fall in line with these, not only to avoid punishment, but because of the broader view of society. The person begins to see that following authority maintains social order. The person sees this in large systems, such as government and corporations.

The postconventional level houses stages five and six. Stage five is social contract and individual rights. In stage five, the person believes that social order is good and correct. Stage six is universal ethical principles. The overarching sentiment here is that actions should create justice for all who are involved, and, as a society, people are obliged to break unjust laws/rules.

Kohlberg's concepts are utilized in therapies to help explain that people can have different reactions to similar ethical concerns. Kohlberg's theory can guide parents and caregivers as children develop their own moral framework and, ultimately, learn about social expectations.

Nursing Application of Developmental Theories

Developmental theories help the nurse know how to assess, intervene, and evaluate the client. These theories help the nurse develop approaches to client care based on clients' developmental levels, regardless of chronological age. These levels are multilayered and unique with each client.

Nursing Application of Cognitive Development Theory

Nurses' understanding of basic principles of human growth and development allows focused care planning, especially for teaching. In addition, nursing expectations for client responses can be realistic and provide situations wherein clients can receive positive feedback for accomplishments. Because interaction with the environment is important to human development, the nurse acts as milieu manager in hospital settings and promotes healthy public communities through advocacy and consulting.

Nursing Application of Object Relations Theory

When nurses learn the client's history, an understanding of childhood experiences may provide cues to client behaviors, emotions, and coping ability so the nurse gains the knowledge to plan appropriate care. For nurses themselves, object relations theory gives opportunities for self-awareness. Nurses may experience reactions to client care scenarios that are unexpected or confusing. These situations can prompt the nurse to seek mentoring or feedback from colleagues.

Nursing Application of Moral Development Theory

Moral development theory can assist nurses to understand clients' reasoning and decision-making. By understanding where clients fall in the stages of moral development, the nurse can customize their care to what the client requires. Understanding these theories allows the nurse to appreciate the importance of their own moral

compass. Nurses often come across ethical dilemmas when interfacing with clients. Kohlberg's theory can contribute to a more educated approach to these dilemmas because it illuminates the level of moral reasoning of all parties involved in the situation, including clients, loved ones, and other health-care providers.

2.7 Holistic Health and Interventions

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define holistic health-care theories and therapies, including social determinants of holistic health care
- Describe mindfulness as a type of holistic health care
- Identify nursing application of holistic theories

Holistic health care is a wellness modality used to treat and prevent physical and mental health problems. Holistic health care can greatly enhance the success of treatment and outcomes and can be combined with pharmacological interventions. Clients in treatment for mental health care may spend a lot of time in a hospital setting trying new therapies or medication regimens. A holistic approach to transitioning back into a community setting can prevent hospital readmissions (State of New South Wales [NSW] Government, 2020). Incorporation of community-based programs after hospital discharge, such as social services, community treatment facilities, and group housing are often used as reintegration techniques. The ultimate goal of holistic health care is increased treatment effectiveness.

Definitions

The multifaceted approach that reflects the client's physical and emotional well-being and considers the whole person and how they interact with their environment is called **holistic health**. It is a focus on one's quality of life versus a physical ailment, illness, or disease. The nurse understands there are numerous factors that affect a client's actual health goals and potential outcomes. These factors include physical, emotional, cultural, family, spiritual, psychological, and environmental influences. Accurate assessment helps the nurse interpret the complex interactions between all the different factors. To assess the impact of each influence, the nurse should perform a functional assessment. Functional assessments include the client's developmental patterns as well as behavior and response to stressors. Analyzing collected data from the functional assessment and applying interventions creates a solid foundation for providing holistic health care.

LINK TO LEARNING

The Functional Analysis Screening Tool (FAST) (https://openstax.org/r/77FAST) is designed to identify a number of factors that may influence the occurrence of problem behaviors.

Social Determinants and Associated Interventions: Healthy People 2030

The conditions of the environments where people live, work, play, worship, and go to school, which represent the nonmedical factors that influence health outcomes, are **social determinants of health (SDOH)**. Ideally, all components of the environment would support health and a good quality of life for the inhabitants. Environmental conditions may contribute to health and well-being or may be detrimental or harmful. Even moderate support can be beneficial in a less-than-optimal environment. For example, someone with no home or income of their own may be part of a faith-based community that comforts and assists them.

As described by *Healthy People 2030*, the five areas that comprise SDOH are economic, education, health care, neighborhood, and community (Figure 2.6). Therefore, unemployment or debt, education that is disrupted or unavailable, low access to health care, a neighborhood with violence or crime, or a larger community without resources can have damaging effects on health of the people.

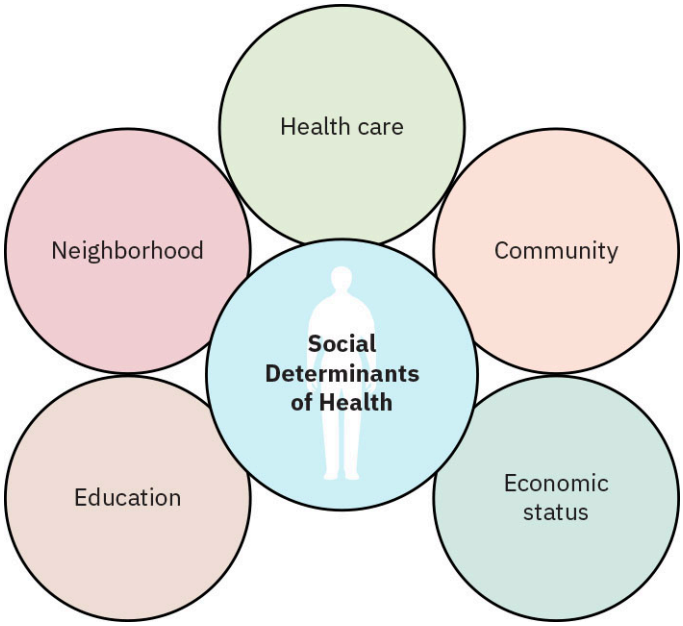


FIGURE 2.6 There are five main components of the environment that can impact health. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Drafted by the Office of Disease Prevention and Health Promotion, *Healthy People 2030* sets data-driven national objectives to improve health and well-being associated with social determinants. Through research, common themes of social determinants emerged among various populations that appeared to be preventing people from achieving health-care goals, as defined by the person. The Healthy People Committee developed interventions for health-care workers to help individuals overcome the effects of these conditions. The goal or mission envisions a society in which all people can achieve their full potential for health and well-being across the life span.

LINK TO LEARNING

Healthy People 2030 (https://openstax.org/r/77healthypeop) is a set of objectives based on public health priorities that are intended to improve the health and well-being of Americans.

The Patient-Centered Medical Home Model

The patient-centered medical home (PCMH) model, developed by the Veterans Health Administration, is an example of a proactive, primary care-based, interdisciplinary team model using person-centered, holistic care, and active communication and coordination among providers. This model is considered effective for clients with complex health-care needs. Figure 2.7 illustrates the medical home model. As homeless veterans stabilize clinically and socially, as evidenced by their moving into permanent housing and demonstrating appropriate self-care and health-seeking behaviors, they are transitioned to traditional care settings to continue their care. Research indicates that the medical home model reduced emergency department visits and hospitalizations of the homeless population by integrating supports that addressed social determinants of health into a clinical care model (Centers for Disease Control and Prevention [CDC], 2021).

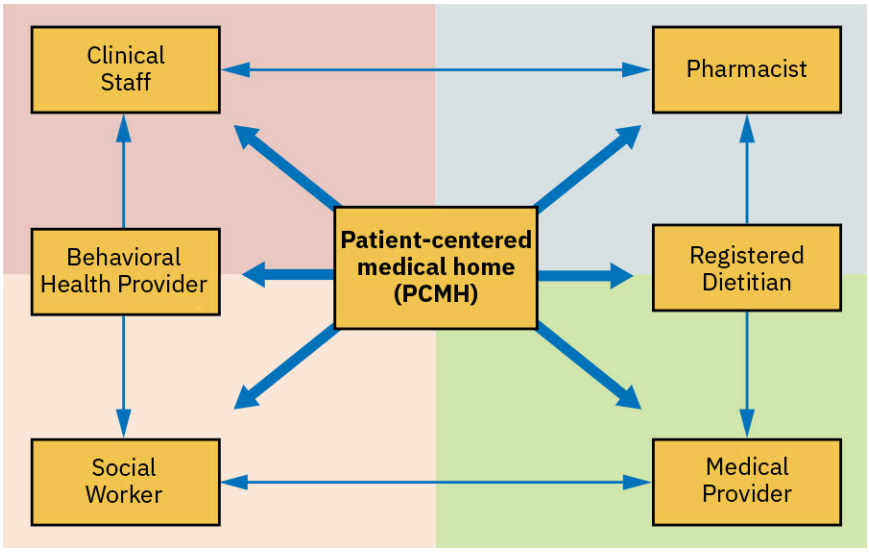


FIGURE 2.7 The patient-centered medical home model was developed by the Veterans Health Administration. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Mindfulness

An individual's state of awareness, achieved through personal focus, being in the present, and/or meditation is called **mindfulness**. Attention to being fully cognizant of a situation without extreme reaction can provide calming and centering. The practice of mindfulness dates back to ancient times and was originally grounded in Buddhist and Hindu traditions (Figure 2.8).

FIGURE 2.8 Mindfulness is a form of meditation to create an awareness of one's body and environment. (credit: "Meditation – High Ground" by Ian Burt/Flickr, CC BY 2.0)

Research has shown that mindfulness can have positive health outcomes related to managing stress, anxiety, and many types of depression (Crosswell et al., 2017). Mindfulness has been described as, "non-elaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises is acknowledged and accepted as it is" (Delegran & Haley, 2016, para 3). Mindfulness is a holistic technique, involving all the person's senses and contributing to overall well-being.

Mindfulness practice utilizes techniques for one to be present and in the moment. One exercise might be the following:

> Compare your default state to mindfulness when studying for an exam in a difficult course or preparing for a clinical experience. What do you do? Do you tell yourself, "I am not good at this" or "I am going to look stupid"? Does this distract you from paying attention to studying or preparing? How might it be different if you had an open attitude with no concern or judgment about your performance? What if you directly experienced the process as it unfolded, including the challenges, anxieties, insights, and accomplishments, while acknowledging each thought or feeling and accepting it without needing to figure it out or explore it further?

If practiced regularly, mindfulness helps a person start to see the habitual patterns that lead to automatic negative reactions that create stress. By observing these thoughts and emotions instead of reacting to them, a person can develop a broader perspective and can choose a more effective response.

Mindfulness-Based Stress Reduction

Mental training used to alter how pain or stress is processed within the central nervous system, thereby diminishing or reducing one's perception of pain or stress, is called **mindfulness-based stress reduction (MBSR)**. MBSR has shown positive outcomes in a variety of health-care settings for both physical and emotional disruptions (Lamothe et al., 2016). MBSR was originally developed for clients with chronic illness who were not responding to existing medical treatments. MBSR was first researched and funded by the National Center for Complementary and Integrative Health (NCCIH) at the University of Massachusetts in 1979. The NCCIH created a Stress Reduction Clinic and treated a variety of clients with health conditions, such as cancer, chronic pain, and autoimmune disorders. Clients completed modules and workshops on techniques like meditation to lower stress levels and increase well-being.

REAL RN STORIES

Nurse: Karen B., MSN
Years in Practice: 14
Clinical Setting: Community health clinic
Geographic Location: Greensboro, NC

Fourteen years ago, when I began my career at a community mental health clinic, I worked with women who had experienced physical trauma from a partner. I felt a hesitancy from the clients to begin the conversation. I felt it myself and I wanted to incorporate a strategy to reduce the stress of the counseling sessions. The office where we met was located overlooking a park and I began to invite the clients to stand with me at the window for a moment of gazing meditation. We did not speak during this time as we watched children playing, people walking their dogs, and birds fluttering on the tree branches. I was humbly surprised when the clients began to assert their readiness to begin the session, having settled themselves during the exercise. It worked for me as well.

Because MBSR showed such encouraging results in physical conditions, mental health providers started combining it with cognitive therapy and incorporating it into the treatment plans of clients suffering from depression. In recent years, MBSR has shown positive outcomes as a coping technique for caregiver burden as well (Nathan et al., 2017). Due to the pandemic and social distancing mandates, mental health-care practitioners have recently started offering MBSR modules and workshops in a virtual platform.

LINK TO LEARNING

The Mindfulness Project (https://openstax.org/r/77mindproj) is a tool with numerous mindfulness activities.

Guided Imagery

Another form of mindfulness is **guided imagery**, which provides an alternate narration the mind can focus on during an unpleasant experience. According to the pain gate theory, the brain can only experience one pathway at a time, either pleasure or pain, but not both (Krau, 2020). Guided imagery allows for the pleasure pathway to take over, decreasing the body's perception of pain. Guided imagery is often used during labor as a coping technique for contraction pain. The nurse helps the laboring mom picture something that brings a pleasant thought or feeling, like her newborn's outfit or ultrasound picture. The mental image accompanied with slow, controlled breathing and relaxation of tension in the shoulders, hands, and feet can provide a nonpharmacological approach to pain management.

Guided imagery has also been proven effective as an intervention in mental health scenarios. For example, during a client's anxiety, the nurse can offer to assist the client with an exercise. Allow the client to sit comfortably in a quiet area. Begin by describing a beach with waves coming in on the sand and going back out to sea. Using the mental image of ocean waves, the nurse can instruct the client to breathe in as the waves approach the beach and breathe out as the waves go back. Nurses also teach guided imagery to promote relaxation and sleep.

Teaching Mindfulness Requires Self-Awareness

To teach mindfulness to clients, the nurse must first examine their own self-awareness and beliefs. Different treatments and interventions work for different clients. There is no one single treatment that is effective in every situation. The nurse must not impose their own beliefs or personal opinions onto the client, nor provide less than quality care just because the client's beliefs differ from their own.

The therapeutic relationship between a nurse and client must be founded on trust and a judgment-free space in order to be effective in producing positive outcomes. For instance, a client with obesity may want to be more accepting of their weight and may need assistance with interventions related to achieving a positive body image. The nurse may believe instead of self-acceptance, the client should be focusing on health promotion and ways to reduce their weight. The nurse has a responsibility, however, to support the client and help them achieve their goals. Using applications of mindfulness, the nurse should be aware of their surroundings and display the empathy needed by the client to achieve their goal. Nurses who practice self-awareness are better equipped to provide quality client-centered care, resulting in more positive outcomes.

Key elements for the nurse to consider when incorporating self-awareness include:

- A client's perception is the most influential factor in determining their response to intervention, rather than how the nurse feels they should respond.
- Behavior and emotions will differ between clients in the same situation, with the same variables.
- No one intervention will work with every client.
- Becoming familiar with a variety of cognitive and holistic interventions will increase effectiveness in promoting a positive well-being.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care

Nurses practice client-centered care when building trust and avoiding judgment in the therapeutic relationship. Building trust means "do what you say you will do." For example, if the nurse states a group exercise will start at 9:00, the group should start on time. If the nurse states they will return to meet with the client after lunch, the nurse should do so. Avoid judgment in nurse-client interactions, by saying, for example, "I can see your point," "This seems important to you," or "Is it fair to say you were angry about that?" instead of responding with comments such as, "You're not making sense," "That's not relevant," or "You shouldn't have felt that way."

Nursing Application of Holistic Health Care

Holism in health care is a psychosocial approach that does not set illness apart, but treats the whole person. Nightingale, by using the environment as therapy, was incorporating a holistic approach. Nurses should consider the physical and social environment when treating clients.

PSYCHOSOCIAL CONSIDERATIONS

Managing the Environment for the Therapeutic Interaction

- Select an area that provides few distractions, with comfortable seating or space to walk with the client, and enough privacy to protect the conversation without being isolated. This may be a conference room, with the door open, an area of the unit dayroom, or a secure outdoor area.
- Consider your own potential discomfort and plan ahead. Consult with another nurse and review printed guidelines.
- Engage the client's participation to talk in the selected area and set the time frame. For example, "Hello, Jordan, let's sit in the conference room for about 15 minutes to finish your admission paperwork."
- Allow the client access to water or a restroom. For example, "You can bring your cup and the restroom is here in the hallway."
- Tell other staff members where you will be. For example, "Jordan and I will be talking in the conference room until about 2:30."
- Show active listening behavior, wait for the client's responses and validate before changing topics. Keep appropriate eye contact, nod when you understand, and don't interrupt the client. It is best to sit diagonally so as not to confront or crowd the client. Be patient, though gentle prompts are okay, for example, "go on . . ." "then what happened?" "It seems you are in agreement with your mom—is that accurate?"
- Focus on the client, ask permission to take notes, though keep to a minimum. For example, "I'd like to make a few notes, so I can follow up with Dr. Smith, if you agree."
- Draw the interview to a close by mentioning the time frame, thank the client, and give an opening to interact another time. For example, "Jordan, our time is up for now. Thank you for talking with me. Let's head back to the unit. I can be available after lunch if you would like to meet again."

(Gorman & Sultan, 2008)

During interviewing and data collection, nursing awareness of the physical environment and the nurse's attitudes are essential components. If the interaction takes place in a busy or noisy area or the nurse expresses impatience or fatigue, the client will not feel supported.

Nurses should also take into account the client's outside environment. In the community, for example, nurses can practice advocacy by volunteering and promoting efforts to address food insecurities, housing initiatives, or transportation systems. In public health settings, nurses can make inquiries with empathy, such as, "Do you sometimes run out of necessities?" or "What would be the best way to help you with child care?" They can then make referrals or arrange consults as indicated by clients' preferences.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Quality Improvement (QI)

Nurses use quality improvement projects or task forces to track client responses and positive outcomes. For instance, surveys can be implemented after the initiation of techniques, such as mindfulness or self-awareness behaviors among staff members, then results analyzed to show correlation of positive care outcomes.

Summary

2.1 Psychoanalytic Theories and Therapies

The psychoanalytic theory from Sigmund Freud provides a foundation to understand psychiatric problems. This theory is the basis for the nurse to view the client through the lens of personality development and unconscious influences on behavior, and to incorporate this into the care of the client.

The id, ego, and superego keep the person in balance between satisfying every primal want and bowing to societal pressures. The use of defense mechanisms is necessary for all humans to emotionally adjust to their environment. At the same time, defense mechanisms utilized over the long-term can become patterns of ineffective coping, causing problems with social adjustment and emotional growth.

Freud also created stages of sexual development that he believed affected a person's emotional growth and/or adaptation. And the two concepts of transference and countertransference reveal that all clients have a past and are attempting to frame their reality in ways that are safe and familiar. These ideas enhance therapeutic communication and active listening to assist the client as needed.

2.2 Interpersonal Theories and Therapies

Interpersonal theories identify interpersonal relationships as drivers for human development. Erikson believed the personality develops throughout the life span and presented an age-based order to reflect this. Nursing observation of client behavior can provide cues to the client's developmental stage, which allows nurses to address psychological needs and develop a therapeutic relationship. Peplau applied interpersonal theory to nursing. She defined the nurse-client relationship, which includes the phases of pre-orientation, orientation, working, and mutual termination. Peplau also presented nurses with focused approaches for the described four levels of anxiety: mild, moderate, severe, and panic.

2.3 Cognitive Theories and Therapies

Behavioral therapeutic interventions for emotional problems can include one or more of the following: milieu therapy, group therapy, family therapy, and forms of cognitive behavioral therapy. Goals of these therapies include awareness of emotions and modification of associated negative behaviors. Learned techniques assist the person to be more effective at coping with stressors in identified situations. Nurses are teachers, advocates, and support persons. Comprehensive knowledge of the different types of behavioral and cognitive behavioral therapy helps the nurse select appropriate and effective interventions and treatment approaches.

2.4 Humanistic Theories and Therapies

Humanistic theory views persons as holistic beings utilizing free will to reach self-actualization, as defined by the person. Maslow's hierarchy of needs model guides nursing assessment and Rogers's concepts of the person's sense of self assists the nurse with individualized care planning. Both theorists cite self-actualization as the ultimate goal of human achievement. In a therapeutic approach based on humanistic theory, clients are empowered and supported toward their own recovery.

2.5 Biological Theories and Therapies

Biological theories have helped with the stigma of mental health by identifying organic bases for many disorders. Biological therapies include medications, diet, surgery, or other therapies such as brain stimulation. Nurses function as educators and advocates through direct care, medication administration, surgical and procedural care, monitoring, and teaching for clients and families. In addition, nurses should remain aware of the latest in developments of biological therapies so that recipients of care receive current information and optimal support.

2.6 Developmental Theories and Therapies

Developmental theories investigate human development through the life span. Theorists Jean Piaget, Margaret Mahler, and Lawrence Kohlberg all contributed developmental theories to explain how children develop throughout stages to reach a more complex way of thinking. Moral development also takes on more complex forms as individuals age and develop the ability to distinguish right from wrong. Nurses can apply these theories to practice to understand exactly where their clients stand in their ability to understand concepts and make decisions. These

theories also come into play when ethical dilemmas arise.

2.7 Holistic Health and Interventions

To provide quality holistic care, the nurse must recognize multiple determinants—the physical, emotional, cultural, family, spiritual, psychological, and environmental influences to which the client is exposed. To achieve this, the nurse must find out as much as possible about a client's personal values, beliefs, and health practices. Healthy People 2030 describes identified obstacles affecting a client's ability to achieve health-care goals. Nurses who become knowledgeable in these obstacles can develop client-specific interventions to overcome negative effects of social determinants. Nurses should remember the client is the best source of information.

Mindfulness has a long history and has been proven as an effective intervention in both physiological and psychological disorders. Techniques such as guided imagery, mindfulness-based stress reduction, yoga, and physical exercise are techniques the nurse can incorporate into the client's plan of care. Nurses must practice self-awareness to build trusting therapeutic relationships and provide judgment-free quality care.

Key Terms

acceptance and commitment therapy (ACT) relies on positive reinforcement and counterconditioning
behavior therapy method to change the person's responses to the environment, usually with reward systems
chlorpromazine also known as Thorazine, a strong antipsychotic medication, first generation
cognitive behavioral therapy (CBT) used to change the way a person feels or perceives an experience and therefore behaves
cognitive development dynamic process with primitive awareness and recognition to a more complex manner of thinking
consciousness aware of one's own existence, sensations, thoughts, surroundings, the part of the mind comprising psychic material of which the individual is aware
countertransference unconscious feeling the health-care worker has toward the client
defense mechanism thought, words, or behavior prompted by the unconscious mind; can reduce anxiety in the short-term; may result in ineffective coping if used longer term
dialectical behavior therapy (DBT) focuses on problem-solving skills and the ability to find and seek acceptance by regulating negative emotions and tolerating stressors
ego part of the psychic apparatus that experiences and reacts to the outside world and thus mediates between the primitive drives of the id and the demands of the social and physical environment
empathy helps nurses to place themselves in the client's shoes, through compassion, understanding, and identification
family behavioral therapy (FBT) type of group therapy where all the participants of the group are related
group therapy addresses interaction pattern problems while also providing disorder-specific support within a group of strangers who have similar challenges
guided imagery alternate narration the mind can focus on during an unpleasant experience
holistic health clinical approach that considers the client's physical and emotional well-being, the whole person, and how they interact with their environment
humanistic theory places the person at the center of mental health care where they are supported to identify personal strengths and discover their own perspectives
id part of the mind that is the most primitive, it drives the instincts, reflexes, and needs
interpersonal process where the nurse and client communicate to develop an understanding of their roles and responsibilities in the therapeutic relationship
milieu therapeutic, controlled, and supportive environment that provides safety and structure while one seeks treatment and works on changing negative behavior
mindfulness state of awareness, achieved through personal focus, being present and through meditation
mindfulness-based cognitive therapy (MBCT) behavioral therapy that is combined with meditation
mindfulness-based stress reduction (MBSR) mental training used to alter how pain is processed within the central nervous system, thereby diminishing or reducing one's perception of pain
moral development provides a framework for understanding the progression through which a child develops in terms of learning right and wrong
nurse-client relationship pre-orientation, orientation, working, and mutual termination phases where the nurse

and client move through these phases in an interwoven manner over time

preconscious part of the mind where thoughts and feelings are available to the conscious mind though not currently being applied

psychopharmacology using chemicals to regulate brain chemistry to assist the client with mental health disorders

psychosexual stages of development proposes that childhood experiences shape the adult personality and can underlie mental health problems

psychosurgery neurosurgery intended to alter psychological responses

rapport process where the nurse creates an atmosphere of safety, trust, and understanding

reality testing when thoughts and emotions can be objectively evaluated by the person

self-actualization realization of full potential or inner fulfillment considered as a drive or need present in everyone

significant other main person, or a parent, from which humans have their first interpersonal interaction

social determinants of health (SDOH) conditions of the environments where people live or work, which represent the nonmedical factors that influence health outcomes

superego part of the personality representing the conscience, formed in early life by internalization of the standards of parents and other models of behavior

theory of object relations how a person relates to the world is dependent upon their past relationships, specifically with the significant person

transcranial magnetic stimulation (TMS) brain stimulation therapy targeting specific brain areas

transference unconscious feeling the client has toward another or the health-care worker that is originally based on a past experience with an important person in their life

unconsciousness repressed memories, thoughts, and unacceptable feelings a person may have

Assessments

Review Questions

1. When caring for a client in the psychiatric unit, the new nurse in the unit approaches the client with the morning medications. The client responds to the nurse with, "I know I can't trust you!" What should the nurse consider when attempting to understand the client's statement?
    a. The statement is inappropriate for the client to express to a professional nurse.
    b. The statement could be an example of transference to the nurse.
    c. The statement is an example of countertransference to the nurse.
    d. The statement is the way the client chooses to express their feelings to the nurse.

2. A forty-year-old client in the therapist's office coughs and makes awkward sounds when the therapist chooses to talk about his childhood sexual abuse. Where does this reflexive behavior stem from?
    a. These are reflexes driven by the id.
    b. These noises are because of a history of verbal ticking.
    c. This is part of his therapy.
    d. The client is consciously interrupting the conversation.

3. A twenty-eight-year-old client enters the family therapy meeting clutching a blanket and holds the blanket throughout the session while rocking back and forth in the chair. What defense mechanism is the client demonstrating?
    a. denial
    b. projection
    c. undoing
    d. regression

4. What is an empathic response for the nurse to give to a client who recently lost their mother to a diagnosis of breast cancer?
    a. "At least she is not suffering any longer."
    b. "Most women do not survive breast cancer."
    c. "What are your plans for the funeral services?"

d. "I can see how difficult this is for you."

5. What theorist defined growth as development in stages with a positive and negative consequence if not met?
   a. Peplau
   b. Orenstein
   c. Freud
   d. Erikson

6. What therapy is used to adapt one's perceptions about life situations?
   a. milieu therapy
   b. psychoanalysis
   c. cognitive behavioral therapy
   d. reality therapy

7. What therapy environment permits the nurse to assess the client while they are exposed to different relationships and behaviors?
   a. milieu therapy
   b. electrical impulse therapy
   c. talk therapy
   d. individual therapy

8. What is one difference between family therapy and group therapy?
   a. Family therapy is a quicker means to solve problems.
   b. Family therapy allows strangers with common problems to interact.
   c. Family therapy provides management of co-occurring problems within the home.
   d. Family therapy is only provided in a hospital setting.

9. In managing the milieu for clients experiencing disorientation and fear, what would the nurse consider a priority?
   a. client and family education
   b. recreational activities
   c. social skills
   d. client safety

10. What is the order of Maslow's hierarchy of needs, from lower level to upper level?
   a. physiological, safety/security, belonging and love/social, esteem, self-actualization
   b. esteem, self-actualization, physiological, safety/security, belonging and love/social
   c. belonging and love/social, esteem, self-actualization, physiological, safety/security
   d. safety/security, physiological, esteem, belonging and love/social, self-actualization

11. Randi feels excluded in group activities and social events and expresses sadness to the nurse. According to Maslow, where have needs not been met?
   a. self-actualization needs
   b. safety needs
   c. social needs
   d. esteem needs

12. What is the significance of empathy and positive regard, according to Rogers's theory?
   a. components of group therapy
   b. components of family therapy
   c. optional to person-centered therapy
   d. necessary to person-centered therapy

13. In nursing practice, Maslow's theory informs nursing _____ and Rogers's theory informs nursing _____.
   a. evaluation; care planning
   b. assessment; care planning
   c. reflection; self-awareness
   d. self-actualization; safety

14. What areas of nursing focus promote the biological theory to help the client with a psychiatric disorder? Select all that apply.
   a. monitoring sleep and activity
   b. administering medications
   c. teaching coping skills
   d. monitoring drug-level lab reports

15. What is the benefit of biological theory, related to perspectives on mental illness?
   a. There is now a cure for most psychiatric disorders.
   b. Clients can now take medication to control their disorders.
   c. Providers lose their compassion with mental illness.
   d. It decreases the stigma of mental illness overall.

16. For the client considering electroconvulsive therapy, what is the appropriate teaching?
   a. ECT does not require a consent.
   b. ECT cannot be used to treat major depression.
   c. ECT uses electrical stimulation to targeted areas of the brain.
   d. ECT uses transcranial magnetic stimulation to targeted areas of the brain.

17. What type of development is described in Piaget's theory?
   a. moral
   b. interpersonal
   c. cognitive
   d. emotional

18. The nurse is assessing a client for moral development. What statement by the client indicates the client is in the preconventional stage?
   a. "I do my best to follow the rules of society, so I won't go to jail."
   b. "I see how the rules are hard to follow for some people and they suffer."
   c. "The rules of society are made to be broken if they are not fair to all."
   d. "We have rules to keep us in society safe and to be civil to one another."

19. The nurse is assessing a child's cognitive ability to think logically. The nurse asks the child to count backward from 10 to 0, and the child complies. What cognitive stage is this child in?
   a. sensorimotor
   b. formal operational
   c. concrete operational
   d. preoperational

20. A nurse in a wellness center is presenting a class on integrating holistic therapies with traditional health-care models. The nurse talks about the trend in health care to treat each client in a manner that connects the person as a whole being. What would best be considered a holistic approach to health?
   a. physical, emotional, and spiritual well-being
   b. emotional and sexual contact
   c. healthy work environment
   d. financial success and postsecondary education

21. A nurse is reviewing common themes or social determinants among populations preventing clients' achievement of health care–related goals. The nurse wants to include interventions into the clients' plan of care to help overcome effects of the identified social determinants. What would the nurse use to base conclusions?
    a. Healthy People 2030
    b. community-based outcomes
    c. culturally competent therapy
    d. national client safety goals

22. Building trust is an important technique for nurses to provide. What professional QSEN competency does this demonstrate?
    a. nursing assessment
    b. client teaching
    c. client-centered care
    d. quality improvement

Check Your Understanding Questions

1. Explain the major concepts of interpersonal theory.
2. What are the three core principles of CBT?
3. What settings can be used for milieu therapy?
4. Explain what the advent of chlorpromazine/Thorazine did for the psychiatric client.
5. Compare and contrast the differences in the postconventional levels of moral development, stages five and six.
6. From the perspective of holistic health care, how should the nurse determine a client's developmental patterns as well as behavior and response to stressors?

Reflection Questions

1. How can nurses apply some of Freud's theory about personality development and past relationships?
2. If you have a peer who suffered from test anxiety, how would you apply Peplau's theory to ask your friend about their anxiety?
3. As a nurse, how can you tailor behavioral interventions for a client with anxiety compared with a client with a behavior-related chronic health condition, considering the principles of behavioral and cognitive behavioral theories?
4. Consider how the humanistic theory influenced your nursing practice as a student nurse in the clinical setting. Discuss your answer in small classroom groups or in a discussion thread on your online learning management system.
5. Why is self-reflection an important aspect of nursing practice when applying humanistic theories? How can self-awareness contribute to providing more effective and compassionate care?
6. How do you see the overlapping of cognitive development, object relations theory, and moral development in human beings?
7. How do you see the overlapping of cognitive development, object relations theory, and moral development in human beings?
8. During therapy, nurses are often required to touch clients. Using techniques of self-awareness, why would the nurse ask permission before touching a client?

What Should the Nurse Do?

1. The nurse is caring for an older adult with dementia in the psychiatric unit. Upon entering the room, the client

is hallucinating, naked, and has urinated on the floor. What should the nurse do first using Maslow's hierarchy of needs as a guide?

a. redirect the client, so as not to encourage belief in the hallucination
b. dress the client immediately, to preserve the client's dignity
c. call the housekeeping department to clean the floor immediately
d. gently guide the client to a safe place to provide personal hygiene

2. The nurse is assessing an adolescent for interpersonal development using object relations theory. The client reports having anxiety when their parents talk about college applications. What is the nurse's best intervention?

Competency-Based Assessments

1. How can a nurse integrate psychoanalytic approaches into a broader, holistic nursing care plan, considering the multifaceted nature of clients' needs?
2. Describe how to create a care plan using psychoanalytic principles to engage a client who may be resistant to discussing personal issues or expressing emotions.
3. Research some ways that a nurse can leverage interpersonal theories to address challenges within a client's support network or family when group dynamics may contribute to mental health issues.
4. List several ways that nursing students can apply interpersonal theories to empower clients to take an active role in improving their social relationships and mental well-being.
5. Perform some research into, and write down ideas as to, how nurses can use behavior modification principles to promote positive health behaviors in clients with chronic conditions, such as diabetes or hypertension.
6. As a nurse, how can you establish and maintain a therapeutic relationship that aligns with humanistic theories, particularly in acute care settings where time constraints may be a challenge?
7. Why is self-reflection an important aspect of your practice when applying humanistic theories? How can self-awareness contribute to providing more effective and compassionate care?
8. Discuss the importance of medication adherence in the context of biological theories. When working with a client, how can you help them understand and adhere to their medication regimens?
9. How can nurses collaborate with other health-care professionals on the interdisciplinary team to ensure comprehensive care when applying biological therapies?
10. How can nurses use developmental theories to support clients experiencing major life transitions, such as adolescence, midlife, or retirement?
11. In what ways might nursing interventions differ when caring for children, adolescents, adults, and older adults, considering developmental theories?
12. Consider the potential benefits of integrating mindfulness practices into client care. How might mindfulness contribute to the holistic well-being of your clients?
13. As a working nurse, how can you conduct a holistic assessment that considers social determinants, mental health, and mindfulness practices? Give an example of a client scenario where holistic assessment would be particularly important.

References

Acha, K. (2017, May 26). Cognitive behavior therapy (CBT): The way we think affects the way we act and feel. https://kennethmd.com/cognitive-behavior-therapy-the-way-we-think-affects-the-way-we-act-and-feel/

American Psychological Association. (2013). Cultural formulation interview (CFI). https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

American Psychological Association. (2017). *What is cognitive behavioral therapy?* APA Div. 12 (Society of Clinical

Psychology). https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

Belsiyal, C. X., Rentala, S., & Das, A. (2022, July 29). Use of therapeutic milieu interventions in a psychiatric setting: A systematic review. *J Educ Health Promot,11*(234).https://doi.org/10.4103/jehp.jehp_1501_21.

Berry, M. (2023). *What to expect during your first 12-Step meeting.* American Addiction Centers. Recovery.org. https://recovery.org/what-to-expect-during-your-first-12-step-meeting/

Blom, I. (2018). Observing development from infancy to parenthood: Separation-individuation, attachment, and intersubjectivity in the clinical encounter. In M. H. Etezady, I. Blom, & M. Davis (Eds.), *Psychoanalytic trends in theory and practice: The second century of the talking cure* (pp. 43–70). Lexington Books/Rowman & Littlefield.

Burke, N. J., Joseph, G., Pasick, R. J., & Barker, J. C. (2009, October). Theorizing social context: Rethinking behavioral theory. *Health Education & Behavior, 36*(5 Suppl):55S–70S. https://doi.org/10.1177/1090198109335338

Centers for Disease Control and Prevention (CDC). (2021, May 12). *Patient-centered medical home (PCMH) model*. https://www.cdc.gov/dhdsp/policy_resources/pcmh.htm

Cherry, K. (2023). *Freud's stages of human development the 5 psychosexual stages of development by age*. Verywellmind. https://www.verywellmind.com/freuds-stages-of-psychosexual-development-2795962

Creswell, J. D., Pacilio, L. E., Lindsay, E. K., & Brown, K. W. (2014). Brief mindfulness meditation training alters psychological and neuroendocrine responses to social evaluative stress. *Psychoneuroendocrinology*, *44*, 1–12. https://doi.org/10.1016/j.psyneuen.2014.02.007

Crosswell, A. D., Moreno, P. I., Raposa, E. B., Motivala, S. J., Stanton, A. L., Ganz, P. A., & Bower, J. E. (2017). Effects of mindfulness training on emotional and physiologic recovery from induced negative affect. *Psychoneuroendocrinology, 86*, 78–86. https://doi.org/10.1016/j.psyneuen.2017.08.003

Darmedru, C., Demily, C., & Franck, N. (2018). Prévenir la violence associée à la schizophrénie avec la remédiation cognitive [Preventing violence in schizophrenia with cognitive remediation]. *L'Encephale*, *44*(2), 158–167. https://doi.org/10.1016/j.encep.2017.05.001

De Jesus, O., Fogwe, D. T., Mesfin, F. .B., & Das, J. M. (2023, February 12). Neuromodulation Surgery for Psychiatric Disorders. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan–. PMID: 29493988. https://pubmed.ncbi.nlm.nih.gov/29493988/

Delegran, L. (2016). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

Delegran, L., & Haley, A. (2016). *What is mindfulness?* University of Minnesota's Earl E. Bakken Center for Spirituality & Healing. https://www.takingcharge.csh.umn.edu/what-mindfulness

Donovan, N. J., Wu, Q., Rentz, D. M., Sperling, R. A., Marshall, G. A., & Glymour, M. M. (2017). Loneliness, depression and cognitive function in older U.S. adults. *International Journal of Geriatric Psychiatry*, *32*(5), 564–573. https://doi.org/10.1002/gps.4495

Erwin, E. (2002). *The Freud encyclopedia: Theory, therapy, and culture*. Taylor & Francis.

Glasofer, D. R. (2024, January 16). What is acceptance and commitment therapy (ACT). Verywell Mind. https://www.verywellmind.com/acceptance-commitment-therapy-gad-1393175

Good Therapy. (2018). Mindfulness-based cognitive therapy (MBCT). https://www.goodtherapy.org/learn-about-therapy/types/mindfulness-based-cognitive-therapy

Gorman, L. M., & Sultan, D. F. (2008). *Psychosocial nursing for general patient care* (3rd ed.). FA Davis Co.

Grace, E. (2019). *Mahler's theory of development*. kids' development. https://www.kidsdevelopment.co.uk/mahlersdevelopmenttheory.html

Grajek, M., Krupa-Kotara, K., Białek-Dratwa, A., Sobczyk, K., Grot, M., Kowalski, O., & Staśkiewicz, W. (2022, August 22). Nutrition and mental health: A review of current knowledge about the impact of diet on mental health. *Front*

Nutr, 9:943998. https://doi.org/10.3389/fnut.2022.943998

Haber, J. (2000). Hildegard E. Peplau: The psychiatric nursing legacy of a legend. *Journal of the American Psychiatric Nurses Association*, *6*(2), 56–62.

Hagerty, T. A., Samuels, W., Norcini-Pala, A., & Gigliotti, E. (2017, April). Peplau's theory of interpersonal relations: An alternate factor structure for patient experience data? *Nurs Sci Q*, *30*(2),160–167. https://doi.org/10.1177/0894318417693286

Hodge, K. (2023, June 12). The role of humanistic and existential therapy in mental health. https://www.mentalhealthcenter.org/role-of-humanistic-and-existential-therapy/

Horiuchi, S., Tsuda, A., Aoki, S., Yoneda, K., & Sawaguchi, Y. (2018). Coping as a mediator of the relationship between stress mindset and psychological stress response: A pilot study. *Psychology Research Behavior Management*, *11*, 47–54. https://doi.org/10.2147/PRBM.S150400

Ito, M., & Matsushima, E. (2017, April). Presentation of coping strategies associated with physical and mental health during health check-ups. *Community Ment Health J*, *53*(3), 297–305. https://doi.org/10.1007/s10597-016-0048-9

Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020, January). Update on the cultural formulation interview. *Focus The Journal of Lifelong Learning in Psychiatry*, *18*(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

Joseph, B. (1988). Object relations in clinical practice. *The Psychoanalytic Quarterly*, *57*(4), 626–642, https://doi.org/10.1080/21674086.1988.11927224

Kourkouta, L., & Papathanasiou, I. V. (2014). Communication in nursing practice. *Materia socio-medica*, *26*(1), 65–67. https://doi.org/10.5455/msm.2014.26.65-67

Krau, S. D. (2020). The multiple uses of guided imagery. *The Nursing Clinics of North America*, *55*(4), 467–474. https://doi.org/10.1016/j.cnur.2020.06.013

Lamothe, M., Rondeau, É., Malboeuf-Hurtubise, C., Duval, M., & Sultan, S. (2016). Outcomes of MBSR or MBSR-based interventions in health care providers: A systematic review with a focus on empathy and emotional competencies. *Complementary Therapies in Medicine*, *24*, 19–28. https://doi.org/10.1016/j.ctim.2015.11.001

Lindamood, W. (2005). Thorazine - purpose antipsychotic. *Chemical and Engineering News*, *83*(25). https://cen.acs.org/articles/83/i25/Thorazine

Lindsay, E. K., & Creswell, J. D. (2017). Mechanisms of mindfulness training: Monitor and acceptance theory (MAT). *Clinical Psychology Review, 51*, 48–59. https://doi.org/10.1016/j.cpr.2016.10.011

Lindsay, E. K., Young, S., Smyth, J. M., Brown, K. W., & Creswell, J. D. (2018). Acceptance lowers stress reactivity: Dismantling mindfulness training in a randomized controlled trial. *Psychoneuroendocrinology*, *87*, 63–73. https://doi.org/10.1016/j.psyneuen.2017.09.015

Malhotra, A., & Baker, J. (2022, December 13). Group Therapy. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK549812/

McLeod, S. A. (2018). *Maslow's hierarchy of needs*. Simply Psychology. https://www.simplypsychology.org/maslow.html

Mcleod, S. A. (2024a). *Defense mechanisms in psychology explained (+ examples)*. Simply Psychology. https://www.simplypsychology.org/defense-mechanisms.html

Mcleod, S. A. (2024b). *Sigmund Freud's theories & contribution to psychology*. Simply Psychology. https://www.simplypsychology.org/sigmund-freud.html

Meyer, L. F., Telles, L. E. B., Mecler, K., Soares, A. L. A. G., Alves, R. S., & Valença, A. M. (2018). Schizophrenia and violence: Study in a general psychiatric hospital with HCR-20 and MOAS. *Trends in Psychiatry and Psychotherapy*, *40*(4), 310–317. https://doi.org/10.1590/2237-6089-2017-0039

Millacci, T. S. (2022). *Humanistic psychology's approach to wellbeing: 3 theories*. PositivePsychology.com. https://positivepsychology.com/humanistic-psychology/

Nash, J. (2019, May 27). *The history meditation: Its origins and timeline.* Positive Psychology. https://positivepsychology.com/history-of-meditation/

Nathan, H. J., Poulin, P., Wozny, D., Taljaard, M., Smyth, C., Gilron, I., Sorisky, A., Lochnan, H., & Shergill, Y. (2017, December 1). Randomized trial of the effect of mindfulness-based stress reduction on pain-related disability, pain intensity, health-related quality of life, and A1C in patients with painful diabetic peripheral neuropathy. *Clin Diabetes*, *35*(5), 294–304. https://doi.org/10.2337/cd17-0077

National Alliance on Mental Illness (NAMI). (2023). *ECT, TMS and Other Brain Stimulation Therapies*. https://www.nami.org/About-Mental-Illness/Treatments/ECT-TMS-and-Other-Brain-Stimulation-Therapies

National Center for Complementary and Integrative Health (NCCIH). (2024). *Serving as an efficient and effective steward of public resources.* https://www.nccih.nih.gov/about/nccih-strategic-plan-2021-2025/serving-as-an-efficient-and-effective-steward-of-public-resources

Orenstein, G. A., & Lewis, L. Eriksons stages of psychosocial development. (2022, November 7). In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK556096/

Pehlivan, T., & Güner, P. (2016). The use of theories in psychiatric nursing-II. *J Psy Nurs*, *7*(2), 100–104.

Schneider, K. J., Pierson, J. F., & Bugental, J. F. T. (Eds.). (2015). *The handbook of humanistic psychology: Theory, research, and practice* (2nd ed.). Sage Publications, Inc.

Schwartz, S., & Corcoran, C. (2017). Biological approaches to psychiatric disorders: A sociological approach. In T. Scheid & E. Wright (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (pp. 98–125). Cambridge University Press. https://doi.org/10.1017/9781316471289.009

Scott, H. K., & Cogburn, M. (2023, January 9). Piaget. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448206/

Shao, K., Pekrun, R., Marsh, H. W., & Loderer, K. (2020). Control-value appraisals, achievement emotions, and foreign language performance: A latent interaction analysis. *Learning and Instruction, 69,* Article 101356. https://doi.org/10.1016/j.learninstruc.2020.101356

Smith, J. (2023). *Lawrence Kohlberg's stages of moral development*. https://seattleanxiety.com/lawrence-kohlbergs-stages-of-moral-development

State of New South Wales (NSW) Government. (2020). *What is a holistic approach?* Mental Health Updates. https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/holistic.aspx

Sussex Publishers. (2022). *Humanistic therapy*. Psychology Today. https://www.psychologytoday.com/us/therapy-types/humanistic-therapy

Sutter Health. (2023). *Eating well for mental health*. https://www.sutterhealth.org/health/nutrition/eating-well-for-mental-health

Tang, Y. Y., Tang, R., & Posner, M. I. (2016). Mindfulness meditation improves emotion regulation and reduces drug abuse. *Drug and Alcohol Dependence*, *163 Suppl 1*, S13–S18. https://doi.org/10.1016/j.drugalcdep.2015.11.041

Thornton, M. & Persaud, S. (2018). Preparing today's nurses: Social determinants of health and nursing education. *Online Journal of Issues in Nursing, 23*(3), 1–9. https://doi.org/10.3912/OJIN.Vol23No03Man05

Zhu, X., Li, W., & Wang, X. (2016). Characteristics of aggressive behavior among male Inpatients with schizophrenia. *Shanghai Archives of Psychiatry*, *28*(5), 280–288. https://doi.org/10.11919/j.issn.1002-0829.216052

CHAPTER 3
Communication, Perception, and Assessment

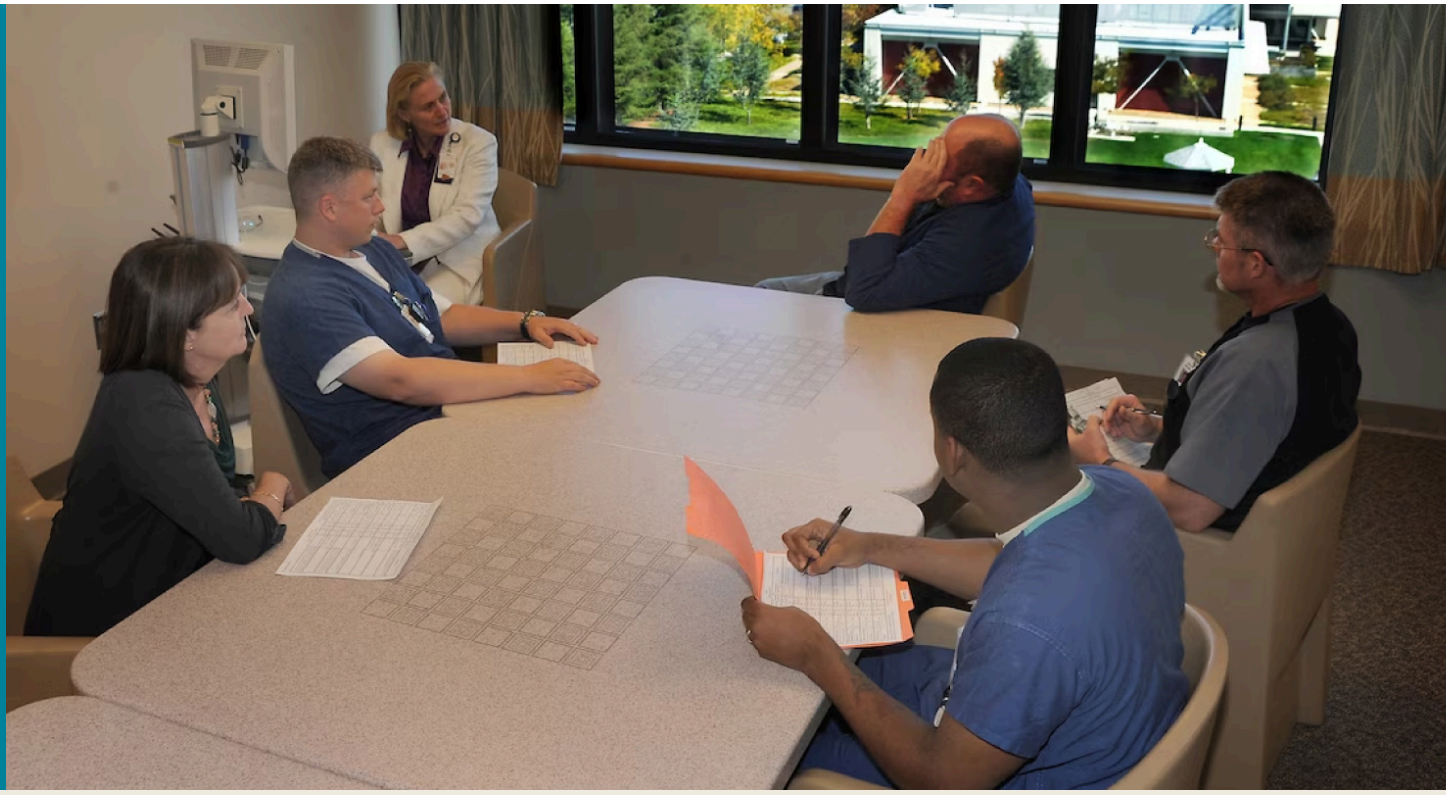


FIGURE 3.1 Psychiatric-mental health nurses are important members of the interdisciplinary team that collaborates to evaluate and treat clients. (credit: U.S. Air Force photo/Staff Sgt. Lillian Moreno, Public Domain)

CHAPTER OUTLINE

INTRODUCTION In the psychiatric-mental health (PMH) specialty, the nurse provides holistic care, using the skills of observation, interaction, assessment, and collaboration. The client's safety and stability are the goals of care. The nurse also benefits from the helping relationship through professional growth. One critical factor that influences communication is self-awareness. The nurse should take time to reflect on how well they communicate and if there is a need for improvement. Nurses must learn to communicate with awareness of tone of voice, body language, nonverbal cues, preconceived views of clients, and the correct information to guide the client into a therapeutic relationship. This chapter presents the nursing techniques of therapeutic communication within the nurse-client relationship, the client's experience, and specific guidelines for nursing care.

3.1 Therapeutic Communication and Relationships

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the significance of self-awareness in nursing practice
- Demonstrate therapeutic communication strategies and techniques when working with clients
- Identify barriers to therapeutic communication
- Discuss the therapeutic relationship and physical, emotional, and social boundaries between nurses and clients
- Explain treatment issues and obstacles in the therapeutic relationship

Therapeutic communication and relationships with clients are at the core of nursing. As nurses greet, involve, and evaluate clients, the manner of interaction is critical. The nurse must use communication techniques to help get the best picture of the client. Therefore, the nurse must know how to communicate effectively. Nurses learn and develop communication skills through every client and colleague interaction, and improving communication is a lifelong pursuit.

Nurses learn to use specific communication techniques and to identify the barriers to communication as they interact and practice with clients. There must be clear communication between nurse and client or there will be a disconnect between the message intent and the message received. If the client perceives the tone of voice of the nurse to be harsh or uncaring, for example, it might present a barrier to establishing trust between the nurse and the client. Active listening is key as a nurse. When the nurse is engaged in the therapeutic process and seeks to capture the meaning, intention, and content of the message, this is called **active listening**. It requires being an active participant in the communication process. Active listening entails facing the client, maintaining appropriate eye contact, and focusing on the client's words, nonverbal cues, and body language. The nurse does so without judgment or interrupting for clarification.

Along with effective communication, nurses need to keep appropriate physical, emotional, social, and cultural boundaries to build and maintain a therapeutic and caring relationship. This section focuses on identifying, explaining, and demonstrating communication and therapeutic relationships as the foundation of the nursing process when caring for clients.

Self-Awareness

Nursing for clients who are in psychiatric care requires **self-awareness**, which entails a nurse being aware of their own behavior, responses, and thoughts during interactions with clients. A nurse with self-awareness will gain understanding of how to develop and improve upon these interactions. The Johari Window is a model of self-awareness (Figure 3.2) developed by American psychologists Joseph Luft and Harry Ingham in 1955. In this model, there are four quadrants: what is known to the person is the *y*-axis, and what is known to others is the *x*-axis.

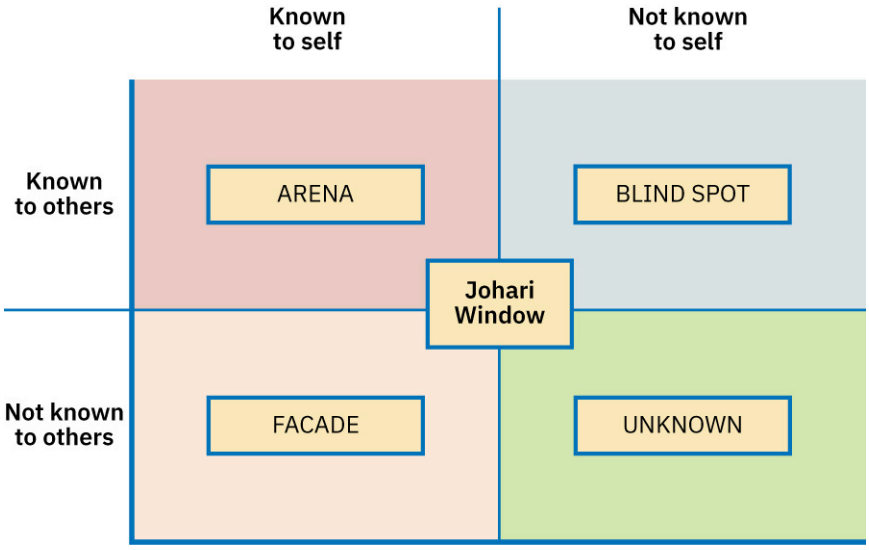


FIGURE 3.2 The Johari model of self-awareness can help improve interactions. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The first quadrant is the arena. This is what is known to self and others. Thoughts are open and provided to others. Both verbal and nonverbal communication are open. The individuals that the person is interacting with are aligned with the person's thoughts, opinions, and viewpoints.

Second, is the façade area. This area is where the person hides thoughts, feelings, and skills from others. They have capabilities that may be desired, but they choose to keep them to themselves. Those around the person do not know that they are holding anything back.

The blind spot is the next area. This is where others know things about the person, but the person is not aware of these things. Others know these skills, opinions, or viewpoints from prior experience with the person. Others may know the person can handle a situation or problem, based on prior interaction, but the person has no self-awareness of this.

Lastly, there is the unknown area. This area is where neither the person or others know the skills, thoughts, opinions, viewpoints, or feelings a person has. This is when a person does not know they have some idea or feeling and others do not know it either.

PSYCHOSOCIAL CONSIDERATIONS

Applying the Johari Window in Nursing Practice

Psychiatric-mental health nurses can offer clients psychosocial support through the nurse's own self-awareness. As a nurse, use the Johari Window concepts to better understand your own behaviors and responses during interactions with clients and coworkers.

Examples:

- Nurse Janet is known as someone who comes to work on time, always willing to stay over to help the next shift, very friendly, has fifteen years of experience, and will answer questions from other staff. This falls in the arena area.
- Three years ago, Janet intervened in a domestic situation with a client at another employment situation and was threatened with legal action and left that job. She is now reluctant to advocate for clients. This falls in the façade area.
- Janet won't speak up in meetings but others would appreciate her expertise and wonder why she doesn't join in and say something. This falls in the blind spot area.
- Janet's nonverbal communication sends some messages that may portray some aspects of these areas of awareness. This falls in the unknown area.

If Janet seeks feedback from colleagues and uses her own self-reflection, she has the opportunity to gain insight and skill in therapeutic interaction.

As a nurse, it is important to know where to start in communication with clients. It is best to be self-aware to improve and have the best outcome for the client. The nurse should start by sharing who they are, what their goal is for the communication, and encourage the client to do the same. The nurse should limit **self-disclosure**, which is an interactive communication process wherein one person shares information about themselves in an appropriate context, modeling the behavior for others in the therapeutic relationship. This can be a therapeutic technique, if utilized within professional boundaries. For example, if the client is tearful when talking about their children, the nurse may offer, "I'm a parent, too." Used in proper context, this comment can show empathy while not elaborating or placing the focus on the nurse.

LINK TO LEARNING

This video explains how to use the Johari Window (https://openstax.org/r/77johariwin) to increase self-awareness and thereby improve communication with clients.

Reflection should accompany and enhance self-awareness. There are many models of self-reflection in the research. One reflective model nurses often use is the Gibbs Reflective Cycle (Figure 3.3) because of its link between introspection and action.

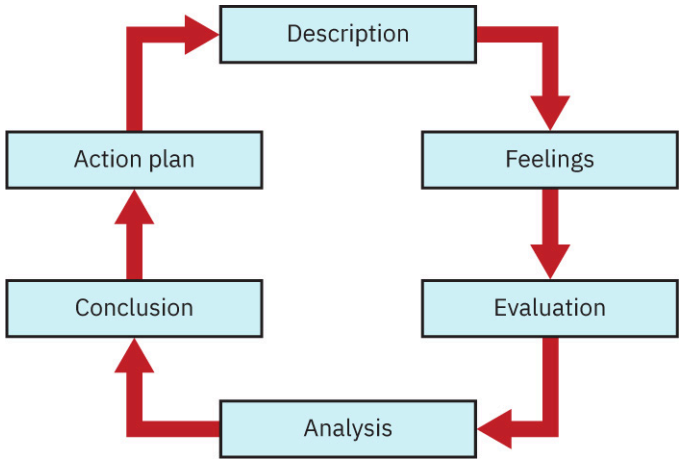


FIGURE 3.3 The Gibbs Reflective Cycle illustrates the six stages of self-reflection. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

There are six stages of this cycle: the description of the situation, what feelings erupt from the situation, evaluating what is good and not so good about the situation, analyzing the situation to determine what there is to learn from it, concluding what could be done differently, and developing an action plan to improve handling the situation next time. Self-awareness with self-reflection allows for further development of therapeutic communication and it enables the relationship between the nurse and client to remain open to change and become enriched with therapeutic actions.

Therapeutic Communication Strategies and Techniques

Communication is an art and a science. When a nurse supports, draws out information for an assessment, or provokes deeper understanding on what a client is communicating, they are participating in **therapeutic communication**. Communication between the client and the nurse must be honest, ethical, and legal. The science portion of communication relates to the process of how communication is accomplished. There is a sender and a receiver of the message. There is interpretation of the message also, through coding and encoding (Figure 3.4). The nurse needs to explain to the client that what the client reveals will be kept confidential within the treatment team. Information that relates to the health and safety of the client or others, or if the client is homicidal or suicidal, would be shared with the health-care team for the safety of all concerned. The client is made aware that this information

will be confidentially shared with those who care for them.

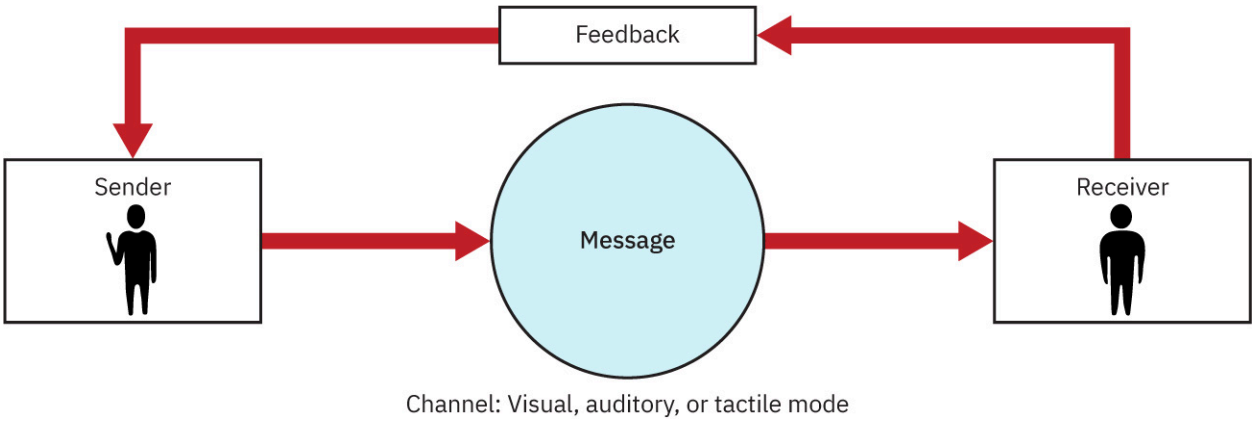


FIGURE 3.4 Verbal communication entails five basic elements: sender, message, channel, receiver, and feedback. The process continues, sometimes fluidly and sometimes with gaps. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

While information in a medical record is privacy protected, there is legal precedent for releasing the information if it poses a serious threat to persons or the public, or when disclosure to law enforcement is required. See this link to the HIPAA Privacy Rule (https://openstax.org/r/77HIPPA) for further information.

Verbal Communication

There are five basic elements of the communication cycle:

- The sender/source: The sender is the one who transports the message. The sender role and the receiver role interact with one another in two-person communication.
- The message: The message is the intended purpose or content of the communication, what is said, relayed, or delivered.
- The channel or mode of communication: The channel is the manner through which the communication takes place. Is it through visual, auditory, or tactile senses?
- The receiver: The receiver is the one who gathers the message.
- Feedback: The feedback is the actual response to the sender.

Because this is a cycle, the elements follow one another, and the process continues, sometimes fluidly and sometime with gaps.

The closer the relationship or how much the two parties have in common often influences how similar the intent of the sent message is to the received message. Meaning and response will be more closely aligned when parties have more in common.

Nonverbal Communication

Communication that takes place without words is called **nonverbal communication**. It includes body movements, facial expressions (called *affect*), and gestures. It also includes nonverbal sounds, such as sighing, laughing, humming, or chuckling. Body movements and facial expressions, such as eye-rolling, grimacing, tapping the foot, crossing the legs and arms, posture, and eye contact or the lack of eye contact, help nurses see the emotion behind the words when communicating with a client. Nurses must be aware that there can be nonverbal messages behind their own body movements and facial expressions.

Sometimes the emotions revealed by nonverbal cues are different than the words that are accompanying them. As a nurse, it is vital to observe and assess the nonverbal signals clients are offering, both during conversations and at times when not verbally communicating with one another. If the client is squirming in their seat while being asked questions about their interaction with a person they are in conflict with, it tells the nurse the client is uncomfortable and to inquire about this feeling. Often, clients are unable to disclose their feelings verbally until the nurse points out the nonverbal signals. This can be an effective way to encourage clients to express themselves verbally, allowing the nonverbal to match the verbal.

Take note of the fact that in American culture, eye contact and head nodding demonstrate acknowledgment and are viewed as positive and agreeable accompaniments to interactions with words. At the same time, however, eye

contact that is maintained for too long or in an intense manner can be interpreted as rude or jarring and aggressive. However, in some other cultures, eye contact does not indicate accord or agreement, but may be perceived as disrespectful. Likewise, although nodding in America generally indicates agreement, in some other cultures, it actually can mean "no" or "thank you" instead. Nurses must be aware of the possible meanings and interpretations of common gestures, facial expressions, and body movements across different cultures. The nurse must be mindful that gestures and expressions in one culture may not mean the same thing in another. Therefore, the nurse needs to be culturally sensitive. See Chapter 8 Cultural Considerations for more information on cultural awareness.

Clients are aware of the nurse's facial expressions, so it is vital that nurses know what they look like when they are speaking (and not speaking) and how to convey concern, caring, and no judgment. If the nurse's face expresses surprise at a client response, for example, the client may feel like they answered a question incorrectly and may attempt to alter their response to please the nurse or get the "right" answer.

Nonverbal information from a client can often provide a more accurate assessment of the client's feelings than the verbal information. A client may say they are not in pain or are not sad, but then wince when the nurse reaches to assess the area or have a flat affect conveying sadness. The reason this information is often more accurate is there is less conscious control over nonverbal actions. If the verbal and nonverbal cues do not match, the nurse must be aware of this and note it as part of the assessment.

CULTURAL CONTEXT

Trust and Health Communication

As a nurse, it is important to be culturally sensitive with each client. There are certain cultural groups that, because of historical events or cultural mores, do not trust health providers and information; trust is built over time with health-care providers and nurses. When communicating with members of cultures that lack trust in the health-care system, it is important to ask the client if and how they prefer to be touched and to explain the unknown as much as possible. Nurses should convey respect and understanding, should ask for clarification, and should restate what the client is saying to ensure that the nurse is understanding correctly.

Along with this lack of trust, according to Maercker et al. (2019), certain groups also hold a strong belief in fatalism, that life events are determined by forces outside one's control. As nurses engage with people with fatalistic beliefs, it is important to acknowledge and discuss some of these beliefs with them before offering assistance. Understanding this can help the nurse communicate better with the client. Overall, clients want to be well and want to know they are on the road to wellness. With some information and sensitivity, nurses can help clients from all cultures by empowering them with the tools to feel more in control of their health and to care for themselves.

Barriers to Therapeutic Communication

Nurses should be mindful of barriers to therapeutic communication so they can overcome the obstacles to communicate with clients effectively. Several common barriers to optimal therapeutic communication that nurses should avoid include challenging, probing, changing the subject, becoming defensive, providing false reassurances, disagreeing, judging, rejecting, and minimizing importance to the client. Here are some other barriers the nurse should consider.

Inattentive Listening

Clients notice when a nurse is not tuned into the communication. If the nurse breaks eye contact, appears to be daydreaming, fidgets, talks over the client, or asks a new question without waiting for an answer to the last one, the nurse is not being attentive. Other obvious inattentive behaviors include tapping the foot or pen on the table, looking at a watch or clock frequently in the interaction, or gazing at the computer or out the window while the client speaks. Nurses should make a concerted effort not only to be attentive, but also to communicate attentiveness. Utilizing similar or the same words a client says verbally communicates active listening. A nonverbal cue like nodding can go a long way toward making it clear that the nurse is listening.

Nurses may record data during interaction with clients, and this should be done with consideration of the client's perception. A brief request or explanation can contribute to the therapeutic quality of the interaction, such as, "I will

make a few notes while we talk," or "I will be entering some information into the computer."

Using Medical Terminology

When a nurse uses medical terminology without defining or explaining it clearly, it may create a barrier to communication with the client. Medical jargon can confuse a client, cause anxiety for them, and create a power differential between the nurse and client. The client may ultimately feel less informed because they do not understand the words the nurse is using and do not feel comfortable revealing their lack of understanding. At the same time, it is important that the nurse not talk down to the client; understanding and meeting the client where they are in terms of ability to understand information related to their health is a skill nurses should develop.

Asking Personal Questions Unrelated to the Visit

Asking inappropriate questions for the sake of interest is invasive. If the client chooses to communicate personal information, they will, but the nurse should not inquire about it. Examples of inappropriate questions would be those that address political party affiliation or views on reproductive issues, or questions that challenge the client's coping, such as "Why do you always show up here when you are in trouble?" or "Don't you think it is time for you to stay on your medications?"

Assessment questions should not include presumptions such as, "Since you refuse to answer the question about sex, are you gay?" These types of questions are inappropriate, judgmental, and cruel. Another is "I see you sitting close to that other male who visits you, daily. That is not your spouse. Is he your other spouse?" Again, this is intrusive. The nurse can ask the question as, "How are you related to the male visitor who comes daily?" The client can then answer as they want.

The nurse may have to gather personal information for therapeutic purposes, but should do it in a nonthreatening way. There are assessment data that will lead a nurse to ask personal questions to collect further information about the client or their situation. An example is if the client presents with signs and symptoms of physical abuse. Inquiring about how a bruise, abrasion, or laceration was acquired may lead the nurse to dig deeper with questioning. That client may show signs of apprehension and shifting eye contact if these questions require the client to admit abuse. This can be a very sensitive issue for the client. The nurse should be cognizant of this. The nurse must remain calm and professional. The nurse could say to the client, "I'm concerned about your safety. I can understand if this conversation is uncomfortable for you. I am here to help you and keep you safe." A caring approach can help reassure the client that the nurse is seeking to gain a better understanding and thus advocate for the client.

Expressing Approval or Disapproval

Nurses should not agree or disagree with clients' values and beliefs. It is the nurse's responsibility to respect clients who carry different types of beliefs, whether they are in accord with the nurse's or are diametrically opposed. If nurses use words, such as should, ought, good, bad, right, or wrong, these terms can send the message that the nurse is judging the client or their decision. The nurse may agree with the client's decision process or the actual decision, just not the value of the decision. A therapeutic response may be, "It sounds like you have given this some thought," or "I can see you have made a decision, tell me how you came to this outcome."

Changing the Subject

When a client is disclosing something that is painful or personal, the nurse needs to use therapeutic techniques to show the client that the information is important and offer care and empathy while this disclosure is happening. Often, nurses who are uncomfortable with the client's information will dismiss the message by changing the topic of discussion. Instead of changing the subject, nurses in this situation should use active listening and ask clarifying questions to keep the message flowing. Clients could view changing the subject as insensitive and uncaring.

Making Remarks That Are Minimizing

Saying something like, "At least you are not here for treatment for terminal cancer; it could be worse" conveys a lack of concern. These types of remarks, though they may be intended to offer a broader perspective, belittle a client's message and feelings. They imply that the nurse is not taking the client's questions or condition seriously. Any statement that begins with "at least" communicates one should be grateful for what is not happening. It implies that the problem the client is experiencing could be worse and to consider themselves fortunate. This is not an empathic response and works against the nurse's objectives because the goal is to have the client open up and

share more about their feelings and situation.

Providing False Reassurance

Similarly, when nurses offer trite responses to a client who is seriously distraught, it can come across as not genuine. It may be the intention of the nurse to offer hope or assurance when saying to a grieving parent, for instance, "In a few years, this will look totally different to you." But the client may actually feel discounted and as if their feeling is not valid now, in the moment. The nurse can explore open-ended questions to encourage the client to discover their voice related to the issue. A better alternative statement of assurance may be, "I am sorry for your loss, grief is hard work and takes time." Another alternative to speaking or replying to the client is to actively listen to the client's thoughts and feelings. This allows the client to feel heard and validated.

Expecting Justifications

Asking "why" can imply an accusation or judgment and often results in defensiveness. For example, suppose a nurse asks a client, "Why did you take all the pills in the bottle, and then call 911?" In response, a client may feel challenged to defend their actions rather than dig deeper to the underlying emotions behind the actions. Instead, the nurse can ask, "Help me understand the desire to hurt yourself" or "Tell me your feelings at this time of self-harm." These questions show concern and caring for the client and allow the client to explore the reason for their actions without feeling judged or defensive.

Disagreeing with the Client

Challenging the client's perception of a situation can also create a barrier to therapeutic communication. It implies that they are lying, misinformed, or uneducated. For example, a nurse says to a client who has anorexia, "Your weight is exactly the same as last week, so you haven't stayed on your nutritional plan in spite of you telling me you are hungry at lunchtime." This statement accuses the client of noncompliance and lying, which can only serve to make the client feel attacked, guilty, and defensive, and that they have "failed" their plan of care. A better response is: "The numbers on the scale are the same as last week. Can you give me your food list for last week's meals?" This helps the client explore with the nurse the reasons for the lack of weight change and is not challenging the client's statement that they were hungry at lunchtime.

Knowing what *not* to do is part of learning how to care for clients. Self-awareness and knowledge of these communication barriers can help nurses enhance their therapeutic communication techniques and form positive and productive nurse-client relationships.

Therapeutic Nurse-Client Relationships

A **therapeutic relationship** is a healthy relationship that develops over time, and is based on mutual trust and respect. In the relationship, there is a nurturing of health, hope, wellness, empathy, and therapeutic interventions to help the client through their current encounter. It evolves through therapeutic communication and by understanding the phases of the nurse-client healing relationship. Here are the four phases of the therapeutic relationship as outlined by Peplau (1952):

1. Pre-orientation phase: During this phase, the nurse self-reflects on their feelings, fears, and thoughts on the client and the client's situation. The nurse analyzes their own personal and professional strengths and weaknesses in the context of the client. They collect information about the client and prepare a plan of care. This phase can be done after bedside report or grand rounds on the clients. This can often be collaborative with the nurse giving the report, discussing the best interventions or asking questions about what insightful thoughts, fears, or feelings the nurse has on the client and the circumstances they are currently in.
2. Orientation phase: This phase is marked by establishing rapport with the client, gaining trust, and creating an environment where the client feels safe and accepted. The nurse gently starts the communication and collects data about the client's feelings and reason for seeking assistance. The nurse also identifies problem areas and plans interventions. The nurse then establishes, with the client's collaboration, mutual goals to help solve the problem(s). The nurse also explains the plan of care to the client. This includes when and how long the nurse will spend with the client and when expected discharge or termination of the relationship may occur.
3. Working phase: This is the phase where most of the therapeutic interventions occur. The nurse and client work as a team to identify stressors, promote insight into the client's problems, and find solutions and ways to implement them. During this phase, the nurse collects more data on the client, promotes healthy coping

mechanisms, and helps the client understand their own behavioral changes by encouraging self-evaluation. The nurse is consistently encouraging the client to function independently and redefine the problem as needed.

4. Termination phase: This is a critical phase in the nurse-client relationship, and, as mentioned above, is set at the Orientation phase. The main point in the plan of care is to have the client resolve their issues with independence and confidence. This is the phase that brings the relationship to an end. The nurse explains the reality of the separation and evaluates the effectiveness of therapy and the progress toward goals. The nurse and client mutually explore the feelings and behavior related to termination.

Nurses should be aware of these phases and assess progress toward the mission of each one, but should also know that the phases do not necessarily work chronologically. They are more fluid in nature, changing as the nurse and client work together and develop a relationship tailored to the client's needs. These phases apply to relationships that have a short or longer time frame and in situations that are emergent or long-term. The therapeutic relationship requires having respect for each other. Respect within the relationship means honoring each other's boundaries within the relationship.

Physical Boundaries

Relationships are characterized by different types of boundaries. It is important to establish and respect physical boundaries in any human interaction. It is particularly critical when developing a therapeutic nurse-client relationship where breach of physical boundaries may be part of the caregiving process. Physical boundaries include what people perceive to be their intimate, personal space, social, and public spaces. These boundaries also include who is allowed to be in these spaces and the degree to which (and by whom) they agree to be touched. According to Van Edwards (2021), **proxemic** is how much physical distance individuals like to have between them when conversing with other people. The anthropologist Edward Hall created the word in the early 1960s. He organized the boundaries as four zones: the intimate space, personal space, social space, and public space (Table 3.1).

Zone	Distance	What It Means
Intimate Space	Physical contact to eighteen inches	It shows close partners, lovers, spouses, and closest of friends.
Personal Space	One to four feet in distance to the other person	It shows relationship status. The closer the parties, the relationship is closer in status, length of knowing, and agreement.
Social Space	Four to twelve feet in distance to the other person	Most strangers start at this distance; as the relationship develops, the distance will close, to no closer than four feet.
Public Space	Greater than twelve feet	Stranger, not known by each other in a public place, both parties are not in any need for contact.

TABLE 3.1 Proxemic Distances

When interviewing a new client, it is important that the client feels physically safe to express themselves without feeling threatened or defensive. Nurses should carefully assess each client's individual physical boundaries. Because caregiving may naturally intrude on the client's physical space, it is paramount for the nurse to express understanding of a client's boundaries, explain the need to cross them, ask for permission, and not be any more intrusive than a situation requires. Physical boundaries can be specific to a person's culture. Therefore, nonverbal communication, such as body language, is important to assess when thinking about physical boundaries.

Emotional Boundaries

The nurse needs to assess the client's emotional state and evaluate what is best for that client in terms of emotional limits. Once noted, the nurse must be self-aware to separate their own feelings from the client's feelings. The nurse can have compassion and empathy for the client's condition without passing judgment and becoming overly involved in placating the client, maintaining respect for the client's emotional state. Respect toward the client and their reason for seeking assistance should be part of the nurse's reflection during the communication. If the client is

depressed, for instance, they may not be able to answer all the questions in one sitting. This client may need blocks of time to discuss the elements of the admission assessment. The client who is crying or despondent may need to reach an emotionally neutral status with the help of the nurse and then the assessment can move forward.

Social Boundaries

Social boundaries represent another important consideration when developing a therapeutic relationship with a client. The nurse should avoid socializing with clients except when making small talk to open a conversation or start an interview. Opening with a bit of socializing often places the client in a relaxed state. After that, however, a nurse should not share intimate details about their life, should not ask invasive and treatment-irrelevant questions about the client's life, and should not take lunch or work breaks with clients. Maintaining professional boundaries takes self-reflection when a nurse finds themself reaching to create a friendship with a client.

When nurses share their own feelings about their lives or situations, it often crosses a line and creates a nontherapeutic relationship with the client. This burdens the client with the nurse's feelings and problems. The nurse-client relationship should be a professional one, characterized by compassion, not a social one. Table 3.2 lists the differences between therapeutic and social relationships.

Therapeutic Relationship	Social Relationship
Directed toward a client's needs per nursing assessment; a nurse *must not* cross boundaries and share their personal story (if clients ask personal questions, answer briefly then return to the client's experience. ("Yes, I have two children. Tell me about your kids." "No, I have never had surgery. What's this experience like for you?")	Two-way: meets needs on both sides; each shares feelings and experiences with the other; may keep secrets, exchange phone numbers, loan/borrow money
Follows steps of the nursing process	Does not involve planning or evaluation
Involves empathy (acknowledging, respecting the other's feelings and point of view, having compassion, being available for problem-solving)	Involves sympathy (sharing the person's feelings, may feel pity, may view the other's situation from own perspective, could involve judgment)
Planned termination with expectations set at the beginning: "I'll be here until 3:00"	No particular time frame
Involves specific phases: pre-oreintation, working, and termination	Does not involve any formal stages
Never sexual, no expectation for client to meet the needs of the nurse, who must keep an emotional distance	May be sexual or codependent

TABLE 3.2 **Differences between Therapeutic and Social Relationships**

REAL RN STORIES

Nurse: Sara, RN
Years in Practice: 0
Clinical Setting: Adult psychiatric unit
Geographic Location: Washington, DC

Sara is a novice nurse who recently began working in a psychiatric adult unit in Washington, DC. She finished orientation two weeks ago and has gone out with a few friends from work for dinner and to a peer's birthday party.

She comes to work one day to visit with a friend from work on her day off. During the visit, Sara notices a client she admitted a few days prior. She says hello to him and asks how he is feeling. The young male, about her age, was admitted with depression related to family issues. The client tells Sara that he is better and thinks he may be going home in a few days. Sara smiles and tells him that this is great to hear.

The next day, Sara finds herself thinking about the client and decides to go up to the unit again on her day off. This time, she asks to visit with the client specifically. Her peers ask her why she needs to visit the client. Sara is evasive and begins to feel uncomfortable with the questioning. The charge nurse explains to Sara that her behavior is a violation of the professional boundaries she needs to maintain with the client. Sara then says, "Oh, that's right; I'm sorry. I should not be here on my day off asking to visit with a client." She turns and walks away, embarrassed.

When she returns to her car, she recalls the lessons on professional boundaries she learned in school. She reflects on why she wanted to visit with the client. She thinks about it deeply and then returns home to journal about her experience and feelings. After journaling, Sara comes to realize she is lonely. She desires a male friend or romantic partner. She then thinks about why she would choose a current client to fulfill this and concludes that the client was an easy person to meet and was physically attractive. After a while, Sara makes an appointment with a counselor to talk about it. She takes the situation seriously and also makes an appointment with her supervisor and charge nurse. She is transparent about her feelings and her actions. Sara tells the nursing leaders she realizes her thoughts and actions were not professional and could have been burdensome to the client. Sara does not care for the client again, and continues to seek professional help for her loneliness. About three months later, Sara is thankful for the experience and has joined an art class to express her feelings, meet others, and learn a new hobby.

Treatment Issues and Obstacles

The focus should always be on the client, not on the nurse. If, because of crossed boundaries, the relationship starts to become nontherapeutic, nurses should first seek self-awareness about the situation, then ask for and accept feedback from peers and mentors about what path to take forward.

Other obstacles to creating therapeutic relationships when treating clients with psychiatric illnesses are side effects of medications, symptoms of the illnesses, and chronicity of the client's diagnosis. Many clients enter psychiatric treatment during a crisis of their illness. This can limit the development of the nurse-client relationship until the crisis has subsided, medications reach a therapeutic level, and the environment is such that the client can communicate well. Hallucinations and delusions as symptoms, until treated successfully, can inhibit a developing nurse-client relationship. Sensory deficits can also encumber therapeutic relationships as can the chronic nature of psychiatric illnesses, which can cause hopelessness in clients and nurses alike. The nurse may need to confront and address their own conflicted feelings about clients' ongoing interventions with their own working peers and supervisor. The nurse's conscious and unconscious behaviors and attitude affect the therapeutic relationship with the client. If the therapeutic relationship becomes untherapeutic, this can have negative consequences for the client's improvement and well-being.

3.2 Client Perception of Illness

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss client beliefs about and stigmas associated with psychiatric-mental illness
- Identify factors that influence the perception of psychiatric-mental illness
- Review treatment compliance and resources for psychiatric-mental illness

Mental health, according to the World Health Organization (WHO, 2022a) is a "state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (para. 1). Mental disorders are "characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior" and are "usually associated with distress or impairment in important areas of functioning" (WHO, 2022b, para. 1). Mental illness has been stigmatized for centuries. Perceptions differ across groups, general public or professional, and those experiencing a mental illness. There are numerous reasons behind the perceptions about mental illness, including cultural beliefs.

Client Beliefs and Stigma

Where do people obtain or learn beliefs and attitudes in general? They come from numerous sources, including families, schools, workplaces, culture, society, and religion. Beliefs and attitudes are formed by those who teach, model, and influence people. Clients' beliefs about mental illness are often formed by societal stigma, cultural beliefs, and treatment issues specific to illnesses rather than by academic sources of information.

There are many misconceptions about mental health in the United States. There are people who believe that individuals choose all of their behaviors. Some people do not understand the degree of pain associated with illnesses like depression and panic or anxiety disorder. They may believe that people dealing with depression are "just lazy," "don't want to work for a living wage," or "want to stay home and not have to interact with difficult people." Others may think that if a person combatting anxiety would "just get over their fear with enough willpower, they could function and not have a problem." These types of ideas and beliefs often lead to a stigma that can lead those living with mental illness to refuse help and begin to believe that they are beyond help, leading to thoughts of suicide.

In the medical field, illness is related to the physical body and organs of the body. Research has shown that mental health or mental illness can also be related to the physical body. For example, chemicals in the brain called neurotransmitters are released and taken into the neurons, or cells of the brain, to allow the brain to function. Without the chemical release in the necessary amounts, correct timing, and proper reabsorption, the brain does not function at its optimum. In other words, mental illness has organic, physical causes.

Another reason behind the stigma is the historic institutionalization of individuals living with mental illness. These clients were once considered incurable so found themselves housed in institutions where they possessed very few rights. This treatment approach created a stigma because clients' liberties were removed, so they were labeled as "separate," and they were not permitted to live in society. As pharmaceutical research advanced, however, new psychiatric medications came about to treat mental illness. Clients receiving effective medications no longer found themselves locked in hospitals and instead were able to live and function within their communities.

When nurses and other health professionals are educated on these facts, the stigma of mental illness lessens. Nurses are taught to observe the client as a holistic being living with an illness. In these cases, the illness involves thoughts, mood, and behaviors.

Factors Influencing Perceptions

Different cultures may have different beliefs and attitudes about mental health and mental illness, and this affects how clients perceive their own conditions. For example, some indigenous cultures in America, such as the Apache and the Iroquois, may believe a person exhibiting signs and symptoms of mental illness is possessed by evil spirits (Danchevskaya, 2020). For this reason, an indigenous practitioner (or someone intimately knowledgeable about the culture) may be the best person to interview and care for such clients. The indigenous health-care provider knows the rituals and can create an environment that shows support for indigenous beliefs while treating with other techniques. Western medical methods to treat mental illness can exist with traditional underpinnings.

Perceptions that influence behaviors make up a person's **belief system**. Nursing consideration of the client's perceptions can clarify assessment findings. Some who value competition may not seem cooperative to those not sharing that value. Those who suppress outward responses may be undertreated for pain. Clients distrustful of providers may receive misdiagnoses, inappropriate medication dosages, or ineffective monitoring for medication side effects.

Families may be blended across cultures, religions, belief systems, and languages, so nurses can only rely on the therapeutic relationship to establish a connection with clients. Nurses must focus on client-centered care and inquire about the client's social identity, for example, the nurse may say, "Within your culture or personal beliefs, what are ways we can help you while you are here?"

Treatment Compliance and Resources

Clients' beliefs and attitudes factor heavily into their understanding of and compliance with treatment. When assessing **compliance**, meaning adherence to treatment recommendations, there are many factors that the nurse must consider in mental health. Some of these factors are within the control of the client and others are not.

Factors that the client cannot control are termed nonmodifiable risk factors and are important to consider. Cognitive impairments, poor insight, cost factors, limited access to health care, and the lack of social support are examples of these factors. Factors that the client can control related to compliance are known as modifiable risk factors. These can include clients' attitudes toward their own health, becoming informed about their medications and the side effects, and discussing these matters with their provider and nurse. The nurse should establish a therapeutic relationship to encourage health plan compliance. The nurse can offer information related to the client's questions to help the client comply with their treatment plan. The nurse can also inform the client about local resources that can help with social connections, costs, and access to health care. Often, there are social resources the nurse can refer the client to for other issues the client may be facing, such as housing or food insecurities.

Directions that clients take related to the problems with their health are called a **help-seeking pathway**. Because of the stigma related to mental illness, there are perceptions that influence clients who want help and affect their treatment compliance. Often, clients do not know how or where to go for help. The primary care provider is often the first link to reaching out for assistance. There may be reluctance to confide the issues related to mental illness. If the client has a therapeutic relationship with the primary care provider, this can aid in getting assistance. Clients who do not have a primary care provider or a local clinic to attend for health-care needs encounter a major barrier to assistance. For the clients who are on medications, they may experience side effects that they cannot explain or describe. These side effects may draw unwanted attention to them and require explanation to their peers, coworkers, friends, family members, and others in their circles. A cultural aspect of the United States is that people can independently resolve their own problems without seeking outside help. These assumptions negatively influence a client if they seek help. Educating the client and their significant others is very important to avoid or change perceptions related to seeking assistance. An analogy often used is if a person has a physical problem, seeking help from a medical professional is expected. The same can be applied to the one experiencing a mental health problem. There are health pathways to assist, treat, and potentially resolve the problem.

There are multiple sources from which clients and families can obtain information about mental health and mental illness. The CDC is a great place to start when investigating psychiatric illness. Here is a list of websites that offer information on mental health issues and how to cope.

- Centers for Disease Control and Prevention (https://openstax.org/r/77CDC)
- Mental Health First Aid (https://openstax.org/r/77NCMW) from the National Council for Mental Wellbeing
- National Institute of Mental Health (https://openstax.org/r/77NIMH)
- 211 help line (https://openstax.org/r/77211Help)
- World Health Organization (https://openstax.org/r/77WHO)
- National Alliance on Mental Illness (https://openstax.org/r/77NAMI)
- Substance Abuse and Mental Health Services Administration (https://openstax.org/r/77SAMHSA)

3.3 Nursing Assessment and Clinical Tools

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Compare a physical head-to-toe nursing assessment to a psychiatric-mental health (PMH) physical nursing assessment
- Identify characteristics of a psychosocial assessment
- Describe the Clinical Judgment Measurement Model (CJMM) to recognize, analyze, and prioritize assessment data

It is important to follow the nursing process when caring for psychiatric clients. Using a holistic approach, the nurse should conduct both physical and mental aspects of assessment. Data from the physical assessment complements the psychiatric-mental health (PMH) assessment. This information may come from the medical record, interview, or physical examination and includes asking the client about existing physical health conditions (comorbidities) that may be affected by medications utilized to treat the mental health condition.

The Clinical Judgment Measurement Model will help the nurse with clients who present with emergent or chronic signs and symptoms of mental illness. The focus in that model is on recognizing, analyzing, and prioritizing the findings. By the end of this section, it should be clear what to focus on for the different assessments and how to use the critical information.

Physical Nursing Assessment

The nursing process starts with the assessment of the client. The physical assessment contributes to the psychosocial assessment. Clients in mental health treatment may be pregnant, using substances, or living with one or multiple chronic medical conditions, such as diabetes or hypertension. The psychiatric diagnosis may be caused or worsened by a physical factor, such as thyroid disorder or cardiac medications contributing to depression. During the physical assessment, the nurse begins to establish rapport with the client by introducing themselves and explaining the process of the assessment. It is essential the nurse be honest and allow for some flexibility in the assessment based on the client's behavior, mood, stability, mental status, and general health. It is helpful to begin with creating the environment and ensuring the client's privacy and safety. Ask the client what brought them into the health-care setting. Then, move into the details.

In a general hospital, psychiatric units may have an exam or treatment room equipped for medical procedures, such as suturing, wound care, women's health, specimen collection, or full physical examinations. These procedures may be performed by professional consultants asked to visit the client. Clients from the hospital's emergency department or from another facility may receive medical clearance as a prerequisite to psychiatry admission.

The physical data obtained by the PMH nurse is likely to be basic, and specifically indicated to clarify or add to psychosocial assessment findings. A personal search is policy in many treatment settings and involves a clothing check for items that are not allowed and observation of the client's skin for rashes, wounds, and physical signs of abuse. Sometimes, clients are given different clothing to wear in the unit.

Vital signs are obtained and the client is asked about allergies and medications. The nurse may follow standing orders for routine or basic lab work and possible X-rays to assist the provider with diagnosis and to discover any issues that need further follow-up. The nurse should complete a neurological assessment initially because this baseline is necessary for the nurse to observe any decline or improvement in the client. The neuro assessment includes:

- Explaining to the client what the nurse will do and asking for permission to begin.
- Orienting to person, place, and time. The nurse will ask the client their name and date of birth, and verify with name badge/bracelet and chart information. This can include a picture of the client. This orientation often contains general knowledge questions: Who is the president of the United States? What season of the year is it?
- The nurse then must check the pupils for PERRLA (pupils equal, round, reactive to light and accommodation).
- Next, the nurse should check the client's tongue to see if it is midline and does not deviate.
- The nurse all the while should be observing the behavior of the client to notice if they are cooperative with what the nurse is asking them to do.
- The nurse will test the strength of the client's grip and their ability to push against the nurse's hands.
- The nurse will assess the client's gait and how prone to falling the client may be. Asking the client to walk on their heels or stand on tiptoe can help the nurse determine the client's sense of balance.

Once this is completed, the nurse should document the findings.

The physical assessment could also include auscultation of the lung and heart sounds, and this must be done in a trauma-informed manner, which is discussed in Chapter 2 Fundamentals of Theories and Therapies. The nurse explains the procedure to the client and is mindful of the effect of touch. Nursing judgment determines how this part of the assessment will be done.

It is vital to establish if the client is thinking about suicide or harming others. This is a crucial safety aspect. If the client reveals this, the nurse needs to gain more insight into how, when, and who they are thinking of hurting.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Evidence-Based Practice (EBP)

The QSEN Competency for EBP involves delivering optimal health care by combining the best current evidence with the nurse's clinical expertise and client/family preferences and values. The nurse will:

- value the concept of EBP
- develop an individualized plan of care
- include components of evidence, client values, and nursing expertise (Cronenwett et al., 2007)

Psychosocial Assessment

A **psychosocial assessment** is an evaluation of a client's mental health in relation to their social well-being. The psychosocial assessment looks at self-perception and the client's ability to function in the community. The objective of the psychosocial assessment is to establish a baseline for the client and understand the client to provide the best care possible for their mental health. Generally, the environment for the psychosocial assessment should be calm, clean, private, and safe for the client and the nurse. The nurse can offer the client a chair. Nurses should help the client to feel comfortable by using a nonjudgmental tone and exhibiting open posture. It is important for the nurse to explain what will happen to help the client feel at ease, know what to expect, and alleviate the client's fear and anxiety.

The psychosocial exam can begin by asking clients about their employment and continue by asking them to describe their current living situation. While asking these questions, the nurse should observe the client's facial expressions, bodily movements, eye contact, posture, tone of voice, and different noises or tics they may have. Is the client jittery, looking around the room, lacking focus on the questions? Is the client mumbling, pointing to items that are not present, or asking if you see something (a hallucination) that is not present? The nurse must be vigilant about noticing the client's behavior and ask questions that help the client articulate what they are experiencing. Questioning the client about their current and most recent mood is helpful. Inquiring about how the client copes with stress can offer the nurse insight into how the client is coping now and how they have historically coped with stressful events.

The aspects of the psychosocial assessment are:

- home environment
- education/employment
- activities outside of work/hobbies
- drug/tobacco/alcohol use
- sexuality/gender
- suicide risk
- violence risk

Home environment means determining how safe and secure the home is and how the client relates to those in the home: parents, children, spouse, significant other, roommate. How do they interact with them, are there frequent arguments, how are arguments resolved, and how does the client cope with the living arrangement?

Education/employment establishes the level of education the client has at the time of the assessment and what the client does for employment. Does the client have a plan or desire to change their job or education level and, if so, how and where are they on this change?

Questions about activities outside the workplace/hobbies determine what the client enjoys doing with their time outside of working. Does the client play sports, create art, enjoy woodworking or reading? What does the client aspire to do for leisure?

Drug/alcohol use is important to assess because clients may use substances to self-medicate or cope with stress and anxiety. Ask the client, without judgment, if there is use of illegal or illicit drugs. It is vital to know when and how much the client has taken and regularly takes when it comes to illicit drugs or alcohol. Withdrawal can affect a client's health and medical and mental stability. The nurse should also ask about over-the-counter medications, herbal remedies, complementary medications, and prescription pain medications. There may be misuse and/or contraindications between these and drugs to be prescribed.

Tobacco use/vaping is also something to investigate. Clients who use tobacco are often limited in their use when admitted to hospital care units. Some facilities are completely nonsmoking. The assessment is a good time to explain this and to determine if the client is a candidate for nicotine replacement therapy or smoking cessation support. This is individualized and should be considered when discussing the plan of care for the client.

Sexuality also requires discussion. Sexuality covers partner preferences, whether or not the client is sexually active, and if they understand how to protect themselves from sexually transmitted infections, unintended pregnancy, and interpersonal violence. Further conversations on these topics can be part of the client's plan of care.

Ask the client about their gender identity and preferred pronouns, and strictly abide by their voiced preferences. How the client identifies should be clear in the documentation, so the entire staff can be respectful.

Risk Assessment

The assessment evaluates suicide risk to ensure client safety. Often, clients feel relieved when a health professional asks them if they intend to hurt or kill themselves. There is a sense of relief that comes from someone noticing a problem and how much pain the client is in.

LINK TO LEARNING

The Suicide Prevention Resource Center produced a pocket card for the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (https://openstax.org/r/77samhsa) for use by health-care providers. It provides triage guidelines, documentation guidelines, and treatment and intervention protocols.

If the client admits to having thoughts of suicide, the nurse must ask deeper questions: What is your plan to do this? How and when are you thinking of carrying it out? How long have you been thinking about it? Affirming the client by telling them you are glad they were honest with you is important to demonstrate empathy and caring for the client under difficult circumstances.

LINK TO LEARNING

Read the APNA Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide (https://openstax.org/r/77apna) for important information about suicide prevention.

Violence risk means asking the client if they think about hurting others. What plan do they have to carry out the violence, and do they have anything written down and where? It is also critical to ask the client if they own weapons and where they are. Continued surveillance of the client may be part of the safety plan.

Asking these hard questions is vital to understanding where the client stands, what they are thinking, and how (and by what) they are being influenced. This assessment helps build trust and rapport with the client. Assuring the client that the information is confidential among the health-care team will encourage the client to be honest and forthcoming.

Tools Available for Psychosocial Assessment

There are many psychosocial assessment and mental health screening tools to use (Figure 3.5). The facility policy will dictate which tool to use. Here is a list of the most common assessments:

- Mini Mental Status Exam
- Mental Status Exam
- Brief Psychiatric Rating Scale (BPRS)
- World Health Organization Disability Assessment Schedule 2 for psychiatric clinicians (WHODAS 2.0)
- McMaster Family Assessment
- Addiction Severity Index (ASI)
- Recovery Attitude and Treatment Evaluator (RAATE)
- Brief Drug Abuse Screen Test (B-DAST)

Psychosocial Nursing Assessment		
NAME: WJ	**DOB: 11/18/1948**	**MRN: 09786544**
Admitting Diagnosis	Adjustment disorder	
Mental Status/ Cognitive Function	Appropriate attire and hygiene, cooperative, speech slowed, blunted affect, sad mood, fully oriented to admission process, accepts need for treatment, denies hallucinations, denies excessive fears, admits to memory loss, hard of hearing, poor concentration, insight limited: "I don't know what's wrong—just getting old I guess."	
Treatment History	Seen in primary care office over last 10 years; no prior hospitalization for mental health	
Medical History/ Medications	Myocardial infarction 2008; atorvastatin, propranolol, primidone, tamsulosin, aspirin; nitroglycerin as needed, states, "I almost never use it."	
Recent Change or Stressors, Effect of Illness, Goals of Stay	Adult children moved out of state, reports "no appetite" past 30 days, widowed × 2 years; "Just want to feel better."	
Lifestyle/Coping	"I stay home, watch TV." Church member, not attending × 6 months: "I handle myself OK, I guess." Reports usual method of handling stress is reading, going fishing with son; now reports low interest, son no longer lives nearby	
Drug/Tobacco/ Alcohol Use	Quit smoking 20 years ago, social alcohol but none in past year, no recreational drug use	
Spirituality/Cultural	Member of Catholic church, not attending, denies cultural need for diet or routine	
Home Environment	Lives alone, owns home, no pets, access to public transportation, feels safe in neighborhood	
Education/ Employment	High school graduate 4 years military service, no combat Retired with pension from accounting job	
Sexuality/Gender	Identifies cisgender male, currently not sexually active	
Strengths	Physically self-care, literate in English, financially secure Does not identify any personal strengths: "I'm pretty much worn out, no good to anybody."	
Leisure Skills	Formerly member of a bowling team, has not participated in past 6 months	
Risk Factors/ Suicide/Violence	"Nobody would miss me if I was gone." Denies ideation or plan for self-harm; states, "I wouldn't mind if God would just take me." Denies ideation or plan to harm others, no guns in the home	

FIGURE 3.5 A general psychosocial assessment covers several areas of a client's life to determine the client's mental health and social well-being. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Clinical Judgment Measurement Model

Clinical judgment is key to working with clients with psychiatric illness. When the client is in crisis, the nurse must recognize the signs and symptoms and determine what action to take to keep the client and others safe. The **Clinical Judgment Measurement Model (CJMM)** was developed by the National Council of State Boards of Nursing to assist graduates to answer client care questions on the nurse licensure exam. The CJMM provides a nursing

framework to decipher client problems. The nurse must recognize cues, analyze them, decide if the cues are important enough to act on immediately or if can they wait, identify and prioritize problems, then generate and implement a plan of action/intervention/solution.

LINK TO LEARNING

Watch this quick video to see how the Clinical Judgment Measurement Model provides a framework to measure your clinical judgment (https://openstax.org/r/77clinicaljudg) on the NCLEX.

There are many scenarios where a nurse practicing in psychiatric care should use this model. For example, suppose a client is admitted and is actively suicidal. The nurse recognizes the cues from the client, prioritizes the need for safety, then formulates the solutions to help the client. Another example is when the client is actively psychotic and is aggressive and hostile toward the other clients in the unit. The nurse again recognizes the cues of unpredictable behavior, lack of impulse control, and delusions. After recognizing the cues, the nurse will analyze the cues and determine actions, such as changing the client's room, administering certain medications immediately and others later if they can wait, and assigning a staff member to monitor the client's actions to keep everyone safe. The Clinical Judgment Measurement Model offers a guiding framework to assist the nurse to answer NCLEX questions about client care.

CLINICAL JUDGMENT MEASUREMENT MODEL

Applying the Clinical Judgment Measurement Model

When treating a client who is actively suicidal or is aggressive and hostile toward other clients, the nurse can apply the steps of the CJMM:

- Recognize cues, such as unpredictable behavior, lack of impulse control, and delusions.
- Analyze cues to determine that the client is aggressive, hostile, or actively psychotic.
- Determine actions, such as client room assignment, medication administration timed as indicated, or assigning a staff member to monitor the client's actions.

Summary

3.1 Therapeutic Communication and Relationships

Communication is an art and a science. The facets of communication—sender, message, channel or mode, recipient, feedback—are consistent, but the human component brings in other considerations like emotions, nonverbal cues, and boundaries. The nurse must continually strive to communicate in a therapeutic manner and avoid common obstacles like inattention, false encouragement, and infringing on physical, emotional, and social boundaries. The nurse must also learn to reflect on the interactions with clients to improve their active listening skills and nonverbal communication and enhance their compassion.

3.2 Client Perception of Illness

Mental health and mental illness are complex and have many dimensions, in part because of beliefs and attitudes toward the topics. Many clients have formed their beliefs from the cultures in which they were raised as children and from their adult experiences. When a client is experiencing a mental illness, the perceptions of mental health treatments can be the driving force behind whether or not the client seeks help and/or complies with treatment. Education is one of the most important ways to influence perceptions and beliefs. Nurses are responsible to help educate on mental health and should take an active part in this mission.

3.3 Nursing Assessment and Clinical Tools

The nurse should conduct physical and psychosocial assessments with psychiatric clients. The psychosocial assessment includes questions about the client's environment, lifestyle, and mood and encourages the client to express their problems. The Clinical Judgment Measurement Model, also addressed in this section, provides a framework for understanding the client needs, how to prioritize their needs, and how to put in place interventions to meet the needs and evaluate the outcomes.

Key Terms

active listening therapeutic technique in which the nurse listens to a client closely, asking questions as needed, to fully understand the content of the message and the depth of the client's emotion

belief system perceptions that influence behaviors

Clinical Judgment Measurement Model framework for nurses to use to decipher the client's problem

compliance adhering to treatment recommendations

help-seeking pathway directions that clients take for help with their health problems

nonverbal communication type of communication where those involved are communicating without words

proxemic amount of space people prefer to have when engaging in conversation with others

psychosocial assessment evaluation of a client's mental health and social well-being; it assesses self-perception and the client's ability to function in the community

self-awareness where the nurse takes time to focus on self, their own words and actions, and reflects on the effectiveness of these in relation to a client interaction

self-disclosure interactive communication process wherein one person shares information about themselves in an appropriate context, modeling the behavior for others in the therapeutic relationship

therapeutic communication when a nurse supports, draws out information for an assessment, or provokes deeper understanding on what a client is communicating

therapeutic relationship healthy relationship that develops over time, is based on mutual trust and respect, and there is a nurturing of health, hope, wellness, empathy, and therapeutic interventions to help the client through their current encounter

Assessments

Review Questions

1. What is the primary rationale for a nursing assessment of a client's nonverbal communication?
   a. Nonverbal communication gives clues to what the client is feeling without words.
   b. Nonverbal communication will not explain the verbal communication.
   c. The client has garbled speech and looks to the family member to help.

d. The nurse should assess the verbalizations first, then look at the nonverbal actions.

2. What main purpose does self-reflection provide for the nurse?
   a. a guide for professional behavior with clients
   b. a guide to encourage the client to disclose their feelings
   c. helps the nurse-client relationship be open to improvement and change
   d. helps the nurse take action on the client's behaviors

3. What is an example of an action by the nurse that demonstrates active listening?
   a. The nurse is facing the client and then looks to the family for answers.
   b. The nurse is leaned back in the chair, arms crossed, asking questions.
   c. The nurse is asking questions and looking at their watch frequently.
   d. The nurse is looking at the client, nodding to answers.

4. A newly licensed nurse shares with their preceptor, "I really like working with Gloria! She and I are so much alike!" What concept should the preceptor review with the nurse?
   a. legal implications of nursing practice
   b. aspects of a social relationship
   c. documentation issues for mental health
   d. aspects of physical boundaries

5. The nurse is preparing to assess the client's attitude toward mental illness. Rank these steps in priority order for effectiveness of the interaction.
   1. The nurse offers educational resources.
   2. The nurse examines their own beliefs.
   3. The nurse plans to use open-ended questions during the interaction.
   4. The nurse explores the client's cultural values without judgment.

   a. 1,2,3,4
   b. 2,1,3,4
   c. 4,2,1,3
   d. 2,3,4,1

6. What statement by a client demonstrates their need for support?
   a. "I will attend group therapy each week because I know it helps me."
   b. "I plan to keep my appointments with the nurse to review my weekly treatment plan."
   c. "I don't like to take medications; however, I know it helps me stay balanced in my thinking."
   d. "This medication I am taking causes so many side effects, I don't know if I can keep taking it."

7. What is an example of a nurse's most therapeutic response when a client's statement demonstrates a barrier to seeking treatment?
   a. **Client:** "My coworkers joke about mental illness, but I don't join in."
      Nurse: "Good for you! They shouldn't make fun of that."
   b. **Client:** "I explained my medication side effects to my little brother and he says he understands now."
      Nurse: "Isn't he only ten years old?"
   c. **Client:** "My father thinks I should handle my problems myself and stop spending money on doctor visits."
      Nurse: "How do you feel about your father's comment?"
   d. **Client:** "I schedule my group therapy for after work."
      Nurse: "The time you go doesn't make any difference."

8. The nurse is planning discharge teaching and notes the client's previous lack of compliance with follow-up care. What is a contributing factor that the client cannot control?

a. the client's attitude
b. limited access to health care
c. discussions with the nurse
d. becoming informed about medications

9. What is an example of the nurse implementing the Clinical Judgment Measurement Model?
a. recognizing cues and prioritizing needs
b. forming solutions based on the nurse's prior experience
c. taking all action immediately
d. taking all action at a later time

10. Why would the nurse continually observe the behavior of the client during both the physical exam and the psychosocial assessment?
a. to see if the behavior matches the verbal communication and if the client is cooperative
b. to determine if the client is listening to the nurse and if the client's responses are truthful
c. to detect the client's sexual identity
d. to evaluate the outcomes of care

11. What is the best nursing response when the client says, "I will answer that question if you promise not to tell anyone"?
a. "You will be closely watched while you are here."
b. "You can trust me; I won't tell anyone."
c. "Information is only shared with the health-care team."
d. "Of course, I have to tell what you say."

12. What is the best nursing inquiry to assess spirituality/cultural data on the psychosocial nursing assessment?
a. "What are your favorite hobbies?"
b. "Are you a member of a faith community?"
c. "What sports do you enjoy?"
d. "How far did you go in school?"

Check Your Understanding Questions

1. Explain in a few words how judging a client's answers is a barrier to communication.

2. What are some reasons for client noncompliance?

3. Describe what assessing sexuality entails.

Reflection Questions

1. How should a nurse handle a situation where a client asks them if they can follow them on social media? What boundary could be violated by the client if this was allowed?

2. What do you think mental illness means? Do you see any bias in your definition?

3. How would you start a psychosocial assessment with a psychiatric client? Describe what the environment would be, and how and what you would ask the client. What are the most important elements to consider for the psychosocial assessment?

What Should the Nurse Do?

Vanessa, a forty-five-year-old female, has presented to the clinic with complaints of persistent anxiety and difficulty expressing her emotions. As a single mother of two teenagers, she reports feeling overwhelmed and emotionally drained. Vanessa has a medical history of hypertension and a recent family loss, contributing to her heightened stress levels. Vital signs are blood pressure of 150/90 mmHg, heart rate of 80 beats per minute, and respiratory rate of 20 breaths per minute. During the initial assessment, Vanessa exhibits signs of emotional distress, such as tearfulness and difficulty maintaining eye contact.

1. What therapeutic communication strategies can the nursing student employ to address Vanessa's emotional distress and establish a trusting relationship?
2. As a nursing student, what specific actions can be taken to address Vanessa's emotional needs and contribute to her overall well-being?
3. Discuss the impact of recognizing and respecting physical, emotional, and social boundaries in the nurse-client relationship on the overall quality of care for Vanessa.
4. As a nursing student, identify potential barriers to therapeutic communication in Vanessa's case, and propose specific interventions to overcome these barriers.
5. Explain how inappropriate self-disclosure or lack of empathy could lead to a nontherapeutic nurse-client relationship in Vanessa's case.

Tony, a thirty-year-old male, has presented to the psychiatric clinic reporting symptoms of persistent sadness, insomnia, and social withdrawal. He describes feeling overwhelmed by irrational fears and an inability to focus on daily tasks. Tony has a history of generalized anxiety disorder. During the assessment, he expresses concerns about seeking help for his mental health, citing the stigma associated with psychiatric illness in his community. Vital signs are blood pressure of 120/80 mm Hg, heart rate of 100 beats per minute, respiratory rate of 16 breaths per minute, and temperature of 98.4°F (37°C). Tony shows signs of restlessness, constant fidgeting, and guarded body language.

6. How might Tony's cultural background and past experiences contribute to his perception of mental illness, and what implications does this have for the nursing care plan?
7. How will a nursing student determine the effectiveness of interventions addressing Tony's concerns about stigma, and what adjustments might be necessary based on ongoing evaluation?

Lucia, a twenty-eight-year-old female, arrives at the psychiatric clinic presenting with a range of concerning symptoms. She reports persistent low mood, changes in sleep patterns, and social withdrawal, indicating a potential recurrence of her depression and anxiety. Lucia's vital signs are stable, with a blood pressure of 120/80 mmHg, heart rate of 80 beats per minute, respiratory rate of 18 breaths per minute, and temperature of 98.6°F. Her medical history reveals a previous diagnosis of depression and anxiety, and she is not currently on any psychiatric medications.

8. Given Lucia's symptoms and history, what problem should be prioritized in developing a nursing care plan, and how does this guide the selection of interventions?
9. What interventions can be generated to address both the emotional distress and the psychosocial issues Lucia is facing, and how might these interventions be integrated into her care plan?

Competency-Based Assessments

1. Address the topic of proxemics for physical distance between individuals for interactions. Give examples of the zones of intimate space, personal space, social space, and public space using your college classroom/campus or the clinical facility your class attends. Discuss your responses in small groups in class or in the discussion thread on your learning management system online.
2. List three obstacles in the therapeutic relationship and describe each from the nurse's point of view and from the client's point of view. Discuss in class or post in the online class discussion thread.
3. As a nursing student, how might you go about engaging in an open discussion with a client about their beliefs and stigmas related to psychiatric-mental illness?

References

Cronenwett, L., Sherwood, G., Barnsteiner J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D., & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, *55*(3)122–131.

Danchevskaya, O.Y. (2020). *Good and evil in Native American mythology*. Moscow State Pedagogical University. https://www.se.edu/native-american/wp-content/uploads/sites/49/2020/06/3Good-and-Evil-in-Native-American-Mythology.pdf

Fogel, A., Nazir, S., Hirapara, K., Ray, S. (2022, September 26). Cultural assessment and treatment of psychiatric patients. In StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-.

https://www.ncbi.nlm.nih.gov/books/NBK482311/

Gibbs, G. (1998). *Learning by doing: A guide to teaching and learning methods*. Oxford Brookes University.

Hall, E. T., Birdwhistell, R. L., Bock, B., Bohannan, P., Diebold, Jr., A. R., Durbin, M., Edmonson, M. S., Fischer, J. L., Hymes, D., Kimball, S. T., La Barre, W., Lynch, F., S. J., McClellan, J. E., Marshall, D. S., Milner, G. B., Sarles, H. B., Trager, G. L., & Vayda, A. P. (1968). Proxemics [and Comments and Replies]. *Current Anthropology*, *9*(2/3), 83–108. http://www.jstor.org/stable/2740724

Lengel, R., & Tortorice, J. (n.d.). *Psychosocial assessment: A nursing perspective*. CEUFast. Retrieved April 23, 2023, from https://ceufast.com/course/psychosocial-assessment-a-nursing-perspective

Luft, J., & Ingham, H. (1955). "The Johari window, a graphic model of interpersonal awareness," Proceedings of the western training laboratory in group development. UCLA.

Maercker, A., Ben-Ezra, M., Esparza, O. A., & Augsburger, M. (2019, September 2). Fatalism as a traditional cultural belief potentially relevant to trauma sequelae: Measurement equivalence, extent and associations in six countries. *Eur J Psychotraumatol*,*10*(1). https://doi.org/10.1080/20008198.2019.1657371.

NCLEX. (n.d.). *Clinical judgment measurement model*. Retrieved April 23, 2023, from https://www.nclex.com/clinical-judgment-measurement-model.page

Peplau, H. (1952). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. G. P. Putnam's Sons.

Themes, U. F. O. (2016, June 16). *Assessment of psychiatric–mental health clients*. Nurse Key. https://nursekey.com/assessment-of-psychiatric-mental-health-clients/

Van Edwards, V. (2021). *Faculty Spotlight: Vanessa Van Edwards on Communication Problems*. Global Leadership Network. https://globalleadership.org/news-and-updates/faculty-spotlight-vanessa-van-edwards-on-fixing-communication-problems/

World Health Organization. (2022a). *Mental health*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization. (2022b). *Mental disorders*. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

CHAPTER 4
Neurobiology and Pharmacological Standards

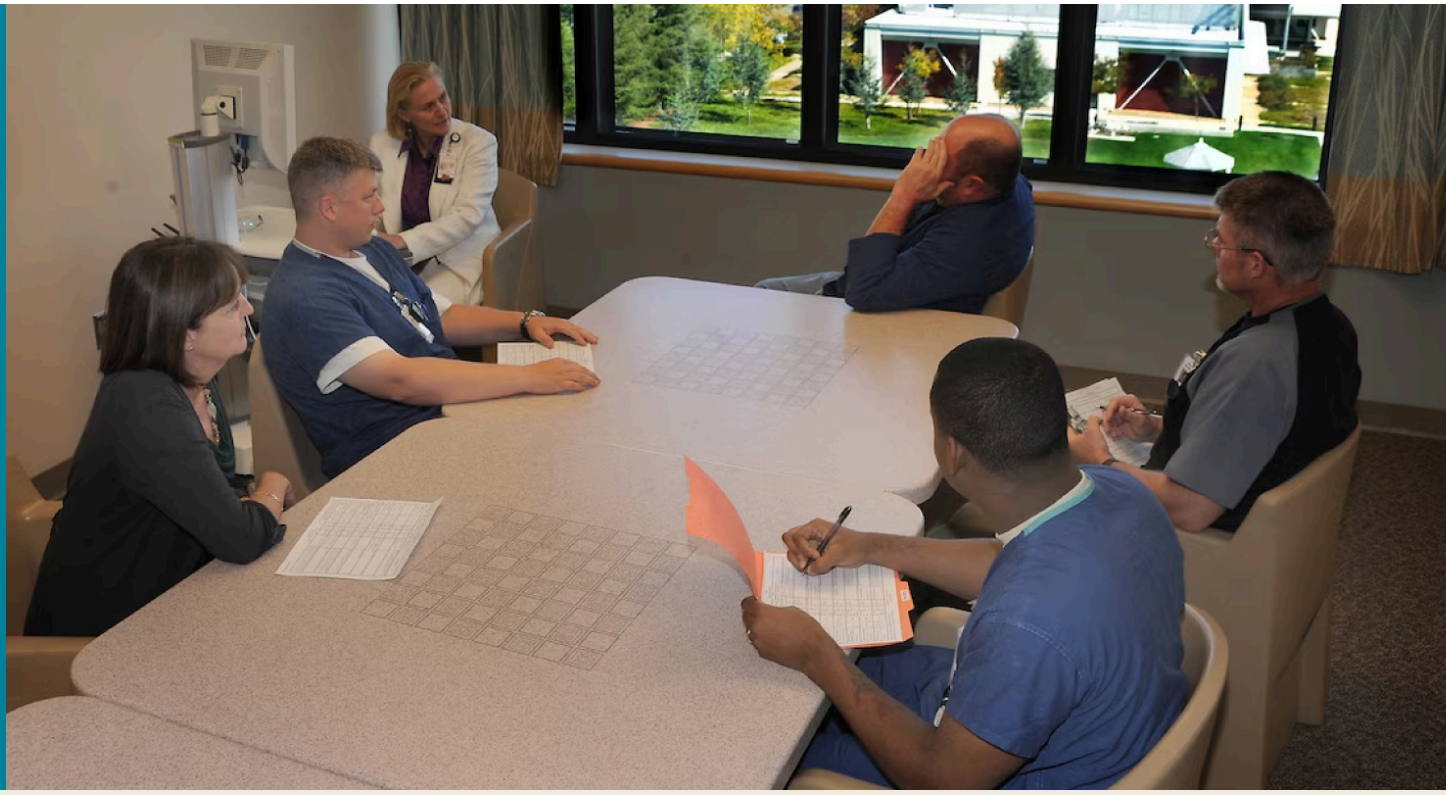


FIGURE 4.1 Psychiatric-mental health nurses are important members of an interdisciplinary team that collaborates to evaluate and treat clients. (credit: U.S. Air Force photo/Staff Sgt. Lillian Moreno, Public Domain)

CHAPTER OUTLINE

INTRODUCTION The human brain is responsible for interpreting and managing responses to environmental stimuli, cognitive processes, emotions, learning, and memories. Human development is shaped by genetic determinants, environmental influences, and human cognitive and emotional interpretations. Despite the explosion of neuroscientific exploration over the past 60 years, the mysteries of the mind still abound, particularly when it comes to mental health disorders. The practice of nursing integrates the neurobiological correlates of human behavior with functional knowledge of how psychopharmaceuticals manage mental health disease. Nurses must develop the knowledge and skills needed to provide nursing interventions to manage psychotropic medications. The combination of knowledge of foundations of neurobiology and pharmaceuticals will facilitate the nurse's ability to competently manage the following:

- Evaluate the effectiveness of psychopharmaceuticals and alternative treatments using assessment data.
- Assess side effects of psychopharmaceuticals and possible interactions with substances (alcohol, tobacco, and other drugs), food, other medications, or supplements.
- Implement client-centered plans of care to manage side effects of psychopharmaceuticals or interactions with substances, food, other medications, or supplements.
- Identify risks to the client's health and potential nursing diagnoses related to care and treatment.
- Synthesize scientific evidence to provide health education on side effects, potential adverse effects, and

health promotion strategies in those who are using psychopharmaceuticals.

4.1 Foundations of Neurobiology

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Review the functions of the nervous system
- Describe the role of neurotransmitters in human behavior
- Explain the relationship between endocrine functioning and psychological and mental health disorders

In order to understand mental health better, nurses must appreciate the underlying biological structures and mechanisms that guide human behavior. This section presents the fundamentals of neuroanatomy, cellular structures, neurotransmitters, and pathways that are integral in the central and peripheral nervous system. An understanding of these systems and their interactions with pharmacology principles will create a foundation for psychopharmacology in the next section.

Basic Principles of Neurobiology

Neurobiology is the study of the nervous system and how the brain works. The **nervous system** is made up of the central nervous system and the peripheral nervous system, and affects actions and senses. It is responsible for interacting with the external environment and managing the human internal environment. The nervous system begins developing during the first few days of embryonic growth and is influenced by a variety of maternal factors, such as environmental stress, exposure to toxins and hazards, health status, and nutrition. The brain's most rapid growth occurs during the third month of gestation through the child's first year after birth.

Breaking it down, the **neuron** is the fundamental cell of the nervous system, and it is responsible for receiving and transmitting electrical signals across the synaptic space. A human is born with most all of their neurons at birth though neurogenesis continues through life. Through environmental learning, **synaptic growth**—a process by which neurons in the brain connect—will occur rapidly during the first six years of life, after which synaptic **pruning** occurs, which is an automatic brain function that eliminates unused synapses, allowing new growth. Psychotropic medications work across the synapses to affect neurotransmitters, but more on that later.

Cells of the Nervous System

The neuron or the nerve cell is the primary cell or unit of the nervous system. It is responsible for transmitting an electrical and chemical message to other neurons or organs in the human body. It consists of a cell body or **soma**, which contains a nucleus. Extending from the cell body are multiple **dendrites** that receive information from other neurons. Once this information is received from other neurons, the information travels to the axon hillock, down the **axon** (the long narrow part of the neuron where impulses are conducted) to the end that contains the neurotransmitters, called the **axon terminus** (Figure 4.2). Here, the information either continues or fades.

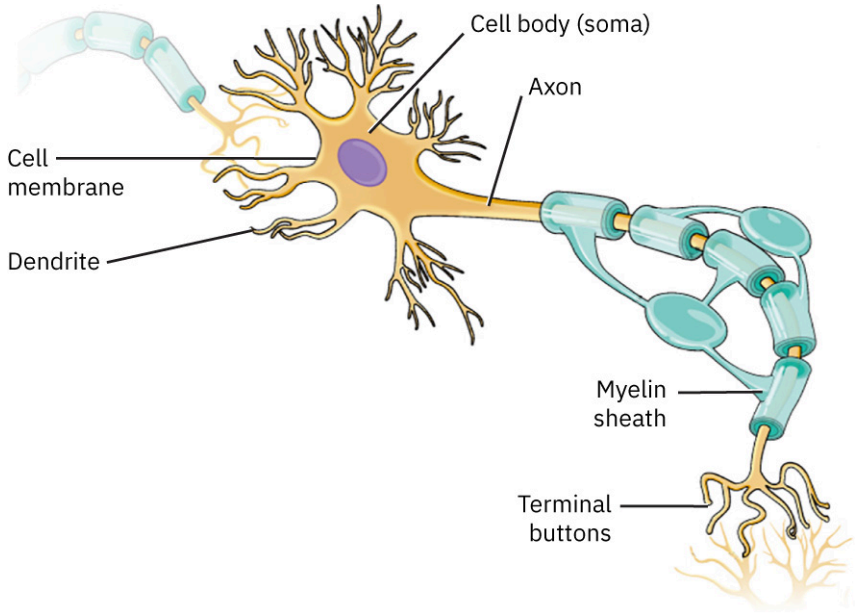


FIGURE 4.2 Neurons are polarized with anatomically and chemically distinct regions. (modification of work from *Psychology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Three types of neurons transmit information in the brain: (1) sensory or afferent neurons, which send information from the outside to the brain, (2) associational or **interneurons**, which connect neurons primarily within the CNS, and (3) **motor neurons**, which take information away from the CNS to effector organs or skeletal muscle at a **neuromuscular junction**, where muscle fibers and nerves connect.

The other primary cells in the nervous system are called **glial cells**, or microglia, which provide structure, repair, and scaffolding for the migration of the nerve cells. There are three types of glial cells: astrocytes, oligodendrocytes, and Schwann cells. The **astrocytes** are only located in the central nervous system and are involved with building new synaptic connections and ensuring an appropriate chemical environment for the neuron. In the central nervous system, the axon hillock is surrounded by a myelin sheath, made up of **oligodendrocytes**, which maintain and generate this sheath. In the peripheral nervous system, the myelin sheath is made up of **Schwann cells**, which surround the neuron and keep them alive. This **myelin sheath** is an insulating layer that allows for an action potential to travel successfully along the length of the axon at the **nodes of Ranvier**, which are gaps in the myelin sheath. This action potential is called **saltatory conduction**.

LINK TO LEARNING

This Khan Academy video describing and illustrating the structure and function of the nervous system (https://openstax.org/r/77NervSystem) provides an excellent primer and/or review of the anatomy associated with psychopharmaceuticals.

The Synapse

The **synapse** is the small area where two neurons converge: the terminus of one axon and another postsynaptic neuron. The terminus of one axon is called the presynaptic bulb or knob. Inside the presynaptic bulb are small vesicles of neurotransmitters that are stimulated into release to the synapse. A **neurotransmitter** is a chemical messenger that carries a message from one neuron to another. These neurotransmitters work like a key in a lock. They unlock an excitatory or inhibitory response by interacting with a receptor in the dendrite at the other end of the synapse. Psychotropic drugs have action at the synaptic space.

There are four types of connections at synapses: axo-axonic, which are between the axons of one neuron to the axon of another neuron; axo-somatic, which are from the axon of one neuron to the soma of another neuron; axo-dendritic, which are from the axon of one neuron to the dendrites of another neuron; and dendro-dendritic, which are dendrite to dendrite.

LINK TO LEARNING

This Khan Academy video offering insight into the structure of the synapse (https://openstax.org/r/77SynapseStruct) provides a review of this critical part of the neurobiology implicated in the use of psychotropic medications.

Neurotransmitters and Human Behavior

Neurotransmitters are chemical messengers that are synthesized and packaged within the neuron; they carry chemical messages across a synaptic cleft and bind to a receptor on a postsynaptic neuron (Figure 4.3). This process advances the excitatory or inhibitory signal. Neurotransmitters can have **excitatory effects** (they promote the generation of an action potential) or **inhibitory effects** (they inhibit an action potential). The main types of neurotransmitters are monoamines, amino acids, and neuropeptides.

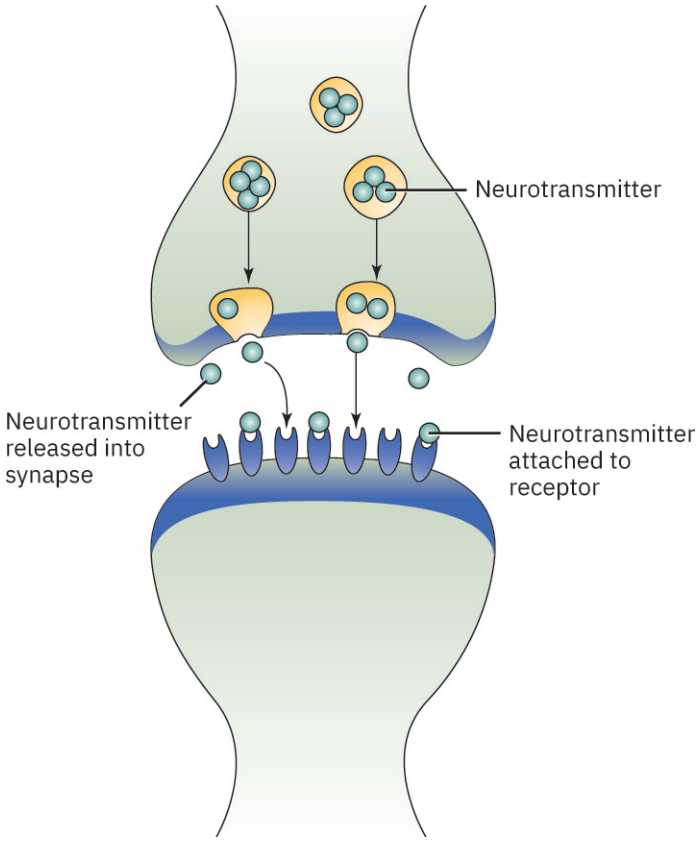


FIGURE 4.3 The synaptic cleft is the space between the terminal button of one neuron and the dendrite of another neuron. (modification of work from *Psychology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

LINK TO LEARNING

This Khan Academy video about the neurotransmitters targeted by psychopharmaceutical medications (https://openstax.org/r/77NeurotranType) provides more information.

Monoamines

Monoamines are neurotransmitters that contain a single amino group. They have a broad range of effects on the central and peripheral nervous systems. Four monoamine neurotransmitters relevant to mental health are:

- The neurotransmitter **norepinephrine**, also known as noradrenaline, promotes alertness, mental focus, pain mitigation, and memory retrieval. Decreased levels of norepinephrine are theoretically responsible for depression and are implicated in fibromyalgia, attention-deficit disorders, and chronic fatigue syndrome.

Research suggests that too much norepinephrine is responsible for psychotic states and mania.

- The neurotransmitter **serotonin**, also known as 5-hydroxytryptamine, is involved with mood and sleep regulation, mitigation of pain, aggression and sexual behavior, stimulation of gastric secretion, and other hormonal behaviors. Decreases in serotonin may result in depressive states, weight gain, sedation, and pain. Increases in serotonin can cause anxiety and, potentially, psychotic states.
- The neurotransmitter **dopamine** manages mood states, attention and focus, motor control and regulation, sexual gratification, reward and motivation, and lactation. Decreased dopamine is related to depression, attention-deficit disorders, and Parkinson's disease. Increased dopamine is related to psychotic states and mania.
- The neurotransmitter **histamine** is responsible for management of awake states, homeostasis, appetite, and smooth muscle contractions. Decreases in histamine cause sleepiness and weight gain, while increases in histamine cause alert states.

Amino Acid Neurotransmitters

The amino acid neurotransmitters include gamma-aminobutyric acid, glycine, and glutamate, which have widespread effects on the brain and spinal cord. These neurotransmitters are involved in most excitatory and inhibitory functions in the nervous system.

- One of the major inhibitory amino acid neurotransmitters in the brain is **gamma-aminobutyric acid (GABA)**. It decreases all sensory impulses, including pain and cognition. Decreases in GABA are responsible for anxiety states and insomnia. Overactivation of GABA through medications, such as hypnotics, benzodiazepines, or alcohol causes central nervous sedation and potential coma or death.
- Glycine has a stimulant as well as inhibitory effect within the central nervous system, which may affect physiological functions, such as immunity, digestion and appetite, pain response, and sleep. Psychosocial effects may appear as alterations in mood and cognition.
- Glutamic acid, or **glutamate**, is *the* major excitatory neurotransmitter in the brain. Glutamate is primarily involved with sensory transmission and learning and memory. Research demonstrates that glutamate dysregulation and diminished function at certain glutamate neurons cause hyperactivity in other brain areas and potentially psychosis. Increases in glutamate can cause neurotoxicity and neurodegeneration.

Neuropeptides

Neuropeptides, a third type of neurotransmitters, comprise small chains of amino acids and are widely distributed within the central nervous system (CNS) and peripheral nervous system (PNS). Neuropeptides responsible for pain mitigation include **endorphins** and **enkephalins**, which function as neurotransmitters, neuromodulators, or neurohormones in the CNS. These molecules act at opioid receptors and function to block pain signals.

Acetylcholine

The neurotransmitter **acetylcholine** is responsible for activation at the neuromuscular junction. Decreases in acetylcholine have been implicated in disease states, such as Alzheimer's, Parkinson's, and Huntington's. Increases in acetylcholine, usually caused by cholinergic crisis (overstimulation of receptors at neuromuscular junctions), are manifested by muscular cramping and weakness, increased salivation, lacrimation, paralysis, and blurry vision.

Central and Peripheral Nervous System

Mental health is a product of genetics, the human, the environment, and the interaction between them. Humans are constantly reading information from the environment and interpreting it. Nursing strategies make an impact at varying levels of these interactions, so it is imperative to understand how the brain works and interprets the outside world. Comprehending the organization and function of each brain organ or system provides the nurse with the ability to assess symptoms accurately and target them with effective interventions.

The nervous system is divided into two different systems: the **central nervous system (CNS)**, which includes the brain and spinal cord, and the **peripheral nervous system (PNS)**, which includes the cranial and spinal nerves. Both are specifically affected by the action of psychotropic medications.

The Central Nervous System

The central nervous system is composed of the brain and the spinal cord. The brain comprises millions of interconnected neurons and other structures. It monitors and responds to external and internal environments,

stores and retrieves memories, maintains homeostasis, and manages emotions. There are three main divisions within the brain: the **forebrain** (prosencephalon), the **midbrain** (mesencephalon), and the **hindbrain** (rhombencephalon). Table 4.1 parses the functions of the various parts of the brain, which are illustrated in Figure 4.4.

Structure		Function
Forebrain	Cerebrum	Divided into two hemispheres; manages sensory processing, emotions, language, and movement; the right side is more creative, the left side is logical and problem-solving
	Diencephalon	Intermediary between cerebrum and lower brain structure; manages sensory information to the cerebrum, emotional memories, regulation of appetite and thermoregulation, and emotions
Midbrain	Mesencephalon	Manages vision, hearing, motor control, sleep and wake states, and temperature regulation
Hindbrain	Pons	Manages respiration and skeletal muscle tone
	Medulla	Manages blood pressure, heart rate, respiration, and reflexes
	Cerebellum	Manages muscle coordination, posture, and position

TABLE 4.1 Structure and Function of the Brain

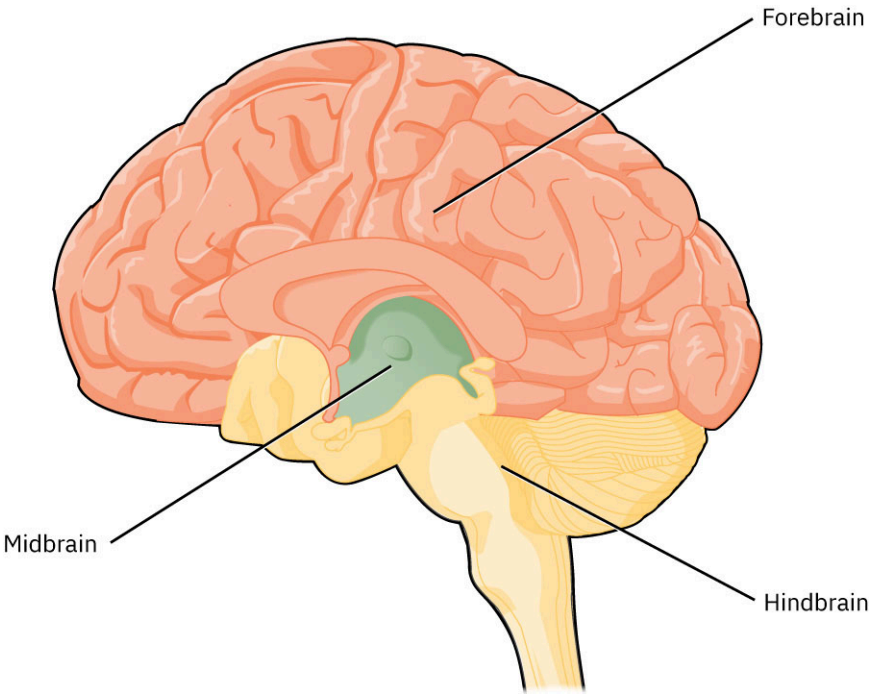


FIGURE 4.4 The brain is divided into the forebrain, the midbrain, and the hindbrain. (modification of work from *Psychology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The other part of the CNS, the spinal cord, transmits sensory information from the periphery to the brain and manages behavioral responses via sensory and motor tracts. The spinal cord originates from the **medulla oblongata**—which forms the connection between the brainstem and the spinal cord—and ends at the conus medullaris with nerve bundles extended from the structure called the **cauda equina**, the collection of nerves at the terminus of the spinal cord. The spinal cord is divided into five sections: cervical, thoracic, lumbar, sacral, and coccygeal. The spinal cord has an inner core of gray matter that contains the cell bodies of neurons and an outer

core of white matter tracts. These outer tracts are divided into three different functional sections: the posterior or dorsal horn, made of interneurons and sensory neurons (afferent); the anterior or ventral horn, made up of motor neurons (efferent); and the lateral horn, which contains cells involved with the autonomic nervous system.

Memory and Learning

Human memory is recording, retaining, and retrieving environmental stimuli. There are two types of memories. One type is **declarative memories**, which include episodic and semantic memories of personal events, facts, and experiences. Declarative memories are formed in the prefrontal cortex and the hippocampus. The other type is **non-declarative memories**, which include those that individuals cannot explicitly recollect consciously, like implicit, performance-based, and motor memories. Four areas of the brain are responsible for managing memory and learning. Inside the brain's medial temporal lobe are the hippocampus and the amygdala (Figure 4.5). The **hippocampus** is part of the limbic system and is responsible for encoding memories, learning, and perception of space. Inside the hippocampus are NMDA glutamate receptors that manage memories through **long-term potentiation**, which is a process of synaptic strengthening through signal increases in the neuron. Stress can cause dendritic pruning in the hippocampus, resulting in memory deficits. The **amygdala** is a pair of small almond-shaped regions located anterior to the hippocampus and is responsible for the formation and encoding of memories, especially those that are highly emotionally charged, such as trauma. High levels of stress can augment the fear startle response mediated by the amygdala resulting in increased levels of norepinephrine, insomnia, high blood pressure, and increased pulse.

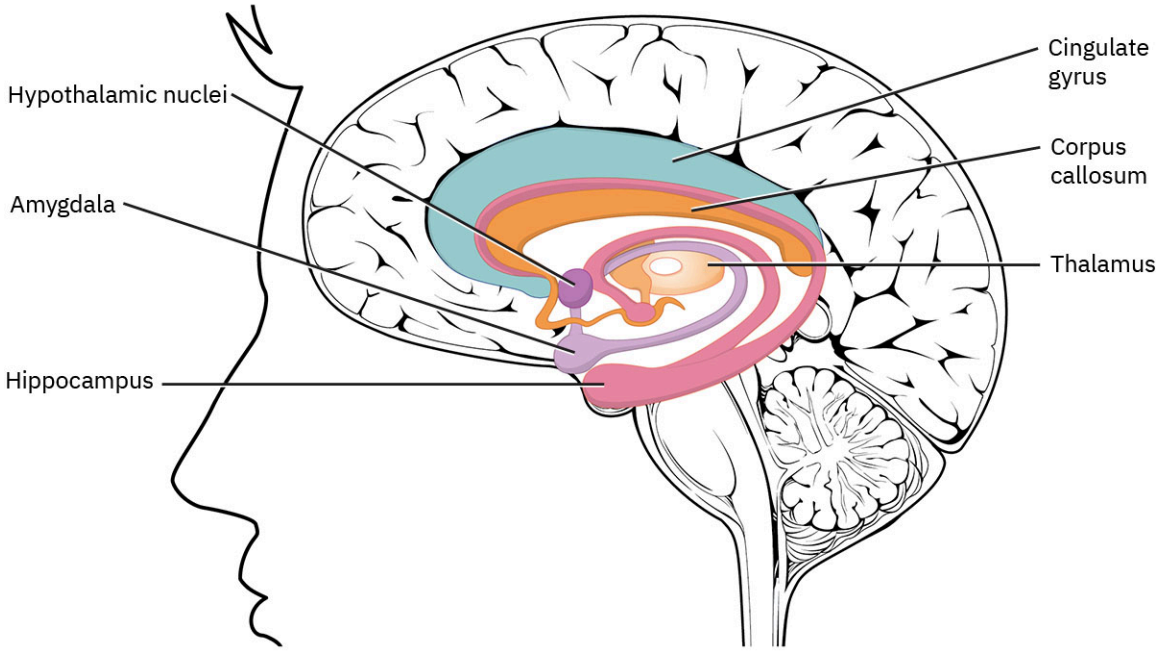


FIGURE 4.5 Structures arranged around the edge of the cerebrum constitute the limbic lobe, which includes the amygdala, hippocampus, and cingulate gyrus, and connects to the hypothalamus. (modification of work from *Anatomy and Physiology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The third area of the brain responsible for managing memories is the diencephalon (Figure 4.6). The **diencephalon** is the central area of the brain located above the brainstem, including the epithalamus, thalamus, subthalamus, and hypothalamus. Areas within the diencephalon are responsible for forming recognition-based memories. Lesions to the diencephalon can potentially cause amnesia. Finally, the **basal ganglia** are a group of subcortical nuclei most often associated with managing motor control, primarily sequential movements; the basal ganglia are involved with the formation of procedural memories. Diseases and disorders involved in the basal ganglia include Parkinsonism, problems controlling movements, medication induced disorders, such as akathisia and dystonia, and Huntington's disease.

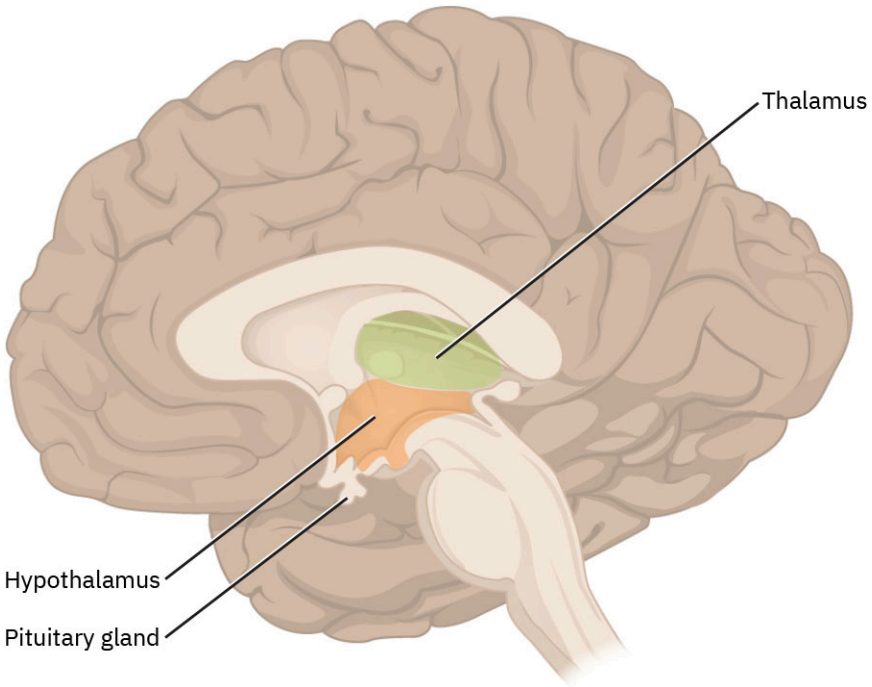


FIGURE 4.6 The diencephalon is composed primarily of the thalamus and hypothalamus, which together define the walls of the third ventricle. The thalami are two elongated, ovoid structures on either side of the midline that make contact in the middle. The hypothalamus is inferior and anterior to the thalamus, culminating in a sharp angle to which the pituitary gland is attached. (modification of work from *Anatomy and Physiology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Movement

Several areas of the brain manage voluntary control over movement. The first is the **motor cortex**, which is in the cerebral cortex and is subdivided into three areas: the primary, premotor, and supplementary motor areas. The **primary motor cortex** is located along the precentral gyrus and is responsible for generating efferent neuronal impulses down the spinal cord to manage movement. The **premotor cortex** lies rostral to the primary motor cortex and is responsible for managing coordinated motor responses. Finally, the supplementary motor areas lie anterior to the primary motor cortex and manage complex, sequenced movements in proximal muscles. Also involved in movement are the basal ganglia, a group of subcortical nuclei associated with managing motor control. Likewise, the **substantia nigra**, the most prominent nucleus in the midbrain, contains a dopaminergic nucleus that manages motor control and involves disease states, such as Parkinson's, Huntington's, and extrapyramidal symptoms. Finally, the **cerebellum** is in the basal part of the brain between the cerebrum and the brain stem. It is responsible for balance, walking, standing, and measuring distance and timing.

Pain

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with or resembling that associated with actual or potential tissue damage." Pain is a phenomenon that has biological, environmental, and social determinants. It is a personal experience that is memory-driven and emotionally interpreted. Pain has implications for mental health through associations with anxiety, fear, powerlessness, social withdrawal, depression, and substance dependence. The processing of pain is called nociception. Nerve cell endings distributed throughout the body that initiate pain sensation through afferent pathways are **nociceptors**. They are categorized by the type of pain stimulus that is transmitted. **A-Delta (Aδ) fibers** transmit pressure, mechanical deformation, and extreme temperature sensations. **C fibers** transmit burning pain, itch, and dull ache. **A-Beta (Aβ) fibers** manage touch and vibration sensations. Pain sensations from nociceptors travel to the dorsal horn of the spinal cord, where they synapse with an interneuron and then cross over to the contralateral spinothalamic tract. The afferent sensations then transcend to the brain through the brainstem, the thalamus, and the somatosensory cortex. The somatosensory cortex interprets the existence, location, and intensity of pain. The reticular formation, limbic system, prefrontal cortex, and brainstem interpret the emotional response to pain based on current and past experiences. Finally, the cerebral cortex evaluates pain perception, threshold, and tolerance. The response to pain is called **pain modulation**, and it can occur during all phases of the pain process. The response to pain from the brain to the periphery is called the descending or **efferent pathway**. Various

excitatory and inhibitory neurotransmitters that work in the central and peripheral nervous systems manage modulating pain, including serotonin, norepinephrine, and inflammatory mediators like bradykinin, interleukins, tumor necrosis factors, and neurokinins.

Sleep

Sleep is a restorative process of decreased mental awareness and physical activity. Several neural circuits and neurotransmitters coordinate the sleep-wake cycle. Sleep is regulated by the **circadian cycle,** a 24-hour cycle determined by light and dark patterns and internal regulatory functions (Figure 4.7). The pacemaker for the circadian cycle starts in the hypothalamus. Internal body temperature, sleepiness, and the ability to fall asleep are coupled with the circadian cycle. The **homeostatic process**, a sleep debt model, also regulates sleep. The more awake a human is, the greater demand or debt is required for sleep. The more that the human is asleep, the less demand for sleep there is. That process repeats every day.

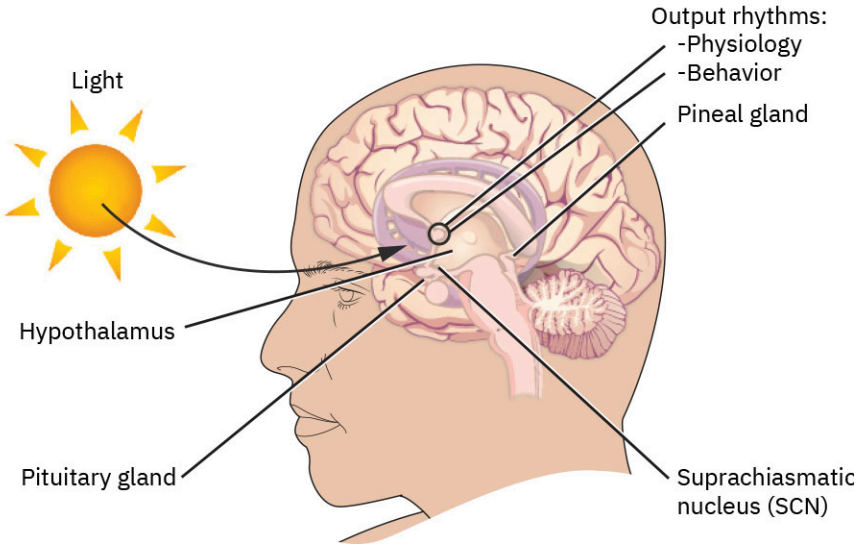


FIGURE 4.7 The suprachiasmatic nucleus sends signals to the pineal gland to regulate the circadian cycle. (modification of work from *Psychology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

There are different phases of sleep that are regulated by neurotransmitters. Awake states are managed by increased firing rates of the monoamines (dopamine, norepinephrine, serotonin, and histamine), orexin, and acetylcholine. The sleep states are regulated by increased firing of GABA and very little firing of the monoamines, orexin, and acetylcholine. The final stage of sleep is REM sleep or rapid eye movement. Most of the time in this stage is spent dreaming. This is a paradoxical sleep as the body is "paralyzed" but the mind is "awake." In REM sleep, inhibitory neurotransmitters release causing overall reduced sympathetic tone. Blood pressure, heart rate, and respirations vary, and may increase, compared with non-REM sleep, and muscle tone decreases. Sexual arousal may occur during REM sleep, which may be due to dream activity or increased blood flow.

Sleep patterns change as humans age. Newborns sleep between 16 and 18 hours a day. A three- to five-year-old child sleeps nine to ten hours a night. Adults sleep an average of seven to nine hours a night, but less as they age. Older adults begin to go to bed earlier and wake up earlier; they spend more time awake at night. Disruption of sleep and rest can be associated with anxiety, poor concentration, ineffective coping, and role function.

LINK TO LEARNING

Sleep can be a complex topic because it involves numerous neurotransmitters and several bodily cycles. Watch this Khan Academy video on sleep (https://openstax.org/r/77Sleep) to learn more.

The Peripheral Nervous System

The peripheral nervous system contains all nerves outside the central nervous system. It is divided into two different pathways: the ascending or **afferent pathway**, which brings sensory information to the brain; and the

descending or efferent pathway, which takes integrated information from the brain. This means that the afferent pathways take things that the client feels, senses, or perceives to the brain, and the efferent pathway manages the response.

There are also functional divisions in the peripheral nervous system. The **somatic nervous system** is a part of the PNS that delivers conscious sensory (afferent) information to the CNS and a voluntary motor response (efferent). The **autonomic nervous system**, regulated by the hypothalamus, manages involuntary homeostatic control over the body's internal processes, like temperature. The autonomic nervous system has two further divisions: the sympathetic nervous system and the parasympathetic nervous system. The **sympathetic nervous system** manages the fight or flight response (increase in heart rate, blood pressure, respirations, peripheral vasoconstriction, decreased GI motility). This response is manifested when the client is anxious, having a phobic response, or when experiencing a trauma trigger. In contrast, the **parasympathetic nervous system** functions to conserve and store energy (decreased heart rate, blood pressure, respirations, peripheral vasodilatation, increased GI motility). This system manifests itself when the client is tired, sleepy, or resting.

Neuroendocrinology

The nervous and endocrine systems work together via hormonal regulation to manage internal and external environments. Groups of molecules that function to send signals to other cellular organisms in the human body are called **hormones**. They are released in response to chemical factors, such as blood glucose levels; endocrine factors, such as other hormones; or signals from neurons. Psychotropic medications, such as lithium, can have neuroendocrine effects: It has been associated with goiters, hypothyroidism, and hyperthyroidism. Additionally, hormonal disorders, such has hypothyroidism, can mimic mental health symptoms such as anhedonia, depressed mood, and decreased energy and motivation.

Endocrine functioning within the CNS is controlled by the hypothalamus and the pituitary gland. There are two lobes in the pituitary gland: the anterior and posterior. The posterior lobe of the pituitary gland releases two hormones: vasopressin and oxytocin. Both are triggered by neuronal impulses from the hypothalamus. The hormone **vasopressin**, also known as antidiuretic hormone, is responsible for retaining water and maintaining blood pressure. It is stimulated in the presence of decreased fluid volume, emotional stress, and pain. When released, **oxytocin** is the hormone responsible for uterine contraction and the stimulation of milk from mammary glands after pregnancy. The anterior lobe of the pituitary stimulates hormones that target other organs. When finished with their actions, they have a negative feedback mechanism that then inhibits the release of the same hormone at the anterior pituitary, causing the diminished effect of that hormone.

The release of prolactin releasing hormone from the hypothalamus stimulates **prolactin**. It stimulates milk production during pregnancy. Certain medications can affect prolactin levels, such as antipsychotics, and can cause amenorrhea or galactorrhea, which is production of milk from the breast unrelated to pregnancy. Thyrotropin releasing hormone triggers the hypothalamus to release **thyroid stimulating hormone (TSH)**, which targets the thyroid gland to release triiodothyronine (T_3) and thyroxine (T_4). Optimal thyroid functioning manages temperature regulation, mood states, and food metabolism.

Protein synthesis and growth during child development are managed by **growth hormone**, or somatotropin. Furthermore, **melatonin**, responsible for initiating sleep during circadian cycles, is released from the pineal gland after **melanocyte stimulating hormone** is secreted from the hypothalamus. The release of this hormone is affected by light and dark conditions. Finally, **adrenocorticotropic hormone (ACTH)** is released and travels to the adrenal glands where **cortisol** is released. Cortisol is responsible for mobilizing glucose for energy; it increases protein metabolism, immune effects, and systemic anti-inflammatory effects. Overall, the release of cortisol enhances the body's stress response. Once released, cortisol has the same negative feedback loop to the pituitary, which terminates the response. This is called the **hypothalamic-pituitary-adrenal (HPA) axis**, or the HPA response. Prolonged stress response and its relationship to the HPA axis has been implicated in disease states, such as post-traumatic stress disorder (PTSD), depression, altered response after traumatic brain injury, and accelerated decline in disease states like Alzheimer's.

PMH Disorders and Their Relationship to the Nervous System

To contextualize psychiatric disorders biologically and neurologically, it is important to consider both anatomical and

neuroendocrine perspectives, genetic determinants, and environmental influences. The **stress diathesis model** posits that there are genetic traits that, when combined with certain environmental influences, create the potential for a mental health disorder. Take, for example, a child who has a genetic predisposition for depression but is raised in a loving environment without significant stress. The theory posits that this child has less chance of expressing that genetic loading for mental disease. Place the same child in an environment with significant environmental stressors, and the theory posits that there is a higher chance for expression of mental disease. Added to environmental and genetic variances are the structural and neurological determinants for mental health disease. Alterations in the monoamines (norepinephrine, serotonin, dopamine), dysregulation of neurotransmitter receptors, and disruption in growth factors can cause mood disorders, which include major depression, bipolar disorder, dysthymia, mood disorder from a medical condition, and substance-induced mood disorder.

Brain circuits involved in mood disorders include the prefrontal cortex, basal forebrain, striatum, nucleus accumbens, thalamus, hypothalamus, amygdala, hippocampus, brainstem, and cerebellum. Schizophrenia, a mental disorder characterized by "disruptions in thought processes, perceptions, emotional responsiveness, and social interactions," (National Institutes of Health [NIH] 2022) stems from hyperactive dopamine in the mesolimbic pathways caused by malfunctioning NMDA glutamate receptors and hyperfunctioning serotonin receptors. Environmental exposures, such as viral illness in utero, are also theorized to be determinants of the disease. The neurobiology of fear and anxiety involves the limbic system (amygdala and hippocampus), the HPA axis, and conditioned responses to external stimuli. Neurotransmitters involved with anxiety and fear include the monoamines, GABA, and glutamate. Insomnia, being unable to fall or stay asleep, happens because of the inability to neuromodulate circuits and neurotransmitters associated with awake states. These neurotransmitters include norepinephrine, dopamine, serotonin, acetylcholine, and histamine. Neurocircuits involved with sleep include the basal forebrain, the locus coeruleus, and the thalamus. Attention deficits**,** characterized by impulsive behaviors, hyperactivity, and/or an inability to focus or pay attention, stem from an imbalance of dopamine and norepinephrine in the orbitofrontal and prefrontal cortex. Impulsive and compulsive behaviors like addiction result from a lack of modulation from the prefrontal cortex to impulsive circuits led by the orbital frontal cortex. The dopaminergic system is integral to this reward-driven behavior.

4.2 Psychopharmacology

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the biological mechanisms of psychopharmacological drugs
- Differentiate psychopharmacological drug classifications
- Discuss psychopharmacological indications, actions, side effects, interactions, and special populations
- Summarize nursing roles and implications related to psychopharmacological drugs

Nursing is heavily involved in the assessment and management of pharmacological agents. Psychopharmaceuticals are substances that can affect mood, behaviors, feelings, or thoughts. For the most part, assessment of these medications requires careful observation and listening skills applied with a level of understanding of how they work within the human body. This section will provide an overview of the science of pharmacology, the classifications of psychopharmaceuticals, how they work and their adverse effects, information on special populations, and management strategies for nurses.

The Biology of Psychopharmacology

The role of psychopharmacology formally began in the mid-20th century with the invention of chlorpromazine, first used to treat psychotic disorders. The emergence of this drug and further advances in science enabled clinicians to understand the etiology of mental illness better. Health-care providers who contemplate psychotropic medications for their clients consider several variables when choosing a medication: symptom presentation, comorbid disease states, age, gender, genetic variables, which medicines work effectively for which symptoms, potential for side effects and drug-drug interactions, and overall safety. Nursing interventions with psychopharmaceuticals involve education, assessment, management of side effects and adverse events, and being prepared to respond to dangerous drug levels and polypharmacy concerns.

Pharmacokinetic and pharmacodynamic factors determine how a medication will work. What the human body does to a drug is called **pharmacokinetics**, and what a drug does to the body is called **pharmacodynamics**. There are

four mechanisms included in pharmacokinetics: (1) drug absorption, (2) drug distribution, (3) drug metabolism, and (4) drug excretion.

Drug absorption is the process by which an unmetabolized drug is transported from the site of administration into the circulation system. Distribution is the amount of drug that ends up acting at its target site. This is affected by blood flow, molecular size, and how it interacts with plasma proteins. Drug metabolism is when a drug is broken down or biotransformed by a two-step process. The first step of biotransformation is the first-pass effect when medications undergo extensive hepatic metabolism through enzymatic processes. The result of this process is a reduction in the bioavailability of the medication. Cytochrome P450, also known as CYP450, enzymes often manage this step of the reaction. If a CYP450 enzyme metabolizes a medication, it is called a substrate. Different variables affect the rate of the enzymatic activity of these enzymes. The first is genetic variation. A human can express genetic alterations that inhibit or accelerate the CYP450 enzymes. Additionally, other medications can either induce or stimulate an enzyme. If this occurs, metabolism speeds up. Other drugs can temporarily inhibit or irreversibly inhibit these enzymes. Inhibition causes the metabolism to slow down or, in the case of the irreversible inhibitor, stop altogether. Phase II biotransformation reactions are also known as conjugation reactions that involve the use of transferase enzymes that "detoxify" drugs into excretable forms. Finally, excretion of the drug happens either primarily via the kidneys or the gastrointestinal tract, but can also occur through sweat, saliva, and tears. Factors that can affect excretion include disease states, such as liver disease, kidney disease, and other disease states that can affect blood or urine flow such as congestive heart failure.

The second factor that determines how a medication works is pharmacodynamics, which is the drug-receptor interaction, or how the drug affects the human body in both the nature and strength of its response. Psychotropic drugs usually target neuronal receptors or enzymes, and in doing so, block, imitate, or alter the actions of neurotransmitters. Once a signal from a neuron's cell reaches the axon terminus, it stimulates the release of a neurotransmitter into the synapse. The neurotransmitter then targets a receptor either at the dendrite of the other nerve or receptor sites on the same nerve. The receptor sites on the same nerve are autoreceptors and shut off neurotransmitters' flow. Receptors located at the dendritic ends of another neuron serve to either continue the stimulus or shut it down through excitatory or inhibitory neurotransmission.

PMH Drug Classifications

Psychotropics have different classifications: antipsychotics, antidepressants, mood stabilizers, anxiolytics, hypnotics, and stimulants (Table 4.2). Antipsychotic medications mainly block 5-hydroxytryptophan (5HT) dopamine receptors. These medications are approved for use in psychotic disorders and mood stabilization. Antidepressant medications primarily target 5HT or serotonin. These medications treat depression, anxiety, trauma, and obsessive-compulsive disorders. Mood stabilizers have unknown mechanisms of action. These medications are indicated for use in bipolar disorders. Anxiolytics, used for anxiety disorders, include benzodiazepines, which enhance the inhibitory effects of GABA-A receptors; medications like hydroxyzine that block histamine; and Buspirone, which targets serotonin. Medications that work predominantly to increase norepinephrine and dopamine are divided into stimulants and non-stimulants. These medications are used to treat attention-deficit hyperactivity disorder and sleep-wake disorders. Hypnotics work on various sleep-wake receptors and are approved for use in circadian rhythm disorders and insomnia.

Drug Classification	Subclassification	Name of Drug
Antipsychotics	1st generation	Fluphenazine, haloperidol, thorazine, chlorpromazine, thioridazine
	2nd generation	Clozapine, risperidone, asenapine, iloperidone, lamotrigine, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone
	3rd generation	Aripiprazole, cariprazine, brexiprazole, lumateperone

TABLE 4.2 Classifications of Psychotropic Medications

Drug Classification	Subclassification	Name of Drug
Antidepressants	Tricyclics	Imipramine, amitriptyline, nortriptyline, protriptyline, doxepin, desipramine, trimipramine
	MAOI	Isocarboxazid, phenelzine, selegiline, tranylcypromine
	SSRI	Fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram
	SNRI	Duloxetine, venlafaxine, desvenlafaxine, levomilnacipran
	NDRI	Bupropion
	Multimodal	Vortioxetine, vilazodone
	Others	Trazodone, mirtazapine
Anxiolytics	Benzodiazepines	Alprazolam, chlordiazepoxide, diazepam, lorazepam, oxazepam, clonazepam
	Others	Buspirone, hydroxyzine
Hypnotics	GABAergic	Zolpidem, eszopiclone, zaleplon
	Benzodiazepines	Quazepam, estazolam, triazolam, temazepam
	Orexin agents	Suvorexant
	Melatonergic	Ramelteon
Stimulants	Nonstimulants	Guanfacine, Atomoxetine
	Stimulants	Amphetamine (d, l), amphetamine (d), methylphenidate (d, l), methylphenidate (d), lisdexamfetamine, serdexmethylphenidate
Mood stabilizers	Voltage channel blockers	Valproate, carbamazepine, lamotrigine, lithium

TABLE 4.2 Classifications of Psychotropic Medications

Antipsychotics

To understand the medications that treat psychotic disorders, such as schizophrenia and schizoaffective disorder, it is helpful to have a working knowledge of the etiology of one of the psychotic disease states: schizophrenia. There are three general hypotheses for the causes of schizophrenia. The first posits that dopamine hyperactivity in the brain's mesolimbic pathway causes the positive symptoms of schizophrenia, which are those that the disease has "added" to the person, such as hallucinations or delusions (see Chapter 15 Schizophrenia Spectrum Disorder and Other Psychotic Disorders). The second hypothesis involves the neurotransmitter glutamate, the major excitatory neurotransmitter in the brain. The theory holds that a hypofunction, formed in the early years of neurodevelopment in the NMDA receptors located on glutamatergic neurons is the cause of schizophrenia. The final theory involves hyperfunction (too much activity) at serotonin receptors. The downstream effect of both hypofunction in glutamate and hyperfunction at serotonin receptors could result in hyperactivity in the same mesolimbic dopamine pathway,

which can lead to psychosis.

The development of the first class of antipsychotics was an accident. The phenothiazine class of medications was designed to act as a preanesthetic medication by manipulating antihistamine. The original medication was found to have a calming effect on clients. Research continued until chlorpromazine was invented. It was trialed successfully for the first time with a client with symptoms of mania. With the advent of chlorpromazine, the first generation of antipsychotics arrived. These medications included haloperidol, trifluoperazine, thioridazine, and fluphenazine. Classified as "first-generation antipsychotics or typical antipsychotics" in the 1950s, these medications primarily block dopamine receptors. The first "second-generation antipsychotic" was developed in the mid-1970s. The mechanism of action differed from the first generation in that it had dual actions at both serotonin and dopamine receptors. The second-generation drugs boasted fewer extrapyramidal symptoms (EPS), which are drug-induced movement disorders. Some clients continued to experience them, however, with additional metabolic side effects, such as weight gain, insulin resistance, and hyperlipidemia. Finally, a third generation of atypical antipsychotics emerged. These drugs have more potent actions at serotonin receptors; potentially partial agonism at dopamine receptors or low occupancy at dopamine receptors, which reduces the potential for EPS; and sometimes minimal affinity for histamine receptors, which can result in limited weight gain and metabolic syndrome.

Indications

Antipsychotic medications are indicated (FDA approved) for use in clients who have a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder (mania, mixed mania, bipolar maintenance, bipolar depression), psychotic disorders, tics, and vocal utterances. They are also indicated for use in Tourette's syndrome, severe behavior problems in children, and treatment-resistant depression.

Side Effects and Interactions

The undesirable effects of a medical treatment or drug are called **side effects**. The side effect profiles of typical and atypical antipsychotics are different, but they have two general categories of side effects in common: metabolic side effects and extrapyramidal side effects (Table 4.3). Metabolic side effects include weight gain, insulin resistance, and hyperlipidemia. The exact mechanism of this has yet to be discovered. The second shared side effects category is **extrapyramidal side effects (EPS)**, or drug induced movement disorders. Extrapyramidal side effects include akathisia, dystonia, tardive dyskinesia, pseudo-Parkinson's, and neuroleptic malignant syndrome. A blockade of dopamine in the mesolimbic nigrostriatal pathway causes these movement disorders. All antipsychotic medications can potentially cause these movement disorders, some more than others. For example, first-generation antipsychotics, such as haloperidol, have more potential to cause EPS than second-generation antipsychotics like lurasidone. The more a medication blocks dopamine, the more potential it has to cause EPS. All antipsychotic medications can be sedating, may cause dizziness, and can lower the seizure threshold. Other significant side effects reported with first-generation antipsychotics include anticholinergic side effects: dry mouth, constipation, blurred vision, and urinary retention. Galactorrhea and amenorrhea are of particular concern for clients. Second-generation antipsychotics have less potential for anticholinergic side effects.

Extrapyramidal Side Effect	Symptoms
Akathisia	Subjective complaints of leg or arm movements, rocking, pacing, feeling restless like they cannot sit still Develops within the first few weeks of starting or increasing dose of medication or reducing or removing a medication that is used to mitigate EPS
Dystonia	Involuntary contractions and spasms of the muscles, painful, starts in the face, neck, shoulders Develops within hours to days of starting or increasing dose of medication or reducing or removing a medication that is used to mitigate EPS

TABLE 4.3 **Extrapyramidal Side Effects and Symptoms** (Caroff & Campbell, 2016)

Extrapyramidal Side Effect	Symptoms
Tardive dyskinesia	Involuntary facial movements, sucking, chewing, lip smacking, tongue protruding, blinking eyes; also affects the body and extremities Develops within months or years
Pseudo-Parkinson's	Shuffling gait, stiff facial muscles, tremors, bradykinesia, akinesia Develops within a few weeks of starting or increasing a dose of medication or reducing or removing a medication that is used to mitigate EPS
Neuroleptic malignant syndrome	High fever (102–104 degrees Fahrenheit), irregular pulse, tachycardia, tachypnea, muscle rigidity, confusion, hypertension, diaphoresis This is a medical emergency

TABLE 4.3 **Extrapyramidal Side Effects and Symptoms** (Caroff & Campbell, 2016)

Most antipsychotic medications have interactions with other dopamine agonists, such as levodopa. They may also cause additional CNS depressant effects when taken with other medications that cause sedation. Additionally, they have the potential to lower blood pressure, which may heighten the effects of antihypertensive agents. Certain antipsychotics contain an enzyme that interacts with cigarette smoking to increase the metabolism of the medication. Therefore, if the client is smoking, or stops smoking, the drug dosages may need to be adjusted.

Clozapine is a second-generation antipsychotic that can potentially suppress bone marrow and cause agranulocytosis, a condition characterized by a low number of white blood cells called granulocytes. It is a severe form of neutropenia. Clients on clozapine are monitored for this risk via a Risk Evaluation and Mitigation Strategy (REMS) program that the Food and Drug Administration requires. Certified providers enroll clients taking clozapine in the program. The clients are then monitored with absolute neutrophil counts (ANC) via weekly blood draws for the first six months, then every two weeks for the next six months. If the client's ANCs remain within normal ranges, then they shift to monitoring every four weeks. If the client is found to have low ANC counts, additional monitoring or steps come into play in accordance with the clozapine REMS algorithm.

Special Populations

First- and second-generation antipsychotic medications are approved for use in children for disorders, such as aggression, Tourette's, and tics. Second-generation antipsychotics are preferred as first-line agents over first-generation antipsychotics due to side effect profiles. For older adult clients, lower doses of first- and second-generation medications are indicated as decreased renal clearance, decreased liver functioning, and decreased cardiac output can create opportunities for altered metabolism. Additionally, these medications should be used with caution for clients with dementia because they have been associated with increased mortality rates.

Nursing Implications

When working with clients who will be starting on antipsychotics, nurses begin with an assessment. They should assess for medications or conditions contraindicated with the medication. Mental status exam and appropriate screening tools are indicated. Nurses should assess for BMI, fasting lipids, fasting glucose, and potential ECG. For clients taking clozapine, there is a risk for severe neutropenia as defined as absolute neutrophil count less than 500/µl. For those clients being initiated and maintained on the medication, nurses should measure baseline blood ANC before starting treatment and during treatment at prescribed times. Several different scales can be used to assess EPS, for instance, like the Extrapyramidal System Rating Scale (ESRS) or the Abnormal Involuntary Movement Scale (AIMS) (Table 4.4). The Simpson-Angus Scale verifies medication-induced Parkinsonism. The Barnes Akathisia Rating Scale identifies antipsychotic-induced akathisia. Once the health-care team identifies, documents, and communicates side effects, they can prescribe medications to mitigate them.

Once an antipsychotic has been prescribed, the nurse should educate the client on the following: drug-drug interactions, medications to avoid, side effects, diet, exercise, monitoring of adverse events, and safety planning strategies. Medications commonly avoided with antipsychotics include other dopamine agonists, such as levodopa. Side effects common with antipsychotics include extrapyramidal symptoms (EPS), metabolic syndrome such as

insulin resistance, hyperlipidemia, weight gain, sedation, sexual dysfunction, gastrointestinal upset, orthostatic hypotension, and lowering of seizure threshold. Educating clients on diet and exercise helps to mitigate the risks for weight gain and metabolic syndrome. Nurses should monitor for adherence, efficacy, side effects, adverse events, and client understanding of education.

EPS	Treatment
Dystonia	Benztropine Diphenhydramine
Akathisia	Reduction of dose or removal of offending medication Benzodiazepines Propranolol Mirtazapine
Pseudo-Parkinson's	Benztropine
Tardive dyskinesia	Reduction of dose or removal of offending medication Valbenazine Deutetrabenazine

TABLE 4.4 Treatment for EPS

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care

Side effects of antipsychotic medications can occur at any stage of treatment and include the extrapyramidal symptoms (EPS), dystonia, tardive dyskinesia, akathisia, and anti-parkinsonian. Providing client-centered care involves assessing and identifying these adverse events; some symptoms can be irreversible if left unmanaged. Additionally, side effects, such as EPS, are a common reason for non-adherence to antipsychotic agents.

Assessment for symptoms of dystonia on examination and observation include muscle stiffness in upper limbs, head, and tongue and eye rolling. For dyskinesias, check for slow or lateral movements of the tongue and jaw, chewing, biting, clenching, puckering, pouting, and lip smacking, involuntary rocking or twisting of the torso or pelvic gyrations, uncontrollable slow "pill rolling" of hands, shuffling gate, and slow-moving lower limbs. For akathisia, look for uncontrollable urges to move legs relieved by standing and walking, inability to sit still, constant movement or walking. Assess also for subjective level of feelings of uneasiness. Assess client perception of the side effects, if they are noted by the client, how much, and how distressing these symptoms are to the client. Do they interfere with the client's functioning? Do they influence the client's willingness to continue the medication?

Tools to evaluate extrapyramidal symptoms include the following: the Extrapyramidal Symptom Rating Scale (ESRS), which assesses for akathisia, dystonia, dyskinesia, and Parkinsonism; the Abnormal Inventory Movement Scale (AIMS), which assesses for tardive dyskinesia; and the Barnes Akathisia Rating Scale, which assesses for akathisia while the client is in a seated position. All signs of EPS should be documented in the client record and promptly transmitted to the provider for medical intervention.

After medical intervention is provided, documentation may include answers to questions such as the following:

- What response does the client have?
- If a medication dose is lowered, does the client show signs of symptoms that have returned as a result?
- If a medication is given to treat the side effects, what response to the medication does the client have?
- Does the client have adherence to their medications?

Accurate assessment of side effects and response to interventions is essential in affording the client confidence with their medications, which translates to adherence to treatment algorithms and positive outcomes.

LINK TO LEARNING

Read this research article reviewing assessment scales and describing the necessity of prevention and detection of medication side effects (https://openstax.org/r/77MedSideEffect) to learn more. Nursing implications include accurate assessments, client education, and nursing awareness of potential side effects with newer drugs marketed as "lower incidence" for side effects.

Antidepressants

Research has not fully explained the etiology of mood disorders. Based on the effects of psychopharmacology (working backwards), one common theory is that deficits in the monoamines contribute to symptoms of depression. As discussed earlier, the monoamines include norepinephrine, dopamine, and serotonin. Antidepressants target monoamines to increase dendritic growth and mitigate mood states. Another theory on the causes of depression is related to stress, genetics, and inflammation. These factors can potentially cause loss of neurons.

The origin of antidepressants is tied to that of antipsychotic agents. The antipsychotic agent chlorpromazine was slightly modified in the 1950s, resulting in the first tricyclic antidepressant, imipramine. Tricyclic antidepressants (TCAs) include imipramine, amitriptyline, nortriptyline, protriptyline, doxepin, desipramine, and trimipramine. These antidepressants increase serotonin and norepinephrine by blocking both presynaptic reuptake pumps. Additionally, these medications block alpha 1 and 2, muscarinic, and histamine receptors.

In March 1982, fluoxetine, the first SSRI was approved by the Food and Drug Administration. Fluoxetine, sertraline, fluvoxamine, paroxetine, citalopram, and escitalopram followed. These medications were novel in both their chemical structure and their safety profile. Tricyclic antidepressants have high lethality in an overdose due to hypotension, cardiac dysrhythmia, seizure, and coma. SSRIs are rarely lethal. These medications block the presynaptic serotonin reuptake pump, resulting in increased serotonin within the synaptic cleft. Other antidepressants followed, with the invention of the serotonin norepinephrine reuptake inhibitor (SNRI), such as venlafaxine and duloxetine; the norepinephrine dopamine reuptake inhibitor (NDRI), such as bupropion; the serotonin receptor antagonist/serotonin antagonist/reuptake inhibitors (S-MM/SARI), such as trazodone; and the serotonin multimodal (S-MM) agents, such as vortioxetine.

The final class of antidepressant drugs, monoamine oxidase inhibitors (MAOI), targets the enzymatic destruction of the monoamines in the synaptic cleft. These medications irreversibly inhibit the enzymes MAO-A and MAO-B from breaking down all three monoamines, resulting in increased neurotransmitter levels in the synaptic space. An example of an MAO-I is phenelzine.

Indications

Antidepressant medications are FDA-approved for depression, most anxiety and obsessive-compulsive disorders, PTSD, panic disorder, social anxiety disorder, premenstrual dysphoric disorder, pain disorders (SNRIs and TCAs, such as duloxetine or amitriptyline), insomnia (doxepin), and Parkinson's disease (selegiline).

Side Effects and Interactions

Different types of antidepressants cause different types of side effects. Tricyclic antidepressants can potentially cause significant side effects. Because overdose carries a high risk of lethality, use these medications with caution for clients who are suicidal or who are known to have self-harming behaviors. Common side effects of tricyclics include dizziness, sedation, fatigue, anticholinergic side effects (blurred vision, constipation, urinary retention, dry mouth, weight gain), sexual dysfunction (impotence in biological men, decreased libido in biological women), headache, irritability, and nervousness. Dangerous side effects include paralytic ileus, hyperthermia, the potential for seizures, hypotension, dangerous arrhythmias, increased ocular pressure, activation of mania, and suicidal ideation. These medications are contraindicated in those who have cardiac disease, have undergone cardiac surgery, have arrhythmias, or have had myocardial infarctions. These medications are not recommended with other medications that prolong QT intervals.

Clients generally tolerate SSRIs well, and they are rarely lethal in an overdose. Notable side effects include gastrointestinal upset, headache, tremors, insomnia, agitation, dizziness, sweating, decreased platelet aggregation, and sexual dysfunction. Serious side effects include mania; suicidal thoughts and behaviors, especially in those

younger than 24 years of age; and decreased seizure threshold. Drug contraindications with SSRIs include MAO inhibitors, and SSRIs should be used cautiously with other serotonergic medications because of the possibility of serotonin syndrome. A potentially life-threatening drug-drug interaction called **serotonin syndrome** is caused when high levels of serotonin are built up in the body. Signs and symptoms of serotonin syndrome include agitation, restlessness, insomnia, confusion, muscle rigidity, tachycardia, hypertension, dilated pupils, sweating, diarrhea, shivering, and headache. It most often happens after introducing a new serotonergic drug, or increasing the dose of one a client is already taking. Mild cases resolve by decreasing or stopping the offending agent, but more serious cases require emergency measures. Moreover, abrupt discontinuation from SSRIs can cause discontinuation syndrome. A time-limited syndrome caused by sudden cessation or tapering too quickly off of an antidepressant is called **discontinuation syndrome**. The symptoms can be characterized as mild to moderate and can last from a few days to a few weeks after stopping the medication. Symptoms can include dizziness, imbalance, insomnia, sensory disturbances, flu-like symptoms, nausea, burning, tingling, electric shock-like feelings, irritability, and agitation.

SNRIs, like SSRIs, are generally well tolerated. Due to their blockade at presynaptic norepinephrine transports, however, there is a potential for these medications to affect blood pressure. Serious side effects include mania; suicidal thoughts and behaviors, especially in those younger than 24; and decreased seizure threshold. Drug contraindications with SNRIs include MAO inhibitors; they should be used with caution with other serotonergic medications because of the possibility of serotonin syndrome. Abrupt discontinuation from SNRIs can cause discontinuation syndrome.

Mirtazapine is an atypical antidepressant, frequently taken at night. The medication is more sedating at a lower dose and serves as an antidepressant at higher doses. It is rarely lethal in an overdose. The medication can cause dry mouth, constipation, dizziness, low blood pressure, and significant weight gain. This medication is not for use in a client with a high BMI, and can increase risk for people with narrow-angle glaucoma. Serious side effects include mania; suicidal thoughts and behaviors, especially in those younger than 24; and decreased seizure threshold. The FDA has issued a warning on most antidepressants that there is a potential increased risk of suicide in those clients taking them under the age of 24. Evaluation of suicide risk in all mental health clients is critical to any assessment and involves collaborative care management approaches between family, other health-care providers, educators, and friends. Drug contraindications with mirtazapine include SSRI, SNRI, and MAO inhibitors. It should be used with caution with serotonergic medications because of the possibility of serotonin syndrome. Abrupt discontinuation from mirtazapine can cause discontinuation syndrome.

Bupropion is a norepinephrine and dopamine reuptake inhibitor. It is taken early in the day to avoid late afternoon activation and insomnia. It is rarely lethal in an overdose, but this medication can be abused by crushing and snorting it. Side effects include insomnia, dizziness, agitation, weight loss, high blood pressure, constipation, dry mouth, and nausea. Dangerous side effects include Stevens-Johnson syndrome, tinnitus, lowered seizure threshold, and activation of mania and suicidal behaviors, especially in those younger than 24. This medication is contraindicated in those with preexisting eating disorders, seizure disorder, traumatic brain injury, alcohol or sedative use disorder, or nervous system tumor. This medication is used with caution in those with severe anxiety, bipolar disorder, or severe insomnia because it can be activating. For instance, it can cause activation or mania in a client who is diagnosed and being treated for a unipolar depression but who has an underlying bipolar process. Monitor for signs and symptoms of hypomania or mania, which can include decreased need for sleep, pressured speech, impulsive behaviors, distractibility, tangential behaviors, racing thoughts, and grandiosity.

Trazodone is a serotonin receptor antagonist and, like mirtazapine, is taken at night. The medication may be used for sleep at a lower dose and serves as an antidepressant at higher doses. It is rarely lethal in an overdose. Side effects include GI issues (nausea, vomiting, constipation, dry mouth), blurred vision, dizziness, fatigue, headache, low blood pressure, tremors, and rare rash. Serious side effects include priapism; mania; suicidal thoughts and behaviors, especially in those younger than 24; and decreased seizure threshold. Drug contraindications include MAO inhibitors, and this drug should be used cautiously with other serotonergic medications because of the possibility of serotonin syndrome. Use is cautioned in people with narrow-angle glaucoma, due to mydriatic activity of the drug, which can increase intraocular pressure. Abrupt discontinuation from trazodone can cause discontinuation syndrome.

Multimodal antidepressants have more than a single effect, that is, inhibiting and activating at receptor sites. This class of medications has properties at various locations on serotonin receptors. They have the lowest potential for

side effects. Reports of lethality in overdose are rare. Side effects include GI issues (nausea, diarrhea, vomiting, dry mouth), insomnia, dizziness, sexual dysfunction, and antiplatelet aggregation. Serious side effects include mania; possible activation of suicidal thoughts and behaviors, especially in those younger than 24; and decreased seizure threshold. Drug contraindications include MAO inhibitors, and these drugs should be used cautiously with other serotonergic medications because of the possibility of serotonin syndrome. Abrupt discontinuation from SSRIs can cause discontinuation syndrome. Collaborative practice decisions should be made concerning SSRI use prior to surgery. Risk for perioperative bleeding as well as risks of discontinuation syndrome and depression relapse must be balanced with benefit of continued symptom management in mood disorders.

MAO inhibitors, the final class of antidepressants, irreversibly block the enzymatic activity of MAO-A and B. There can be life-threatening side effects if a client on MAO inhibitors ingests food containing tyramine (Table 4.5)—which can cause a hypertensive crisis—or medications that require the enzymatic destruction of MAO A/B. Signs and symptoms of the hypertensive crisis include rapid or precipitous increase in blood pressure, sweating, anxiety, headache, and nausea and vomiting.

Category	Examples
Food high in tyramine	Strong or aged cheeses Cured meats Smoked or processed meats Pickled or fermented food, like sauerkraut and kimchee Soybeans, fava beans, snow peas, tofu Tap beer Yeast spread, brewer's yeast Meat tenderizers, soy sauce, teriyaki sauce, miso, shrimp, and fish sauce Dried or overripe fruits
Drugs	All other antidepressants Meperidine Sympathomimetic agent Guanethidine Other serotonergic agents: tramadol, Zofran, carbamazepine, methadone, migraine medications, such as sumatriptan Some antipsychotics, such as ziprasidone St. John's Wort Dextromethorphan and other decongestants Drugs of abuse: MDMA, cocaine, methamphetamine Certain types of alcohol (talk to the health-care provider_

TABLE 4.5 Food and Drugs to Avoid with MAOIs

PSYCHOSOCIAL CONSIDERATIONS

Education on Psychopharmaceuticals

The nurse should work with the provider and team to ensure that the client:

- understands the need for their medications
- understands the side effects of the medications
- can afford the cost of medications
- can take the medications as seldom as possible, for example, one time a day dosing versus four times a day
- knows the medication may take three to four weeks or longer before they feel better
- knows when to call their provider or go to the emergency department
- is engaged in stigma reduction when the nurse utilizes person-centered language (avoiding labeling person

with diagnostic categories), offers comparisons between physical and mental illness, and provides examples such as, "When I get that question, I say . . ." or "I push back against those attitudes by . . ."

Special Populations

SSRIs and SNRIs have been proven safe and effective in most clients above age six, but it is important to weigh the risks versus the benefits carefully when considering SNRIs and TCAs for this population. MAOIs are not for use in clients under the age of 16. Multimodal agents, such as vortioxetine, have not been established as safe or effective in children. SSRIs and SNRIs can be safe and effective in older adult populations. Those recovering from cardiac surgery and those diagnosed with arrhythmias or CVAs should generally be prescribed an SSRI, which will not exacerbate the condition.

Nursing Implications

Nurses caring for clients who take antidepressants should assess for medications or conditions that are contraindicated with the antidepressant. For clients taking bupropion, for instance, the assessment should include a history of any preexisting seizure disorders, head injury, or eating disorders contraindicated for the medication. Nurses should assess client suicidality through evidenced-based suicide assessment tools, such as the Columbia Suicide Severity Rating Scale. Nurses should use a collaborative approach with the client to develop a suicide safety plan and educate on the national suicide hotline at 988. They should limit access to certain antidepressants to clients who are at risk of self-harming behaviors. Nurses should educate clients on potential for drug/drug interactions, such as over-the-counter medications or herbal remedies like St. John's wort. For those clients taking MAOIs, education includes dietary restrictions and medications to avoid, such as over-the-counter cold medications to avoid antihypertensive crisis. Nurses should document any side effects or adverse events related to the medication and notification to the provider. They should also assess changes in condition once medical intervention has taken place and document the response. Nurses should use motivational approaches to manage nonadherence to medication.

CLINICAL JUDGMENT MEASUREMENT MODEL

Psychopharmacology

The Clinical Judgment Measurement Model is an evidence-based model that identifies six cognitive skills needed to make appropriate clinical judgments. Consider these skills in the context of psychopharmacology.

A nurse works in a clinic with clients diagnosed with severe mental illness. Client X, a 57-year-old, presents to the clinic two days after converting from risperidone PO to risperdal consta injection. The client is complaining of muscle stiffness, sore jaw, sore neck, and an inability to close their mouth. The client's eyes are rolling back into their head. They are having difficulty talking.

1. **Recognize cues**: Gather information, such as medication history, signs, symptoms, health history, and so forth.

2. **Analyze cues**: How does the client history and signs/symptoms relate to the client presentation and the client's needs or concerns?

3. **Prioritize hypotheses**: Establish priorities based on the client's needs or problems. The priority here is the side effects from the antipsychotic medication. The client recently had a change to the dosing of their medication that may have contributed to the current symptoms.

4. **Generate solutions**: Identify outcomes and nursing interventions to meet the client's needs or address the problems.

Expected outcome: Reduction in the adverse events related to possible medication reaction.

Nursing interventions: Assess for EPS using scale, take vital signs, notify provider, monitor client per agency policy, administer medications as indicated, evaluate the effects of the medications by reassessing the client one hour postadministration.

5. **Take action**: Implement the nursing interventions using priorities of care and planned outcomes to promote,

maintain, or restore the client's health. Collaborate with other members of the health-care team, and participate in coordination of care by implementing the plan of care, documenting care, giving/receiving report, assisting with rounding, educating the client, and so forth.

6. **Evaluate outcomes**: Gauge the client's response to the interventions to see if the outcomes have been met. If met, continue to monitor. If not met, gather more information and/or revise the plan of care.

One hour post medication administration, the client is now able to move their mouth without soreness, is able to talk, and has no muscle stiffness or soreness after injection.

Mood Stabilizers

Mood stabilizers are used to treat bipolar mood disorders and differ from medications to treat unipolar depression. Mood stabilizers help mitigate both the highs of mania and the lows of depression. The biological etiology of bipolar disorder, like unipolar depression, is unknown. A possible genetic determinant has been linked to CACNA1C2, a gene that affects the amygdala, responsible for emotions. As with depression, deficits in neurotropic factors, stress, and inflammation have also been linked to the disease. There are three types of medications used to treat bipolar disorder: antipsychotic medications, as already discussed, lithium, and anticonvulsants.

Lithium

The mechanism of action for lithium is unknown. It is considered to be a first-line choice in the management of mania and mixed mania, and with bipolar maintenance. There is also evidence linking lithium to a reduction in suicidal thoughts. Lithium is a salt and is excreted via the renal system. Therefore, clients should have optimal renal functioning to take this medication. Lithium also requires monitoring trough blood levels 12 hours after the last dose. Optimal lithium levels fall between 0.6 to 1.2 mEq/L. Side effects include ataxia, mild tremors, thirst, frequent urination, weight gain, acne, hair loss, and euthyroid goiter. Lithium toxicity can start when blood levels reach 1.5 mEq/L, with severe toxicity (which is life-threatening) at 2.5 mEq/L and above. Dangerous and life-threatening side effects include lithium toxicity, seizures, diabetes insipidus, arrhythmias, and renal impairments. This medication is contraindicated for those with renal impairments, those who suffer from cardiac disease, and clients with sodium depletion or who are severely dehydrated (Table 4.6). Medications to avoid taking in conjunction with lithium include NSAIDs; COX-2 inhibitors, such as celecoxib, metronidazole, calcium channel blockers, ACE inhibitors, and diuretics.

	Signs and Symptoms	Lithium Levels
Mild to Moderate	Nausea, vomiting, diarrhea, tremors, fatigue, drowsiness, weakness	1.5–2.5mEq/L
Severe	Agitation, hyperthermia, tachycardia, hypotension, confusion, delirium, slurred speech, renal failure, coma, death	2.5–3.5 mEq/L and above

TABLE 4.6 Signs and Symptoms of Lithium Toxicity

Anticonvulsants

Anticonvulsants are another type of mood stabilizer that includes valproic acid, lamotrigine, and carbamazepine. While the exact mechanism is not known, these medications target voltage-sensitive sodium channels. The end goal is the overall reduction in excitatory neurotransmission at the synaptic cleft, which results in mood stabilization. Valproic acid is the only anticonvulsant mood stabilizer that requires monitoring of trough blood levels. The therapeutic range for valproic acid is 50–125 µg/mL, with toxic levels > 150 µg/ML. Side effects of valproic acid include sedation, GI issues (nausea, vomiting, diarrhea), weight gain, and alopecia. Adverse events associated with valproic acid include activation of suicidal thoughts, hepatotoxicity, tachycardia, and valproic acid toxicity. Signs and symptoms of valproic acid toxicity include nausea, vomiting, myoclonus, somnolence, dizziness, hallucinations, irritability, headache, lethargy, respiratory depression, and coma. Drug interactions with valproic acid include lamotrigine, carbamazepine, topiramate, cimetidine, erythromycin, ibuprofen, phenobarbital, and phenytoin.

LINK TO LEARNING

Management of lithium levels involves understanding peak and trough levels. Review the details of monitoring lithium (https://openstax.org/r/77MonitorLith) from Psych Scene.

Lamotrigine and carbamazepine side effects are sedation, dizziness, nausea, constipation, and blurred vision. Adverse reactions for both include activation of suicidal ideation and potential for Stevens-Johnson syndrome. Carbamazepine has the potential to cause aplastic anemia and agranulocytosis. Drug interactions with lamotrigine include valproic acid, oral contraceptives, phenobarbital, phenytoin, and lithium. Drug interactions with carbamazepine include hormonal contraceptives, other anticonvulsants, and lithium.

Special Populations

Lithium is not indicated for mood stabilization for children under seven, and valproic acid is not for children under the age of 10; lamotrigine and carbamazepine are not indicated for use as mood stabilizers for children at all. All mood stabilizers are indicated for older adult clients with adequate renal and metabolic states. Lithium has the potential to become neurotoxic in older adult individuals, so it should be monitored closely. When initiating anticonvulsants in older adults, low start with low doses, titrate slowly, and monitor closely for safety and efficacy. Use of mood stabilizers during pregnancy and breastfeeding requires medical management.

Nursing Implications

Nurses caring for clients taking mood stabilizers should assess for medications or conditions that might be contraindicated with the mood stabilizers. They should also assess client suicidality through evidenced-based suicide assessment tools, such as the Columbia Suicide Severity Rating Scale, and should limit access to mood stabilizers to those who are at risk of self-harming behaviors. Nurses should educate clients on the following: drug-drug interactions, medications to avoid, side effects, monitoring of adverse events, and safety planning strategies. Monitor adherence, efficacy, side effects, adverse events, and client understanding of education. Nurses should also monitor baseline BMI, labs, and blood pressure, and should continue with trough blood levels for valproic acid and lithium. Nurses should report signs and symptoms of lithium and valproic acid toxicity. Nurses should educate clients on lithium on the importance of maintaining adequate hydration, not overhydrating, and on the signs and symptoms of toxicity.

REAL RN STORIES

Nurse: Rafael, RN
Years in Practice: 8
Clinical Setting: Mental health practice
Geographic Location: Colorado

A nurse with eight years' experience working in mental health took a call from a 27-year-old client who had a diagnosis of bipolar disorder. The client had previously been prescribed lithium 300mg po bid. The client called with concerning symptoms: nausea, vomiting, diarrhea, and gross hand tremors. The nurse asked how long the client had been having the symptoms. The client reported that the symptoms had been happening for the past five days. The nurse asked the client if they had been prescribed any new medications recently or if the client had any dose changes by their provider. The client was not taking any other medication other than lithium. The client had not had any medication changes for over two months. The nurse then asked the client if they were taking the medication twice a day as prescribed or if the client had been dehydrated, overexercising, or sick. The client denied all the above. The nurse then asked if there was anything unusual that happened five days ago. The client said that the only thing that happened five days before was that they picked up their new bottle of lithium at the pharmacy. The nurse then asked the client to go retrieve the bottle of medication and read the bottle to them. The client read the following off the label of their prescription: lithium 600mg po bid. The nurse then realized that the client was taking the wrong dose. The nurse notified the APRN provider who then called the pharmacy. The pharmacy had an order for lithium 300mg po bid but had dispensed lithium 600mg po bid. The client had been taking twice the amount of

medication prescribed and was having signs and symptoms of lithium toxicity. The client was asked to go to the emergency department for an evaluation and have a lithium level drawn, after which they were treated for potential lithium toxicity.

Anxiolytics

Anxiolytics, or antianxiety drugs, are a class of medications that decrease anxiety. This class includes benzodiazepines, buspirone, and hydroxyzine. Benzodiazepines are positive allosteric modulators on the GABA receptor. They increase the flow of negative ions through the cell wall of the neuron to allow for more inhibitory actions. In effect, this will directly oppose the excitatory nature of the brain. It "slows things down" and decreases the sensory flow of information to the brain. These medications have a variety of duration of actions and a potential for dependence and abuse. Buspirone is a serotonin receptor partial agonist, but the mechanism of action is unknown. The medication is given two to three times a day, requires several weeks to work, and is usually prescribed as an adjunct to another medication. Hydroxyzine is a histamine antagonist and is classified as an antihistamine. The medication is given two to three times a day as needed for anxiety.

Indications

Most benzodiazepines are indicated for short-term treatment for generalized anxiety disorders, anxiety, and panic. Some are indicated only for insomnia. Buspirone is indicated for long-term anxiety management, whereas hydroxyzine is used as an as-needed medication for anxiety.

Side Effects and Interactions

Side effects of benzodiazepines include sedation, dizziness, fatigue, and confusion. There is the potential for these medications to cause a paradoxical reaction, a heightened anxiety, excitability, and nervousness. All benzodiazepines have the potential to create tolerance and cause abuse. Abrupt discontinuation of long-term use of benzodiazepines can result in withdrawal seizures. These medications are tapered slowly to alleviate that dangerous situation. Adverse reactions include CNS depression and overdose. Clients with closed-angle glaucoma should not take benzodiazepines. These medications also should not be given to clients who have alcohol use disorder unless the client is under medical supervision for alcohol withdrawal treatment.

Side effects of buspirone include sedation, headache, nervousness, excitement, drowsiness, and insomnia. Dyskinesias are possible with this medication. Adverse reactions are rare but can include cardiac symptoms. Drug interactions include any serotonergic medication that can cause serotonin syndrome. Hydroxyzine side effects include sedation, fatigue, dizziness, and QT prolongation. Drug interactions with this medication include any medication that causes QT prolongation, such as escitalopram, citalopram, or ziprasidone. This medication should be used with caution in clients with any known cardiac disease.

Special Populations

Benzodiazepines are not frontline medications for children and may have paradoxical effects. There is limited information on the efficacy of buspirone for children over the age of six, so it is usually not prescribed in pediatrics. Hydroxyzine can be used for children over six in divided doses while monitoring for paradoxical effects. Benzodiazepines and buspirone can be used for anxiety in older adults, with lowered doses and monitoring for clearance, cognitive impairment, and fall risk. Hydroxyzine should not be prescribed to older adult clients with cardiac disease or those with dementia. Lower doses should be given to all other older adult clients while monitoring for clearance, cognitive impairment, and fall risk.

LIFE-STAGE CONTEXT

Medications for Older Adults

The American Geriatric Society publishes a guideline called the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, most often referred to as the Beers List. This evidenced-based approach provides information to health-care providers on the safe management of medications of adults ages 65 and older. The list is divided into categories of medications that might cause adverse effects or have limited effectiveness, and those medications that are contraindicated with certain disease states.

Assessment of medications for those 65 and older begins with medication reconciliation: obtaining a list of client medications, asking the client about current medications—including over-the-counter and supplements—and changes to prescribed medications. Assessment continues with identifying medications listed in the Beers List and the potential complications: drug-drug interactions, potential for adverse events, or contraindications with current disease states. The next step is to educate clients on the potential for adverse events. For example, if the client has impaired mobility and the medication causes CNS depressant effects like dizziness, the situation warrants educating the client on managing falls. Ensure health literacy of client education through return communication of the education received. Assessment and management of medications for those over the age of 65 is part of client safety and best practices for which nurses are responsible.

Nursing Implications

Nursing management of clients taking anxiolytics starts with an assessment for medications or conditions that might be contraindicated with the medication. It continues with the nurse educating the client on the following: drug-drug interactions, medications to avoid, side effects, monitoring of adverse events, and potential for tolerance and dependence for those who are taking benzodiazepines. Nurses should monitor adherence, efficacy, side effects, adverse events, and client understanding of education. Clients taking benzodiazepines should be taught not to abruptly stop the medication if they have been using it long-term. When they do discontinue, nurses should monitor for signs and symptoms of withdrawal, which can occur within 24 to 48 hours after the last dose depending on the half-life of the benzodiazepine, using a scale like the Clinical Institute Withdrawal Assessment Scale. Alternative benzodiazepines may be ordered to ameliorate the alcohol withdrawal symptoms. Signs and symptoms of benzodiazepine withdrawal include anxiety, nausea, tremors, diaphoresis, headache, heart palpitations, hallucinations, depression, autonomic instability, and seizures.

Hypnotics

Hypnotics are a class of medications that help clients fall and stay asleep. Sleep is a biological process that involves a homeostatic and circadian drive. Neurotransmitters involved in these processes include those that stimulate sleep like melatonin and GABA and those involved in the wake cycles, such as acetylcholine, dopamine, serotonin, norepinephrine, and histamine. There is an additional neurotransmitter, orexin, that promotes the balance between wake and sleep states. Hypnotics have several different targets in the sleep-wake cycle. One medication, ramelteon, works at the melatonin receptor to induce the sleep cycle. The GABA A positive allosteric modulating drugs, such as zolpidem, zaleplon, and eszopiclone, work at the same receptors as the benzodiazepines (but at a different subunit, so they lower the potential for tolerance and dependence) to decrease “excitatory” sensory noise that reaches the brain, allowing the client to sleep. Orexin-targeting medications, such as suvorexant, inhibit wake-promoting neurotransmitters, such as histamine, norepinephrine, and dopamine. These actions allow for stabilization and maintenance of sleep.

Indications

Hypnotics are indicated for sleep onset insomnia, sleep maintenance insomnia, short-term insomnia, and treatment of insomnia with early morning awakening as a symptom.

Side Effects and Interactions

Side effects of hypnotics generally include sedation, dizziness, fatigue, and headache. Medications that work on GABA receptors have side effects, including amnesia and amnestic events, such as sleep eating, sleep driving, sleep cooking, and sleep texting/making phone calls. Adverse events for GABA receptor medications include tolerance and dependence, the potential for CNS depression, and overdose. Adverse events related to orexin agents include the remote potential for tolerance and abuse, sleep paralysis, hallucinations, and cataplexy. Therefore, these medications are generally not for use in those with narcolepsy.

Special Populations

Hypnotic medications have not been proven safe or effective in children. Ramelteon, the melatonergic hypnotic, is safe for use in older adult clients; dose adjustments are not necessary. GABA receptor medications can be used cautiously in older adult clients, but there is an increased risk of falls. Lower doses are generally recommended, and clients should be placed on falls precautions.

Nursing Implications

Nursing management of clients taking hypnotics starts with an assessment for medications or conditions with which the hypnotics might have a contraindication. Educate clients on the following: drug-drug interactions, medications to avoid, side effects, monitoring of adverse events, and potential for tolerance and dependence for those who are taking GABA receptor hypnotics. Monitor for adherence, efficacy, side effects, adverse events, and client understanding of education. Clients taking GABA receptor hypnotics should be educated not to abruptly stop the medication if they have been using it long-term, because it can cause withdrawal anxiety and worsen insomnia. Nurses should monitor for total sleep time, time to fall asleep, number of awakenings during the night, and time to fall asleep after awakenings. Nurses should educate the client on sleep hygiene and nutritional and exercise factors that affect healthy sleep states.

Stimulants

Attention-deficit/hyperactivity disorder (ADHD) is a state caused by the inefficiencies of two significant neurotransmitters, norepinephrine and dopamine, that promote information processing in the brain's prefrontal cortex. Too much of these neurotransmitters causes overexcitability, inability to concentrate, and a flight or fight response. Conversely, too few neurotransmitters make the client drowsy, inattentive, and sleepy. When these two neurotransmitters work efficiently, the client is alert, awake, and cognitively able to attend to events in their environment. The medications used to regulate these two neurotransmitters for those who have ADHD are called non-stimulants, and they generally work to make the two neurotransmitters work more optimally; the non-stimulants are called guanfacine and atomoxetine. These medications work slower and are not controlled substances. Stimulant medications, by contrast, work within the central nervous system to increase the availability of neurotransmitters by blocking the reuptake transporter into the presynaptic neuron. Stimulants are controlled substances and have the potential for tolerance and dependence. Stimulants are usually considered first-line agents for treating ADHD in school-age children. If caregivers object to stimulant medication and/or there are medical contraindications, however, non-stimulant medications are an option.

LINK TO LEARNING

This Berkeley Well-Being video discusses the details of fight or flight (https://openstax.org/r/77FightFlight) as a normative response to a threat in the environment and its links to some mental health symptoms.

Indications

Non-stimulants and stimulants are indicated for treating ADHD, narcolepsy, and excessive sleepiness.

Side Effects and Interactions

Guanfacine is a norepinephrine receptor agonist and a non-stimulant. Side effects of this medication include lowered blood pressure, low pulse, dry mouth, constipation, sedation, fatigue, and nausea. Dangerous side effects include bradycardia. Atomoxetine is a selective serotonin /norepinephrine reuptake inhibitor. Side effects include anorexia, weight loss, tachycardia, hypertension, insomnia, activation, dry mouth, constipation, nausea, urinary hesitancy, sexual dysfunction, and anxiety.

Stimulants take a variety of actions to boost norepinephrine and dopamine within the central nervous system. Side effects include insomnia, weight loss, headaches, tics, dry mouth, Raynaud's, anxiety, and activation. Adverse events include tachycardia, hypertension, priapism with some stimulants, tardive dyskinesia, neuroleptic malignant syndrome, activation of mania or suicidal thoughts, seizures, and cardiac events. These medications are generally contraindicated in those with severe anxiety, a history of cardiac disease, seizure disorders, tics, glaucoma, and current alcohol or benzodiazepine use disorder. Drug-drug interactions include MAO inhibitors, medications that increase blood pressure, and antihypertensive medications. Use stimulants with caution with mood stabilizers because stimulants may destabilize those with bipolar disorder.

Special Populations

Non-stimulant and stimulant medications are generally not recommended for use in children under the age of six. These medications are not recommended for older adult clients with a cardiac disease history.

Nursing Implications

Nursing management of clients taking non-stimulants and stimulants starts with assessing medications or conditions contraindicated with the medication. Nurses should educate clients on the following: drug-drug interactions, medications to avoid, side effects, monitoring of adverse events, and potential for tolerance and dependence. Nurses should monitor for pulse, blood pressure, height, weight, adherence, efficacy, side effects, adverse events, and client understanding of education. Nurses should educate clients on maintaining nutritional status, especially during midday hours; taking medications when directed; not taking medications too late in the day, which could interfere with sleep; and behavioral strategies to manage attention deficits, such as exercise and structure in the environment.

PSYCHOSOCIAL CONSIDERATIONS

Concordance and Motivational Interviewing for Medication Adherence

Adherence is behavior that coincides with prescribed medical health advice or plan of treatment. There are certain challenges to adherence to a plan that includes psychotropic medications: negative beliefs about the medication effectiveness, family or social support beliefs about medications, and the potential for side effects. Motivational interviewing is a client-centered approach to increase motivation by discovering client medication uncertainty though a guided communication approach. It is designed to empower the client to explore their thoughts and concerns about medication ambivalence in a respectful manner and facilitate a change process to honor client autonomy and decision making about taking medication.

Through a process of open-ended questions, nurses explore the clients' thoughts and beliefs about the medication. They should honor the clients' concerns about the medication, and consider where they are in the change model. Nurses should educate the client about the risks and benefits of the medication versus not taking the medication, and then explore any options that the client can take to alleviate concerns about the medication. Through this process, the nurse and the client can gain concordance or shared agreement about their therapeutic goals.

LINK TO LEARNING

Use this comprehensive video on the indications and side effects of psychopharmacological medications (https://openstax.org/r/77PsychpharmMed) as a visual reminder.

4.3 Innovations in Mental Health

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe how alternative treatments are used in psychiatric-mental health settings
- Explain how digital tools can be used to identify and track at-risk clients
- Describe the role of telemental health in the treatment of psychiatric-mental illness

The past 60 years has seen dramatic change in the treatment of mental health disease—from the chronic internment of the serious mentally ill and treatment with insulin-based shock treatments to the home-based, data-driven technologies of today. This section covers the innovations in medicine, technology, and internet-based applications that are advancing the science of mental health care.

Alternative Treatments

Alternative treatments are considered those that are done instead of the standard treatment procedures. For those who are engaged in mental health care, standardized treatment includes individual or group therapy, psychopharmaceutical treatments, and more intensive treatments, such as residential or in-client treatment facilities. This section will review the more commonly used and approved alternative treatments for mental health disorders.

Transcranial Magnetic Stimulation (TMS)

A noninvasive treatment called **transcranial magnetic stimulation (TMS)** was developed in 1985 and approved for use in those with major depressive disorder in 2008. The treatment consists of an electromagnetic coil that is placed against the client's head (over the prefrontal cortex) that delivers a magnetic pulse to stimulate nerve cells in the brain. Different combinations and types of stimulations manage different symptoms. The exact mechanism of action is not quite understood, but theories posit that TMS stimulates areas of the brain that have decreased neuronal activity. Indications for TMS include failure of at least one antidepressant and approval by insurance, if applicable. Approximate costs for TMS range between $6,000 and $12,000 with the TMS course entailing approximately 20 to 30 clinic sessions lasting 30 to 40 minutes each, but these costs and number and length of sessions can vary by insurance coverage. Effects of TMS are statistically significant with optimal remission rates. Prior to referral to TMS, clients should be assessed for risk factors related to seizures, traumatic brain injury, intracranial masses, neurological disease, metal in the head or neck, alcohol or benzodiazepine withdrawal, or medications that lower seizure threshold (bupropion, theophylline, and stimulants). Side effects include pain and irritation at the site of the magnet, tingling, facial muscles that twitch, and lightheadedness. Some clients with trauma might become triggered by the experience. After the first course of treatment, clients might engage in maintenance treatments or a tapering regimen. Deep TMS is the stimulation of deeper brain structures by the same TMS devices. It is indicated for major depression and obsessive-compulsive disorder. The treatment algorithms are commensurate with that of regular TMS.

Esketamine

A innovative treatment for treatment-resistant depression and major depressive disorder with suicidality is **esketamine**, which is derived from a drug called ketamine, an anesthetic. It works very differently from traditional antidepressants; theoretically, it causes an increase in brain-derived growth factor (BDNF), which has been implicated as a factor in unipolar depression. Esketamine has been found to have optimal remission rates when treating depression and has FDA approval for this use. It has also demonstrated a rapid reduction in suicidal thoughts. Side effects include increased blood pressure, nausea, vomiting, anxiety, depersonalization/derealization, hallucinations, vertigo, and sedation. Prior to treatment, assess clients for conditions that are contraindicated, such as hypertension, substance misuse disorders, CNS depressed states, and hepatic impairment; also assess vital signs before and during treatment. Esketamine comes in a nasal spray at a 28 mg dose and is usually administered in a clinic setting. Clients arrive at the clinic, generally self-administer the esketamine, and then wait for 40 minutes to one hour before someone else drives them home. Treatments last up to 10 weeks with one to two treatments per week.

Ketamine may be administered intravenously (IV) or intramuscularly (IM) by a qualified professional. Infusions are administered weekly or more frequently; injections may have different administration schedules. Because FDA approval for ketamine is still as an anesthetic, with "off label" use for mental health treatment, insurance policies may not cover the expense.

Electroconvulsive Therapy

The use of electrical currents under anesthesia to produce a seizure is **electroconvulsive therapy (ECT)**. It is FDA approved for treatment resistant or severe unipolar depression. How ECT works to decrease depressive symptoms is not known. There are theories that the induction of the seizure activity releases the neurotransmitters that are involved in depressive states (serotonin, dopamine, and norepinephrine), and it potentially results in stimulation of brain derived neurotropic factor (BDNF), which is responsible for neuronal growth, learning, and memory. Clients who are referred for ECT are first evaluated to see if they are a candidate for the treatment. They are then screened for medical history to determine if there are any contraindications for the treatment (potentially those with coronary disease, with asthma or COPD, poorly controlled hypertension, those with implanted pacemakers, or those who are pregnant). Seizures can cause increases in blood pressure, heart rate, and intracranial pressure. Assess and manage client status before and after the procedure.

Also prior to ECT treatment, educate clients on the risks versus benefits and side effects of the treatment versus no treatment at all. The risks include the risks of anesthesia, medical complications of the procedure inclusive of heart attack, stroke, respiratory difficulty, or continuous seizure. Other side effects include dental complications, irregular heart rate, memory loss, and confusion upon awakening from anesthesia that usually lasts no more than an hour. The recommended number of ECT treatments is between six and 12, based on the clinical response. Once the client

is ready for their treatment, they are usually brought to a surgical suite or pre-anesthesia holding area where the procedure takes place. The client is sedated and provided anesthesia. The client is given either unilateral or bilateral treatment (meaning that electrodes are placed on one side or both sides of the temporal region) based on their symptomology. Once the procedure is done, the client wakes from anesthesia.

Nursing care prior to the treatment includes:

1. ensuring that the client has understood and signed informed consent
2. making sure the client has had nothing by mouth for at least eight hours prior to the procedure
3. removing all dentures, jewelry, eyewear (glasses, contact lenses), hearing aids
4. having the client void before the procedure
5. giving perioperative medications

Nursing care during the procedure includes:

1. monitoring vital signs and symptoms
2. placing oral/dental protection device
3. giving procedural medications
4. assessing client during procedure

Nursing care after the procedure includes:

1. monitoring vital signs and symptoms
2. assessing cognitive status
3. checking for gag reflex, fluids, ambulating, and toileting
4. placing client on falls precaution

Virtual Reality

A useful and effective treatment for anxiety and fear disorders, such as phobias and traumatic stress, is **virtual reality (VR)**, a computer generated two- or three-dimensional environment that contains scenes or objects that allow the user to immerse in a seemingly real surrounding. Using VR, mental health professionals can engage in cognitive treatment like exposure therapy to gradually "expose" their clients *in vivo* to fear-related situations, in a controlled environment, while managing their fear response with use of relaxation techniques taught prior to the VR experience. It is the same principle for those who experience trauma triggers. VR immersion can assist clients with modulating the trauma trigger through safe encounters while managing their negative beliefs with relaxation exercises and cognitive reframes. Side effects of VR include dizziness, headache, nausea, eye strain, and decreased sense of present self or dissociation. Those who experience light-triggered seizures are not candidates for VR experiences. Recommendations for VR treatment include engaging in between eight and 12 sessions for 15 minutes each or for a single session that lasts from 45 minutes to three hours.

Digital Tools to Identify and Track At-Risk Clients

Nearly one in five U.S. adults have or will have a mental health diagnosis in their lifetime. With a paucity of mental health providers and an explosion of technology, clients and providers are turning to digital tools to assist at-risk clients. For those with access to the internet and technology, there are a variety of applications for use in mental health. They range from applications to track sleep, mood, stress, and vital signs, such as heart rate and respirations, to those that track symptoms of mental health disorders. There are apps that can follow along with providers to assist with, monitor, and evaluate cognitive and behavioral interventions. Some apps take the user along guided imagery exercises. Others provide motivational experiences to lift mood and provide feedback for substance use disorders. There are tools that combine cognitive behavioral therapy and nutrition to achieve a healthier diet. Applications assist in goal attainment, recovery from loss, and management of anxiety and panic. Applications track self-harming and suicidal thoughts and can assist with the formation of suicide safety planning. In a world where stigma and lack of providers creates barriers to care for mental health issues, these applications can create bridges to care that reach millions. While they do not replace the clinician, they can provide additional resources and tools for those who have access to the virtual world.

Telemental Health

An extension of the virtual platform for those seeking mental health care is **telemental health**. It is the provision of

mental health services though telephone or videoconferencing. Telemental health is a cost-effective alternative to in-person mental health services, especially in cases where access is limited. It is not useful in areas where broadband or cellular communication is not available. In the aftermath of COVID-19, major regulatory efforts have tried to expand broadband capabilities to extend the reach of telemedicine. Insurance companies and state and federal regulations have become increasingly supportive of internet-based mental health care, especially after the pandemic. There are several considerations before providers can engage in internet-based treatment. The services must be HIPAA-compliant, meaning that the providers' internet-based platforms and communications are required to have secure communication and privacy features. Moreover, clients must be informed ahead of their first appointment that internet-based services are part of the care algorithm. Altogether, internet-based mental health care is a cost-effective and stigma-free way to engage in evidence-based care for those with the health literacy and technology to engage.

LINK TO LEARNING

Review this Evidence-Based Resource Guide from SAMHSA on the use of telehealth for treating mental illness and substance use disorders (https://openstax.org/r/77TelhlthMental) to learn more.

Summary

4.1 Foundations of Neurobiology

This section provided a review of the components and functions of the nervous system relative to mental health disorders nurses encounter in practice. It explained how neurotransmitters, like serotonin and dopamine, endocrine functioning, and hormones, affect human behavior. Their presence/absence or proper functioning can heavily influence expressions of mental health disorders.

4.2 Psychopharmacology

The nursing role when it comes to psychopharmaceuticals is to assess for mental health symptoms and medications, collaborate with the client to recognize medication barriers and engage in nursing interventions to combat them, and identify side effects and adverse events of psychopharmaceutical agents. This section provided knowledge for skills associated with medications used to treat a variety of mental health disease states and the indications, risks, and population considerations related to these medications.

4.3 Innovations in Mental Health

Advances and modernization in medicine and technology have improved the science and delivery of mental health care over the past 60 years. In doing so, these innovations have increased access to care, decreased stigma, and broadened treatment approaches to appeal to more consumers, some who might be wary of traditional pharmaceutical methods. Advancing innovations in knowledge for mental health care and delivery systems is critical to achieve optimal client outcomes.

Key Terms

A-Beta (Aβ) fibers nociceptive neurons that manage touch and vibration sensations
A-Delta (Aδ) fibers nociceptive neurons that transmit pressure, mechanical deformation, and extreme temperature sensations
acetylcholine neurotransmitter responsible for cognitive functions, work on skeletal muscles, and ganglia
adrenocorticotropic hormone (ACTH) part of the HPA axis, is released and travels to the adrenal glands where it then triggers the release of cortisol
afferent pathway part of the peripheral nervous system that brings sensory information to the brain
amygdala pair of small almond-shaped regions located anterior to the hippocampus and responsible for the formation and encoding of memories, especially those that are highly emotionally charged, such as trauma
astrocytes located in the central nervous system and involved with building new synaptic connections and ensuring an appropriate chemical environment for the neuron
autonomic nervous system regulated by the hypothalamus, manages involuntary homeostatic control over the body's internal processes, like temperature, inclusive of the sympathetic nervous system and the parasympathetic nervous system
axon long, narrow part of the neuron where impulses are conducted from the axon hillock to the axon terminus
axon terminus end of the axon that contains neurotransmitters
basal ganglia group of subcortical nuclei most often associated with managing motor control, involved with the formation of procedural memories
C fibers nociceptive neurons that transmit burning pain, itch, and dull ache
cauda equina collection of nerves at the terminus of the spinal cord
central nervous system (CNS) comprises the brain and spinal cord
cerebellum in the basal part of the brain between the cerebrum and the brain stem; responsible for balance, walking, standing, and measuring distance and timing
circadian cycle 24-hour homeostatic cycle regulated by the hypothalamus determined by light and dark patterns and internal regulatory functions
cortisol released in the wake of adrenocorticotropic hormone, and part of the HPA axis, is responsible for mobilizing glucose for energy, increasing protein metabolism, immune effects, and systemic anti-inflammatory effects
declarative memories inclusive of episodic and semantic memories of personal events, facts, and experiences
dendrites extensions of a neuron from the soma that receive information from other neurons

diencephalon central area of the brain located above the brainstem, including the epithalamus, thalamus, subthalamus, and hypothalamus, responsible for forming recognition-based memories
discontinuation syndrome time-limited syndrome caused by sudden cessation or tapering too quickly of an antidepressant
dopamine monoamine neurotransmitter responsible for the management of mood states, attention and focus, motor control and regulation, sexual gratification, reward and motivation, and lactation
efferent pathway response from the brain to the periphery
electroconvulsive therapy (ECT) use of electrical currents under anesthesia to produce a seizure
endorphins neuropeptides that function as neurotransmitters, neuromodulators, or neurohormones in the CNS
enkephalins neuropeptides that function as neurotransmitters, neuromodulators, or neurohormones in the CNS
esketamine innovative treatment derived from ketamine for treatment-resistant depression and major depressive disorder with suicidality
excitatory effects promotion of an action potential between neurons by neurotransmitters
extrapyramidal side effects (EPS) drug-induced movement disorders
forebrain made up of the cerebrum and diencephalon, responsible for higher-level cognitive function, emotions, and management of sensory information
gamma-aminobutyric acid (GABA) major inhibitory neurotransmitter responsible for sensory transmission and learning and memory, decreasing all sensory impulses, including pain and cognition
glial cells (also, **microglia**) provide structure, repair, and scaffolding for migration of the nerve cells
glutamate major excitatory neurotransmitter in the brain
growth hormone (also, **somatotropin**) manages protein synthesis and growth during child development
hindbrain made up of the pons, medulla, and cerebellum, responsible for the management of respiration, blood pressure, heart rate, muscle coordination, posture, and body position
hippocampus part of the limbic system and responsible for encoding memories, learning, and perception of space
histamine monoamine neurotransmitter that is responsible for management of awake states, homeostasis, appetite, and smooth muscle contractions
homeostatic process sleep debt model, modulated by the amount of time that a person is awake or asleep
hormones group of molecules that function to send signals to other cellular organisms in the human body
hypothalamic-pituitary-adrenal (HPA) axis hormonal negative feedback loop that is released in the context of environmental stressors, purpose is to mobilize energy, immune function, and systemic anti-inflammatory responses
inhibitory effects inhibition of an action potential by neurotransmitters
interneurons those that connect neurons primarily within the CNS
long-term potentiation process of synaptic strengthening through signal increases in the neuron
medulla oblongata connection between the brainstem and the spinal cord
melanocyte stimulating hormone secreted from the hypothalamus, responsible for releasing melatonin from the pineal gland
melatonin responsible for initiating sleep during circadian cycles
midbrain made up of the mesencephalon, responsible for the management of vision, hearing, motor control, sleep and wake states, and temperature regulation
motor cortex made up of the primary, premotor, and supplementary motor areas, is responsible for voluntary control over movement
motor neurons those that take information away from the CNS to effector organs or skeletal muscle at neuromuscular junctions
myelin sheath made up of oligodendrocytes in the central nervous system or Schwann cells in the peripheral nervous system, it forms an insulating layer that allows for an action potential to travel successfully
nervous system made up of the central nervous system and the peripheral nervous system
neuromuscular junction where muscle fibers and nerves connect
neuron fundamental cell of the nervous system, responsible for receiving and transmitting electrical signals
neurotransmitter chemical messenger that carries messages from one neuron to another
nociceptors nerve cell endings distributed throughout the body that initiate pain sensation through afferent pathways
nodes of Ranvier gaps in the myelin sheath

non-declarative memories those that individuals cannot explicitly recollect consciously **norepinephrine**, also known as noradrenaline, is one of the monoamines, responsible for flight or fight response, increase in blood pressure/heart rate/respirations, peripheral vasoconstriction, and focus and concentration
oligodendrocytes type of glial cell that maintains the myelin sheath in the central nervous system
oxytocin when released, is responsible for uterine contraction and the stimulation of milk from mammary glands after pregnancy
pain modulation response to pain
parasympathetic nervous system part of the autonomic nervous system that functions to conserve and store energy
peripheral nervous system (PNS) contains all nerves outside the central nervous system
pharmacodynamics what a drug does to the body
pharmacokinetics what the human body does to a drug
premotor cortex lies rostral to the primary motor cortex and responsible for managing coordinated motor responses
primary motor cortex located along the precentral gyrus and responsible for generating efferent neuronal impulses down the spinal cord to manage movement
prolactin stimulated by the release of prolactin releasing hormone from the hypothalamus, responsible for the stimulation of milk production during pregnancy
pruning automatic brain function that eliminates unused synapses, allowing new growth
saltatory conduction action potential conducted along the axon at the nodes of Ranvier
Schwann cells type of glial cell in the peripheral nervous system that maintains the myelin sheath
serotonin neurotransmitter and a monoamine, responsible for the promotion of mood and sleep regulation, mitigation of pain, aggression and sexual behavior, stimulation of gastric secretion, and other hormonal behaviors
serotonin syndrome potentially life-threatening drug-drug interaction that is caused when high levels of serotonin are built up in the body
side effects undesirable effects of a medical treatment or drug
soma cell body of the neuron that contains a nucleus
somatic nervous system part of the PNS that delivers conscious sensory (afferent) information to the CNS and a voluntary motor response (efferent)
stress diathesis model theory that posits that there are genetic traits combined with certain environmental influences that create the potential for the expression of a mental health disorder
substantia nigra prominent nucleus in the midbrain, contains a dopaminergic nucleus that manages motor control
sympathetic nervous system part of the autonomic nervous system that manages the fight or flight response
synapse small space between neurons where chemical transmission occurs
synaptic growth process by which neurons in the brain connect
telemental health provision of mental health services though telephone or videoconferencing
thyroid stimulating hormone (TSH) released when stimulated by thyrotropin releasing hormone from the hypothalamus, responsible for optimal thyroid functioning, which manages temperature regulation, mood states, and food metabolism
transcranial magnetic stimulation (TMS) noninvasive treatment that consists of an electromagnetic coil being placed against a client's head (over the prefrontal cortex) and delivering a magnetic pulse to stimulate nerve cells in the brain
vasopressin, also known as antidiuretic hormone, responsible for retaining water and maintaining blood pressure
virtual reality (VR) computer generated two- or three-dimensional environment that contains scenes or objects that allow the user to immerse with a seemingly real surrounding

Assessments

Review Questions

1. What is the term for the body of the neuron?
   a. synapse
   b. soma
   c. axon

d. dendrite

2. What are the components of the central nervous system?
   a. brain and spinal cord
   b. brain and peripheral nerves
   c. peripheral nerves and spinal cord
   d. spinal nerves and spinal cord

3. What is the function of a Schwann cell?
   a. building new synapses
   b. providing scaffolding
   c. innervating the CNS
   d. providing insulation

4. Decrease in norepinephrine is responsible for _____.
   a. awake states
   b. increased focus
   c. less pain
   d. depression

5. Dopamine is responsible for _____.
   a. pain
   b. reward and motivation
   c. sensory perception
   d. sleep

6. What is GABA?
   a. major inhibitory neurotransmitter
   b. major excitatory neurotransmitter
   c. major monoamine
   d. major hormone

7. What are endorphins and enkephalins?
   a. alpha receptors
   b. histamines
   c. neuropeptides
   d. amino acids

8. What medication is an antidepressant?
   a. a. alprazolam
   b. zolpidem
   c. guanfacine
   d. vilazodone

9. What is a dangerous adverse event from a tricyclic antidepressant?
   a. lethality in overdose
   b. extrapyramidal symptoms
   c. potential for dependence
   d. discontinuation syndrome

10. What is the therapeutic range for lithium?
   a. 0.2 to 0.6 mEq/L
   b. 0.6 to 1.2 mEq/L

c. 0.9 to 1.5 mEq/L
d. 1.2 to 1.5 mEq/L

11. What should be avoided when taking a MAO inhibitor?
a. sumatriptan
b. ibuprofen
c. vitamin C
d. carrots

12. What is a sign of dystonia?
a. shuffling gait
b. high fever
c. neck spasms
d. restlessness

13. What side effect of medical treatment is a medical emergency?
a. discontinuation syndrome
b. neuroleptic malignant syndrome
c. akathisia
d. dyskinesia

14. What are signs and symptoms of lithium toxicity?
a. nausea, vomiting, diarrhea, and tremors
b. high fever, neck contusions
c. restlessness, shuffling gait
d. lightheadedness

15. What medications cause life-threatening complications when discontinued abruptly?
a. antidepressants
b. antipsychotics
c. stimulants
d. benzodiazepines

16. What is a characteristic of TMS?
a. It is a nasal spray.
b. It is done in the client's home.
c. It causes dissociation.
d. It is indicated for depression.

17. What is a contraindication for TMS?
a. history of seizures
b. history of eating disorder
c. history of panic disorder
d. history of liver cancer

18. What is a side effect of esketamine?
a. hypertension
b. panic
c. suicidality
d. hypotension

19. What condition can be treated with virtual reality?
a. PTSD

b. psychosis
c. mania
d. hypomania

20. What is a limitation for telemental health?
a. living in a rural area
b. living in the city
c. lack of internet
d. lack of television

Check Your Understanding Questions

1. Define, in your own words, the difference between the central and peripheral nervous systems.

2. In a few short sentences, what occurs at a synapse?

3. What are the phases of sleep?

4. What is the difference between pharmacokinetics and pharmacodynamics? Give an example.

5. What is the nursing intervention/treatment for two types of extrapyramidal symptoms?

6. What are nursing considerations for older adult clients taking hypnotics or benzodiazepines?

7. What are the areas of education for a client considering esketamine treatment?

8. What is the difference between esketamine and TMS treatments?

9. What are limitations of internet-based mental health interventions?

Reflection Questions

1. How do neurotransmitters affect human behavior?

2. How does the nervous system work with the endocrine system?

3. What are the functions of the monoamines?

4. In what ways are antidepressants and mood stabilizers different?

5. What are all the necessary elements on which a nurse educates a client who is taking lithium?

6. How would you educate a client who asks about using a sleep application on their phone?

7. What type of virtual reality platform would you recommend for a client who has a significant phobia to flying? How would you educate the client on its use?

What Should the Nurse Do?

Sara, a 35-year-old female, has come to your local community health clinic due to a recent onset of symptoms. She has been experiencing severe anxiety, persistent insomnia, irritability, and difficulty concentrating, which have been interfering with her daily life and work. Sara has no significant prior medical history but reports a family history of mental health disorders. Upon initial assessment, her vital signs appear within the normal range, with a blood pressure of 120/80 mm Hg, a heart rate of 80 beats per minute, and a respiratory rate of 16 breaths per minute. During the initial assessment, Sara showed signs of restlessness by constantly fidgeting.

1. What specific verbal and nonverbal cues does Sara exhibit during the assessment that may indicate the presence of a nervous-system-related issue?
2. Based on Sara's family history of mental health disorders and her reported symptoms, which neurotransmitters or hormonal imbalances could potentially be contributing to her current condition?

José, a 35-year-old male, has been referred to a psychiatric clinic by his primary care physician. José reports persistent feelings of sadness, hopelessness, and loss of interest in activities he used to enjoy. He also experiences significant changes in his appetite and sleep patterns, with frequent early morning awakenings. José mentions that

these symptoms have been present for the past six months, and they are affecting his daily life and relationships.

Upon further assessment, José reveals that his family has a history of mood disorders, including depression. His primary care physician has prescribed him an antidepressant medication, fluoxetine, an SSRI. José expresses concerns about starting medication and asks for more information about how it works and its potential side effects.

3. As the nurse, what initial assessment data should you collect from José to better understand his current mental health status and his readiness to begin treatment with fluoxetine? How can you recognize cues that may indicate the severity of his depression?
4. After gathering the assessment data, analyze the information you've collected from José. Based on his presentation and family history, what are the psychopharmacological drug classifications that may be relevant to his condition? How do these classifications interact with his current symptoms, and what potential complications should you consider?
5. What are the primary hypotheses regarding the cause of José's depression, and how would you rank them in terms of likelihood, considering both psychiatric and pharmacological factors? What nursing interventions and client education would be essential in his care plan?
6. José has decided to start taking fluoxetine. What nursing actions should you take during the implementation phase to ensure his safety and therapeutic effectiveness of the medication? How can you support him in adhering to the treatment plan?

Competency-Based Assessments

1. You are providing client education to a group of individuals with generalized anxiety disorder. Create a client education video that addresses these two points:
    - Explain how chronic stress and anxiety can lead to altered brain structures involved in emotional regulation.
    - Describe the potential long-term effects on the nervous system.

2. You are providing client education to a group of individuals with generalized anxiety disorder. Create educational materials that explain the role of gamma-aminobutyric acid (GABA) as an inhibitory neurotransmitter in regulating anxiety.

3. You are providing client education to a group of individuals with generalized anxiety disorder. Create educational materials that provide information on the relationship between chronic anxiety and the release of stress hormones, such as cortisol. Explain how elevated cortisol levels might exacerbate symptoms of GAD.

4. You are a nursing student preparing for a pharmacology exam. You are given a list of psychopharmacological drugs and are tasked with classifying them into their respective drug categories and describing the biological mechanisms of action for each drug category. Provide detailed explanations for your classifications and mechanisms.

5. You are a clinical nurse assigned to care for a client who has been prescribed multiple psychopharmacological drugs. Review the client's medication profile, which includes antidepressants, antipsychotics, and anxiolytics. For each medication, discuss the following:
    - Indications for use
    - Mechanism of action
    - Common side effects
    - Potential drug interactions
    - Considerations for special populations (e.g., older adult, pediatric, pregnant clients)

    Medication profile

    Diagnosis: Major depressive disorder with comorbid generalized anxiety disorder and schizophrenia

    Medication list:

    - Fluoxetine

- Risperidone
- Alprazolam

6. You are a mental health nurse assigned to work with a client, Alex, who has been diagnosed with severe anxiety disorder. Alex is open to alternative treatments and wants to utilize digital tools for self-management. Develop a case study analysis that describes alternative treatments that can be integrated into Alex's care plan to complement traditional therapies for anxiety and explain how these treatments can be utilized in a psychiatric-mental health setting.

7. You are a mental health nurse tasked with developing a plan to integrate digital tools and telemental health services for a remote client population with various mental health conditions. Explain how digital tools can be used to identify and track at-risk clients in remote settings. What specific parameters should be monitored, and how can this data inform client care?

References

Bahji, A., Vazquez, G. H., & Zarate Jr, C. A. (2021). Comparative efficacy of racemic ketamine and esketamine for depression: A systematic review and meta-analysis. *Journal of affective disorders*, *278*, 542–555.

Caroff, S. N., & Campbell, E. C. (2016). Drug-induced extrapyramidal syndromes: Implications for contemporary practice. *Psychiatric Clinics*, *39*(3), 391–411.

Fitzgerald, P. B. (2021). Targeting repetitive transcranial magnetic stimulation in depression: Do we really know what we are stimulating and how best to do it? *Brain Stimulation*, *14*(3), 730–736.

Hodo, D. W. (2006). Kaplan and Sadock's comprehensive textbook of psychiatry. *American Journal of Psychiatry*, *163*(8), 1458.

Ioannou, A., Papastavrou, E., Avraamides, M. N., & Charalambous, A. (2020). Virtual reality and symptoms management of anxiety, depression, fatigue, and pain: A systematic review. *SAGE open nursing*, *6*, 2377960820936163.

Krzystanek M, Surma S, Stokrocka M, Romańczyk M, Przybyło J, Krzystanek N, Borkowski M. (2021). Tips for Effective Implementation of Virtual Reality Exposure Therapy in Phobias-A Systematic Review. *Front Psychiatry*. Sep 21;12:737351. doi: 10.3389/fpsyt.2021.737351. PMID: 34621197; PMCID: PMC8490820.

McCance, K. L., & Huether, S. E. (2018). *Pathophysiology: The biologic basis for disease in adults and children*. Philadelphia: Elsevier Health Sciences.

Purves, D., Augustine, G. J., Fitzpatrick, D., Hall, W., LaMantia, A. S., & White, L. (2019). *Neurosciences*. Vlaams-Brabant, Belgium: De Boeck Supérieur.

Stahl, S. M. (2021). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications*. Cambridge, England: Cambridge University Press.

Wheeler, K. (2013). *Psychotherapy for the advanced practice psychiatric nurse: A how-to guide for evidence-based practice*. New York: Springer Publishing Company.

CHAPTER 5
Therapeutic Settings

FIGURE 5.1 Group therapy can occur in a variety of settings, such as this session in the woods by a river. (credit: "Men Sitting Talking by River Outdoors" by JourneyPure Rehab/Flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION The available therapeutic settings within a community, both inpatient and outpatient, are an important consideration when providing appropriate psychiatric-mental health care. Nurses and other health-care providers should be knowledgeable about the resources their community has to offer.

Not all communities have the same mental health resources accessible. There may be instances when the most therapeutic option is a resource found in another community. Networking between facilities is an important part of working in the psychiatric-mental health (PMH) field. Positive working relationships between facilities create better outcomes for clients by providing more options for treatment. Reaching out can include calling facilities to find out if they currently have a program to address a client's needs, finding out if beds are available if inpatient treatment is necessary, and even asking if someone from a facility can provide interprofessional team training on their services. Because the least restrictive environment that is safe and effective is the most therapeutic setting, place preference on keeping a client in the community for as long as possible before considering an inpatient placement.

5.1 Psychiatric-Mental Health Treatment Settings

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the main types of treatment settings
- Identify advantages of each treatment setting
- Identify disadvantages of each treatment setting

The word *milieu* describes the environment in which mental health treatment occurs. There are many different milieus to consider when thinking about treatment settings. In **milieu therapy**, clients are treated in a structured, safe environment where their participation in day-to-day routines, communities, and relationships is the method of therapy. Milieu therapy dates back to the 1950s residential treatment of emotionally disturbed children (Smith & Spitzmueller, 2016). In more recent years, the type and role of milieu has expanded from primarily inpatient environments to community environments where interactions occur between health-care/nursing staff and the client and between clients sharing experiences. Some examples of milieu settings include inpatient behavioral health units, outpatient therapists' offices, community mental health centers, methadone clinics, and substance use rehabilitation programs. Within this therapeutic setting or milieu, the client learns positive coping skills, appropriate reactions to and communication with others, and practical applications of the therapeutic experience to their lives outside of the treatment environment. Treatment settings themselves are as varied as the clients who need treatment. The clinician and the client must work together to find the most appropriate fit for treating the presenting symptoms.

Types of Treatment Settings

The chosen site for the treatment is based on the type and acuity of a client's symptoms and the ability to treat them safely outside of the inpatient setting. More specifically, decisions about treatment environments are based on safety of the person and others, the person's mental capacity at the time of care, and, in some cases, state laws (Pirotte & Benson, 2023). Choosing the least restrictive effective environment, however, is the overriding goal. A **least restrictive environment** is one in which the client receives the most effective treatment that places the fewest restrictions on their life. These environments take into consideration a person's personal rights to be able to choose where they receive care, their ability to make decisions, their right to be involved in collaborative care with their treatment providers, and their right to refuse care or request a different type of care than that recommended by the health-care provider.

There are many different types of mental health services offered in the community, for example:

- Patient-centered medical homes are comprehensive, coordinated, patient-centered models of primary care (AHRQ, n.d.). This type of setting offers mental health and medical care all in one facility. This often encourages the client to keep up with their medical care because they are already comfortable receiving their mental health care in the same setting.
- Community mental health centers offer free, low-cost, or sliding scale care for those who lack resources to pay for mental health care. These centers are typically in the center of town making them convenient, especially if transportation is a barrier to care.
- County programs, such as Comprehensive Community Services (CSC) or Community Support Programs (CSP), offer intensive case management services that allow a person to live in their own home with the support of trained personnel who assist them with transportation to health-care provider appointments, running errands, peer support services, and care coordination.
- Forensic nursing is an area of specialty that provides nursing care in correctional facilities, including psychiatric-mental health care. The advantage to this type of program is that an incarcerated person can continue to receive their mental health medications. The disadvantage is that many programs lack funding to provide a psychiatrist who sees the incarcerated people as often as is needed for their mental health needs. There is also lack of coordination with local community systems to provide appropriate mental health care to individuals upon release from correctional facilities, leading to relapse and recidivism.
- Psychiatric home care provides community-based treatment for clients who are homebound. The client is able to continue to live in their own home with the support of the visits they receive from their assigned nurse. Remaining at home helps clients to feel like they have autonomy.

- Certified peer specialists are people in recovery who support clients by helping them with lived experience examples and by providing hope. Peer specialists offer support by sharing their own experiences with a client. The support offered through this type of interaction can increase a person's hope that they, too, will be able to recover.
- Telepsychiatry provides therapy and services through videoconferencing. This option became very popular during COVID-19 and there are now many applications that clients can access directly from their phones so that they can talk to a therapist at any time. Telepsychiatry through a therapist's office requires scheduled appointments at specific times. This may not be an option for people who live in rural areas without internet connection, who do not have cell phones or computers, or for those who feel more comfortable talking to a therapist face-to-face.

Outpatient Treatment

Outpatient treatment occurs in the community; it means receiving a health-care treatment with no overnight stay. Clients often visit their primary care provider first when concerned about their mental health. If a client has a more severe mental health challenge, they are typically referred to specialized psychiatric care providers, such as psychiatrists, psychiatric-mental health advanced practice registered nurses/nurse practitioners, psychologists, social workers, counselors, or other licensed therapists.

In terms of outpatient treatment, clients may see a therapist to discuss ongoing issues, get assistance developing positive coping skills, and determine triggers that worsen symptoms. A client may be connected to a community mental health center where they attend appointments with their psychiatrist or therapist and can participate in group therapy. A person with a **severe mental illness (SMI)**, a mental illness that interferes with a person's ability to function in life, may be followed closely by a case manager from, for instance, an Assertive Community Treatment (ACT) program, which has a team available 24/7, so that person can continue to live independently. An ACT program offers a team of specially trained case managers who support their clients by providing transportation to medical and mental health appointments; help with transportation for errands, such as grocery shopping; and assist with care coordination, such as scheduling appointments with various doctors. Another such service is Comprehensive Community Support, which "focuses on five life domains: independent living, learning, working, socializing and recreation" (Presbyterian Medical Services, 2023, para 1). This type of program, and others like it, promote resilience by teaching clients about community resources and how to access/use them. Outpatient treatment is the primary goal—and often the best route—for most people dealing with a mental illness.

Some community mental health centers encourage training clients who have gone through mental health issues and are working on their recovery to become certified peer specialists (see 6.3 Peer Support). One thing that a peer specialist might be trained to do is run Wellness Recovery Action Plan (WRAP) groups. These programs provide tools and teach participants how to create action plans to live a safe and healthy life (Advocates for Human Potential, 2023).

Advantages

Outpatient settings can be more convenient, less expensive, encourage longer-term client/counselor relationships, keep the client working, and are more amenable to family support. In outpatient settings, clients are cared for in or near the communities in which they live. For those with limited access to transportation, a community health center is often easily accessible via foot or public transport. Over time, clients build trusting rapports with their therapists, leading to better long-term outcomes. Other advantages include clients being able to continue with their daily activities and having close support from their families. This option is also more cost-effective than inpatient treatment, especially for clients with jobs who can continue to work. Clients can also immediately apply what they are learning from their outpatient treatment provider to their daily lives.

Disadvantages

In rural areas, there may not be access to a local health-care center, requiring the client to travel long distances to receive mental health care. This can cause barriers, such as lack of transportation for those who do not drive or an inability to take off time from work to travel a long distance for an appointment. An additional problem in some areas is a general lack of mental health providers, which decreases the availability of appointments and the flexibility to find times that are convenient for the client. Moreover, some outpatient treatment centers have access to fewer specialized resources than inpatient offerings and offer less supervision than inpatient options.

REAL RN STORIES

Nurse: Lenore, MSN, RN-BC
Clinical Setting: Community mental health center
Years in Practice: 19
Location: New Hampshire

As a nurse who had worked primarily in the inpatient behavioral health setting, it was refreshing to begin working at the local community mental health center. Part of my new role was as the medication nurse for the clients who received monthly, twice monthly, and weekly injections of their psychiatric medications. I was thrilled to care for some of the same clients I had cared for in the hospital. I already had a rapport with these clients and now could treat them where they lived in the community.

One client would often stop by even when he did not have an appointment. Marc had schizophrenia. With medication, he was able to live independently and do odd jobs. One day, he asked me, "Do you really think I have schizophrenia? I just don't know if I do." I replied, "Yes, I think you do. You tell me you hear voices that no one else hears. You feel worse if you miss getting your medication. But, remember, you are not alone. You have your team here to support you." Marc left my office to go about his day. A week or two later, Marc stopped by my office. It was obvious he had been thinking about our conversation when he said to me, "Lenore, you have always been nice to me and honest with me. I really appreciate it." I am sure it took a lot for Marc to say that to me. That was about ten years ago, and I still think about it from time to time. The therapeutic connections we make with our clients matter.

Patient-Centered Medical Homes

A **patient-centered medical home** (or the medical home model) provides comprehensive, coordinated, client-centered models of primary care. These facilities are not available in every community, but the trend to provide medical homes is a national initiative through the Agency for Healthcare Research and Quality (AHRQ, 2022). Nurses can access the AHRQ website for more information on finding local medical homes. The medical home model, developed by the Veterans Health Administration, is an example of a proactive, primary care, interdisciplinary team based on client-centered, holistic care, and active communication and coordination among providers. This model is considered effective for clients with complex health-care needs. Core elements of the medical home model distinguish it from traditional primary care, such as:

- Clinical outreach: Outreach to people without homes, individuals in shelters, and to those in community locations, such as soup kitchens
- Low threshold access to care: Open access with walk-in capacity and flexible scheduling (i.e., clients do not need an appointment to be seen by their care team)
- Integrated services: Several different kinds of health-care providers in one location, for example, a psychiatrist, a therapist, and a health-care provider; mental health services and primary care services are located close to each other
- Sustenance needs: Food or food vouchers, hygiene kits, clothes, bus passes, other transportation assistance
- Health-care management: Integrated with community agencies with an emphasis on ongoing, continuous care
- Continual staff training: Focusing on development of care skills for those without homes

Advantages

Clients are seen where they feel comfortable and accepted. The lack of need for an appointment means that clients can walk in when they are feeling capable of getting to the medical home and are willing and ready to see a provider. Because of the variety of services offered in one place, this model is convenient to those clients who have work, transportation, and time considerations. Seeing a variety of different providers in different settings may prove overwhelming or practically impossible. This type of setting works well for those clients with a distrust for medical providers based on their cognition or prior poor treatment or for individuals with multiple medical comorbidities. Examples of clients having cognitive problems include those experiencing acute psychiatric symptoms, such as paranoia or hearing negative voices (auditory hallucinations), a person born with cognitive disabilities, or a person who has dementia. Any of these people may have also had a poor prior treatment experience due to things like perceived stigmas from those providing care, being discharged from a medical provider's practice due to missed

appointments (this happens due to lack of transportation, not feeling well enough to attend the appointment, or even forgetting the appointment due to their illness), or being unable to build a rapport with that provider.

Disadvantages

Not all communities have this sort of medical model available. Some practices that try to follow this model find that it is financially difficult. They need to be reimbursed at higher dollar amounts in order to make health-care providers within their practice interested in pursuing the work, and the required documentation that goes into developing this model can be prohibitive. They also may find the need to hire extra personnel whose job it is to specifically communicate and coordinate care with other area specialties and offices (Budgen & Cantiello, 2017).

LINK TO LEARNING

This TED talk (https://openstax.org/r/77sangudelle) discusses the use of digital tools to fight the stigma associated with getting mental health treatment.

Telehealth Home Care Treatment

COVID-19 led to increased availability of telehealth appointments both through traditional therapists' offices and online applications. In **telehealth**, health-care providers use digital technologies to deliver medical care, health education, and public health services by remotely connecting multiple users in separate locations. Nurses must be aware of potential barriers affecting client use of telehealth (i.e., lack of internet access or lack of support for individuals learning new technologies), as well as state and federal policies regarding telehealth and their nursing license across state lines.

LINK TO LEARNING

The telehealth hub at the Department of Health and Human Services website provides telehealth information tabs for clients and providers, including licensing requirements and interstate compacts (https://openstax.org/r/77telehealth2).

Teletherapy is mental health counseling over the phone or online with videoconferencing. When engaging in teletherapy, nurses should treat clients as if they are sitting across from them and should focus on eye contact and empathetic expressions to build a connection, just like during a face-to-face encounter (Telehealth.hhs.gov, 2021). Group therapy can also take place via telehealth. Connecting clients through telehealth can build community, reduce feelings of isolation, and provide a forum to share new perspectives. Group therapy, even through telehealth, can create a sense of belonging and build a trusted support system (Telehealth.hhs.gov, 2021).

Advantages

Clients can receive services within the comfort of their own homes where they feel safe and less anxious. The use of telehealth and teletherapy can also provide a connection to services and support that may otherwise have been inaccessible. This option provides "therapy at the fingertips" for those who are tech-savvy. It is more cost-effective, is convenient, saves time, offers access that may not have been available otherwise, and eliminates other stigma sometimes associated with seeking mental health services.

Disadvantages

The lack of internet connection in some rural areas and homes eliminates the option for in-home treatment through teletherapy. Plus, there may be more distractions in a client's home during a therapy session and the connection between client and provider may suffer or take slightly longer to develop than when in person. Some clients are not appropriate candidates for in-home or teletherapy due to the acute nature of their symptoms. These clients include those who are actively suicidal or at risk for self-harm and those with cognitive, hearing, or vision problems (DeCarlo et al., 2020).

Home Care

In many cases, when someone thinks of home care nursing, they are thinking of the medical care given to some

clients after they are discharged home from the hospital but need follow-up for a limited time to help with things like dressing changes, ostomy care, or even to check on newborn wellness. But some home care facility teams may also include psychiatric nurses who provide in-home visits to homebound clients. This type of care is a way of keeping clients in their homes, in the least restrictive environment, so that they can live as normal a life as possible while still receiving mental health treatment. The home care psychiatric nurse provides regularly scheduled visits to the client to monitor any psychiatric symptoms they may be having, provides safety checks to ensure the client is not having any suicidal urges, does medication checks to make sure the client is taking their medication as prescribed, helps with coordination of other medical or community services, and may even draw labs so that the client does not need to leave their home for these services. Combining existing home care programs with the option of in-person or telehealth visits has increased wellness in these clients (Boland, 2018).

Advantages

There are several advantages to mental health home care. Visits to a client's home can allow nurses to ensure the client's understanding of and monitor adherence with a client's medication. The home visit provides socialization to a person who might otherwise feel isolated, and the level of intimacy between the RN and the client grows as the client becomes more comfortable having the RN in their home. Home visits offer an opportunity to meet the client where they are, understand their surroundings, and see what limitations and safety obstacles the environment may pose. For instance, there may be fall risks from scatter rugs or a lack of shower rails. The nurse can make environmental safety recommendations to the client and family based on home observations. The nurse has the added benefit of observing the connection between family members and the client and providing overall support and education to the entire family (Boland, 2018).

Disadvantages

In rural areas where there may be a lack of mental health services available, a single nurse may be required to travel many miles to see clients within the home environment. Travel time makes home visits less efficient, and the nurses can see fewer clients in a day because of transport time between appointments. Other concerns for the nurse include safety of being in the client's home, amount of time spent in the appointment, especially if family is present, and maintaining professional boundaries.

Substance Use Rehabilitation

The treatment of substance use disorder is called **substance use rehabilitation**; it takes place in a variety of settings because no one way works best for everyone. It may entail use of medication to reduce cravings, group therapy, family education, and a long-term recovery process. The treatment of substance use disorder is typically delivered in freestanding programs in hospitals, residential, or outpatient settings that vary in the frequency of care delivery, the range of treatment components offered, and planned duration of care. As clients progress in treatment and begin to meet the goals of their individualized treatment plan, they often transfer from clinical management in residential or intensive outpatient programs to less clinically intensive outpatient programs that promote client self-management (Substance Abuse and Mental Health Services Administration & Office of the Surgeon General, 2016).

As with all treatment, the amount of time that a client spends in treatment is based on what substances they have been using and their individual needs. An example of a typical progression for someone who has a severe substance use disorder might start with three to seven days in a medically managed withdrawal program, followed by a one- to three-month period of intensive rehabilitative care in a residential treatment program, followed by an intensive outpatient program (two to five days per week for a few months), and later a traditional outpatient program that meets one to two times per month. Many people seek the help of a medically managed withdrawal program to get them through their detox symptoms and ensure that they can safely withdraw from the substance/s they have been using. Depending on the substance used, there may be certain medications to help the client through this period. In the case of a person who has been using alcohol as their drug of choice, this type of withdrawal support can be lifesaving as withdrawal from alcohol can dangerously increase blood pressure and cause seizures or death. For clients whose current living situations are not conducive to recovery, one approach is to recommend outpatient services in conjunction with recovery-supportive housing. Best practices recommend that clients with serious substance use disorders stay engaged for at least one year in the treatment process, which may involve participating in three to four different programs or services at varying levels of intensity, all of which are ideally designed to help the client prepare for continued self-management after treatment ends (Substance Abuse and Mental Health Services Administration & Office of the Surgeon General, 2016). For example, medication assisted treatment (MAT)

is evidence-based and methadone clinics are helpful to people recovering from opiate addiction.

Advantages

Offering a variety of programs to a person with a substance use disorder enables them to feel autonomy in the process of choosing their treatment. Programs can be chosen based on location, type of services offered, cost and insurance coverage, and personal preference. When choosing a program, an individual may choose something that is close to where they live so that they can continue to have the support of their family and friends. Some people want a holistic program that offers medical, psychological, and spiritual wellness, while others prefer a spiritual-only-based program. For many people, cost is the biggest factor, so they have to choose a program that accepts insurance or Medicaid/Medicare. People who are not limited by a specific budget have a much larger variety of programs from which to choose, which allows for individual preferences in determining treatment.

Disadvantages

Programs that are self-pay only and not covered by insurance, Medicaid, or Medicare can pose huge barriers to those struggling with substance use disorders. Clients also must be motivated to change as assessed by the health-care team when presenting treatment options to the client. Prochaska's Stages of Change (Figure 5.2) illustrate the cyclical pattern of substance use treatment, recovery, and relapse that can become a barrier to ongoing wellness (Krebs, 2018). Clients can become discouraged and stigma surrounding substance use can prevent people from seeking and continuing to receive the help that they need.

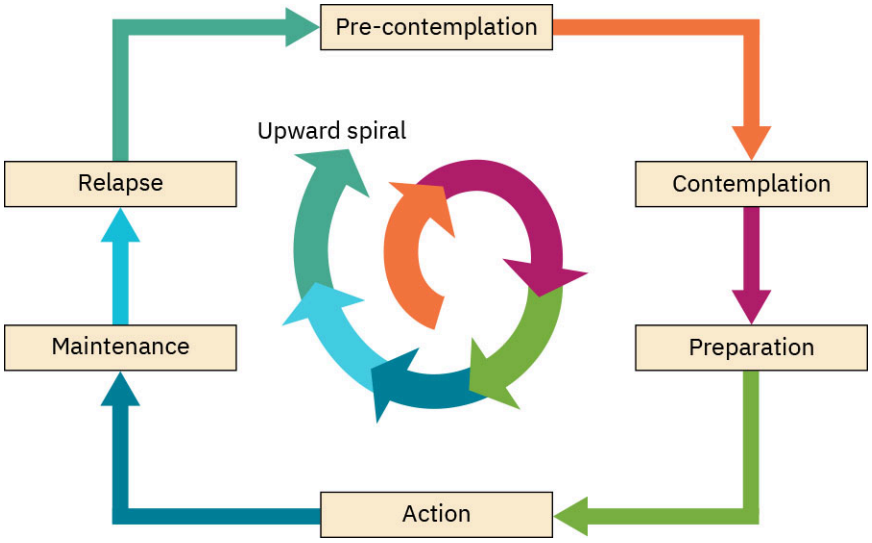


FIGURE 5.2 Each stage of Prochaska's Stages of Change occurs and progresses during the recovery process: pre-contemplation, contemplation, preparation, action, maintenance, and, possibly, relapse. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

CULTURAL CONTEXT

Overdoses in Native Americans

As the opioid crisis continues in the United States, nurses should be aware of the high overdose rates (OD) among Native Americans. Statistics of OD rates put this cultural group in second place, behind White people. The highest mortality rates are in Minnesota, Washington, Alaska, and Oklahoma (Venner, K. L. et al., 2018).

Treatment concerns for Native Americans involve a lack of western medicine health-care providers who recognize that healing for many Native Americans is holistic in nature. Their traditional medicine wheel allots equal importance to mental, physical, emotional, and spiritual health contributing to a person's overall health. Although clinical studies have proven that medication-assisted treatment for opioid addiction has a much higher rate of response than only using psychosocial treatments, there are many barriers to Native Americans using this method of treatment: lack of cultural training, lack of access to medication resources, limited access to prescribers and high turnover rate of those prescribers, discrimination received by Native Americans, and the Native Americans' differing

beliefs about length of time that it is acceptable to continue taking a medication (Venner, K. L. et al., 2018).

As a nurse, you can bridge the cultural gap that might occur when providing substance use care in a treatment facility. You can do things like assign clients of similar ages to the same support groups, incorporate cultural preferences, and include the family in care planning. Doing these things helps the client feel that their whole identity has been validated.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is required to help direct federal resources under the Tribal Law and Order Act of 2010 (SAMHSA, n.d.). It helps the tribes set up Tribal Action Plans (TAPs) to ensure that tribes have the resources and programs to address issues with substance use and recovery.

Partial Hospitalization and Intensive Outpatient Services

A step-down program for clients who require a higher level of care and support than that offered by outpatient treatment but who do not need twenty-four-hour supervision is called a **partial hospitalization program (PHP)**. They are usually available six to eight hours a day during the workweek and are located on the hospital grounds. Services range from counseling, medication management, and education to clinically intensive programming, such as individual or group therapy. These services are less intensive and less restrictive than inpatient programs and are appropriate for clients living in an environment that supports recovery but who need structure to avoid relapse. One step down from partial hospitalization are intensive outpatient services. These services still require that the client attend therapy several times a week but allow the person to maintain their regular daily schedule with extra support.

Advantages

This type of program generally offers specially trained doctors, nurses, and social workers as well as other members of the interprofessional team, but allows the client to live in their own home with their family. They can return to work on a limited basis (depending on the number of days the psychiatrist prescribed for attendance). This is considered a less restrictive environment option than being in an inpatient unit as it gives the person more autonomy.

Disadvantages

While the client can have effective follow-up with nurses and therapists in these group-based programs, they may not be able to return to work in full capacity as soon as they would like. And while the treatment itself is intensive, during the evening hours, the client may feel increased stress as they must rely on what they have learned to begin to care for themselves without the assistance of others. The home environment is also an important consideration. Where and with whom a person lives can affect their ability to handle daily stressors, especially if they are having mental health difficulties. An unstable home environment will not provide the support that a person needs when they are transitioning out of the hospital setting. A client also needs to be able to follow the schedule of the partial hospitalization program (PHP) or intensive outpatient program (IOP), have transportation to the facility, and be able to participate in treatment at the site. Additionally, they need to be stable and safe enough to remain in an outpatient setting for treatment.

Inpatient Treatment

Clients with acute mental health symptoms, or those who are at risk for hurting themselves or others, may be hospitalized. These clients are often initially seen in the emergency department for emergency psychiatric assessment. Clients may seek voluntary admission, or in some situations, may be involuntarily admitted after referral for emergency evaluation by law enforcement and/or health-care providers.

Acute-care psychiatric units in general hospitals are typically locked units on a separate floor of the hospital. The purpose is to maintain environmental safety for clients. State-operated psychiatric hospitals serve clients who have chronic serious mental illness. They also provide court-related care for criminal cases where the client was found "not guilty by reason of insanity." While uncommon, this judgment means the client was deemed to be so mentally ill when they committed a crime that they cannot be held responsible for the act; instead, they require long-term, inpatient mental health treatment.

Advantages

Inpatient mental health treatment runs 24/7 and is monitored by specially trained doctors, nurses, and social

workers as well as other members of the interprofessional team. The environment has been created to make safety the priority. It takes clients out of environments that may have been exacerbating to their mental health conditions. Trained staff can modify or quickly change medications that they notice are not having the intended effects or are having intolerable side effects. In other words, in the inpatient setting, it is possible to make quicker pivots in treatment. Having regular access to in-place therapeutic groups helps clients recognize their strengths and build positive coping skills through shared experiences with others.

Disadvantages

Stigma remains high in this treatment setting. Some clients are afraid that "people will find out." Not wanting anyone to know they are receiving mental health treatment adds to the isolation clients may feel as inpatients. Insurance companies may limit the number of days that a client can remain an inpatient, regardless of health-care providers recommending a longer stay. If the client has been involuntarily admitted to the unit, they may be angry at the health-care provider and staff for keeping them against their will. Taking away a person's rights can cause them to lose autonomy, which can affect motivation and recovery. Planning for discharge is important, as the same triggers may be present once the client returns to a lesser restrictive environment.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competencies: Client-Centered Care, Teamwork

A thirty-two-year-old female presents to the emergency department stating she has had a seizure and requests something for her "nerves." The client has a history of alcohol abuse, alcohol withdrawal, and does not have a permanent home. The client is admitted for observation related to alcohol withdrawal. You are the receiving nurse on the PMH unit. Consider how to approach the first two QSEN Competencies.

Client-Centered Care: Assess and respond to a change in client condition/reevaluate after interventions, assess for S/S acute alcohol withdrawal, assess for suicide risk, discuss options for a client who wants to drink alcohol, incorporate client/family input in treatment plan, intervene when conflict or need for client education is noted

Teamwork and Collaboration: Participate in shift-to-shift handoff, reach out to social work to advocate for discharge planning that acknowledges concern regarding homelessness, notify the provider as needed using SBA, receive verbal orders, delegate/seek help as needed

Residential Treatment

Residential treatment includes long-term care facilities, group homes, and supportive/transitional housing. These treatment options are for those people who, because they are not able to be independent, need long-term care for chronic and/or severe mental illness, brain injury, dementia, intellectual and physical disabilities, behavioral issues, and substance use recovery.

Advantages

Clients living in these facilities receive 24/7 care by trained health-care providers in a safe, homelike environment. They have opportunities to engage with others, participate in treatment, and learn positive coping skills to deal with activities of daily living. These facilities are the clients' homes during their treatment and have additional benefits, such as activities, education, medication management, and group therapy.

Disadvantages

These facilities do not generally serve as acute care treatment centers. When a client has an exacerbation of symptoms or an acute episode of their disorder, the client is often sent to inpatient hospitalization for stabilization. The client does not have a choice of roommates if the facility does not offer private rooms, so there is a chance of conflict between clients with behavioral challenges. Many people who live in residential treatment facilities never move out of this type of living environment. This may be due to lack of family members who can support them, behavior issues that prevent them from living with family, or their own inability to fully immerse themselves in the real world. Stigma often prevents these individuals from being able to move out of a group home; landlords may not be willing to provide housing. Private insurance or Medicaid may not cover costs of this type of treatment. For example, Texas Medicaid does not cover group homes, and most supportive living facilities are self-pay (NAMI Texas, n.d.).

5.2 Group Therapy

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify the functions of a group, particularly in the context of group therapy
- Discuss the seven characteristics of group dynamics

Group therapy is a treatment option available to help people experiencing mental health issues. This setting provides the opportunity to learn from others' experiences, allows for support of one another, opens the floor to education, and encourages participants to share their feelings in a safe environment. Groups can be geared toward a particular problem or diagnosis. They can also be specific to teaching coping strategies or social skills (American Psychological Association, 2019).

Functions of a Group

Group therapy serves many purposes for its participants: a place of belonging, a forum to share/learn new knowledge, an appropriate outlet, and an opportunity to practice supporting others and receiving support. A therapeutic group works as a unit to support its members and make them accountable for participation within the group (American Psychological Association, 2019). Working together to learn from and gain sustenance from one another is the biggest strength of a group. Each member of the group brings their own experiences to it. Depending on the topic of the group, members may be encouraged to share their individual experiences. Sharing these experiences helps the group members feel a sense of comradery with others who may have similar experiences. The sharing helps them to realize they are not alone in what they are going through. The group leader (in some cases, this is a nurse) teaches the members how to support one another and how to accept the support of others. Attending groups may be the expectation of the facility, a recommendation of the individual's therapist/provider, or their own personal treatment choice.

Group Dynamics

A group starts with everyone agreeing on a like purpose or objective. Then, there are several important factors (Figure 5.3) that further define how the group will operate and what it will look like when pursuing those objectives. These factors of group dynamics include roles, size, composition, leadership, cohesiveness, status, and norms.

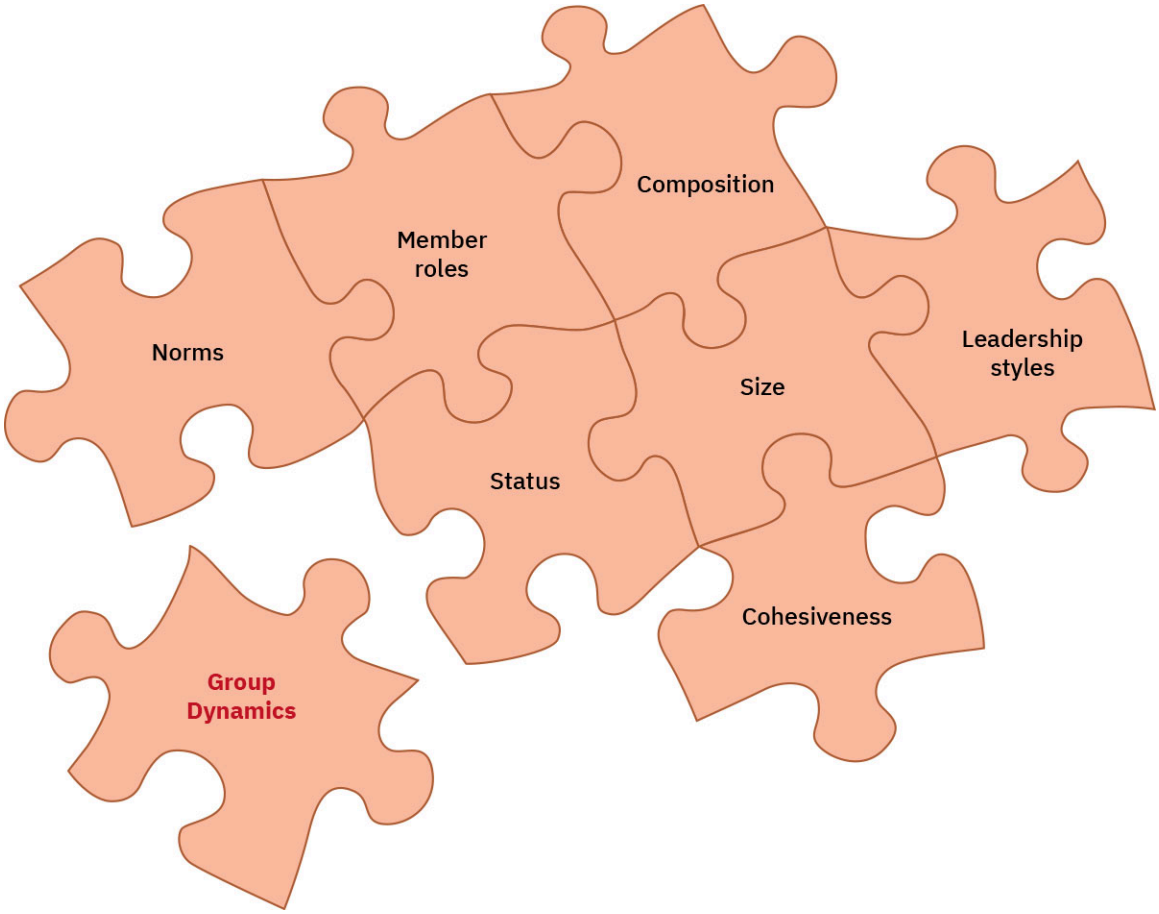


FIGURE 5.3 The dynamics of a group are influenced by multiple factors and are ever-changing. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Depending upon the type of group, some of these factors might change over time (if the group meets regularly over a set time period). If the group is a one-time group, then these factors would not change unless a participant gets up and leaves the room. If the group is a recurring group and is an open group (meaning that new members can join at any time), then there could be changes in size, composition, and cohesiveness over time. If the group is a recurring group that is a closed group (meaning that the same members attend for the duration of the group, such as a six-week group that meets each week on Tuesday), then there probably would not be a lot of change to these factors.

Member Roles in a Group

Typically, there is a group leader (facilitator)—this can be a peer support person or a trained health-care provider, such as a therapist or a psychiatric nurse—and group participants. The leader facilitates the direction of each group meeting, keeps order, and promotes healthy interaction between participants. The participants are often people with similar backgrounds in experience or diagnosis who have the chance to gain strength, skills, and perspective from being part of the group. If the group is a closed group, then the same members will be in the group from start to finish, for the specified duration of the group. In an open group, a new member can join at any time. This will change the dynamics and possibly the roles of the group members as new personalities join the mix.

Group Size and Composition

The group size and composition are usually decided upon by the facilitator prior to the beginning of the group. Depending on the topic of the group, it may be better to limit the number of participants in order to make the shared conversation more intimate. Choosing participants with similar concerns or symptoms helps them to feel a sense of belonging and connection with others within the group (Malhotra & Baker, 2022). Unless the group is focused on helping clients with a particular diagnosis, groups usually function better if its members are not currently in an acute state (i.e., psychotic or under the influence). Someone in an acute state would be better suited to individual therapy. Most inpatient units will have a morning meeting to start the day and an evening meeting to end the day. All clients are encouraged to attend these groups. There may also be specific groups offered if there are a lot of people

currently in the unit with the same diagnosis. For instance, if there are many people with bipolar disorder who are experiencing auditory hallucinations (hearing voices), then there might be a group offered on this topic so that clients can learn/share coping mechanisms.

Group Leadership Styles

There are numerous leadership styles common across many environments, such as business, health care, and education. This section discusses several of those styles and how they affect the work of the participants in group therapy. No matter which leadership style, the leader must remain flexible and able to adapt to changing situations in order to meet group goals.

CLINICAL JUDGMENT MEASUREMENT MODEL

Analyze Cues: Leadership Styles in Group Settings

To understand how well the different leadership styles work within the group therapy intervention, nurses must be able to identify the types of leadership styles. Each style represents a different way that a group's leader will encourage members to interact with one another. Before facilitating a therapeutic group, the nurse needs to think about the leadership style that will work best to reach the intended outcome. The group leader is there to assist its members to learn about and understand both individual and interpersonal problems (Ezhumalai et al., 2018). In this way, group therapy is intended to bring about positive change through the sharing of information, ideas, lived experiences, and coping skills to apply to stressful situations.

For example, participative leadership is often used in the Wrap Up Group that ends the day in an inpatient behavioral health unit. At this meeting, clients are asked to share how their days went, what they accomplished, and are often asked to sign up for certain responsibilities in the unit, such as turning off the TV and straightening chairs in the TV room or returning all phones to the nurses' station. This leadership style encourages everyone to work together.

Authoritative Leadership

The **authoritative leadership** (or autocratic) style is one in which the leader is in command and exerts control over the group members (Cherry, 2022). In authoritative leadership, the leader would be in complete control; it can be viewed as "bossy or dictatorial" (para 7). This style is best used when there needs to be quick decision-making. This leadership style might be used in a group setting in which participants are given a set time limit to complete a task.

Delegative Leadership

The **delegative leadership** style relies on the group members to do the work at hand. This style is also referred to as laissez-faire. Here, the leader offers little direction to group members, often leaving them without needed guidance. This leadership style might be beneficial for a team building group in which the leader is actually trying to get group members to work together to problem-solve. This leadership style would be stressful to a group of people who have OCD or anxiety.

Participative Leadership

The **participative leadership** style (also known as democratic) entails listening to group concerns and allowing members to help with decision-making. This style of leadership encourages the group members to participate actively. They feel heard and part of the decision-making process even though the leader has the final say (Cherry, 2022).

Servant Leadership

The **servant leadership** style works toward the greater good of the members of the group, placing emphasis on learning and growth, contentment of group members, and feelings of ownership by group members. Chobanuk and James (2015) suggest that this style of leadership motivates others and gains positive results.

Transactional Leadership

In **transactional leadership**, the leader uses a reward and punishment system in order to get results from the group and achieve group goals (Chobanuk & James, 2015). Studies have concluded that this type of leadership does get results. This leadership style is sometimes used to make learning fun, such as playing a bingo game to teach about

medication and then offering a small prize to the winner. This is especially useful when treating children. This leadership style might have the opposite effect for people experiencing paranoia as they might feel that the leader is against them if they are not the winner and do not receive a prize.

Transformational Leadership

The **transformational leadership** style involves being a change agent; leaders view group members as valuable and change as positive. Transformational leaders possess four attributes to varying degrees. They are charismatic (highly liked role models), inspirational (optimistic about goal attainment), intellectually stimulating (encourage critical thinking and problem-solving), and considerate (Bass et al., 1996). They encourage participation through "adapt[ing] to the environment, demonstrat[ing] flexibility for change and resolution of issues" (Chobanuk & James, 2015, p. 114). Many leaders are now using this style to help participants in group therapy settings feel more included/supported.

Group Cohesiveness

Cohesiveness refers to the belonging that each member feels to the group or "interpersonal support, acceptance and esteem within the group" (Bryde et al., 2021, p. 1). It is what brings the members together to work on the task at hand. Participants often feel closer to one another than they do to the group leader and that is expected as a therapeutic point because the ultimate goal is for the participants to feel like they are not alone in what they are experiencing. The group leader will often read a list of expectations prior to the start of the group. This list might include the necessity to treat all with respect and the possibility of being asked to leave the group if these expectations are not followed. By setting up the group expectations, the leader is helping to ensure that the group members feel supported by one another. The leader also makes sure that everyone who wants to speak or participate gets an equal opportunity to do so by using positive reminders or a timer to ensure that no one monopolizes the conversation.

Group Status and Norms

Within any group will be a hierarchy of group members and norms by which the group abides. Hierarchy represents each member's status within the group and can be based on time they have been in the group (longer time = more experience with the process), similarities to other group members, differences from other group members, educational level, and group role. Cultural and ethnical differences may also play a part in determining an individual's status within the group, and they will certainly influence the group norms. Norms are beliefs that people learn over time from their family, cultural and religious upbringing, and the people with whom they interact daily. Groups create their own norms. In groups with less diversity, there will be a higher chance of shared norms (Meeussen et al., 2018). As a group's size and diversity increases, common norms decrease. It is the job of the leader to mitigate any conflict that may arise and create common norms specific to the group setting. Beginning each session with a review of the group's ground rules is helpful so that all members understand acceptable behavior while participating.

PSYCHOSOCIAL CONSIDERATIONS

Criteria for Client Placement in Group Therapy

Some criteria to consider before placing a client in group therapy include (1) the client's characteristics, needs, preferences, and stage of recovery; (2) the program resources; and (3) the nature of the group or groups available. Clients are matched with the type of group and program resource that best matches where they are in their recovery journey. Do they prefer to be treated alone or would they prefer to work in a group of other people in the same stage of recovery? If they continue to relapse, for instance, they may not be a good match for a group of people who have been sober together for a long time. Gender and age considerations should also be noted as some people do not want to be in a mixed group of male and female clients and it would be inappropriate to mix adolescents with adults.

Group Types

Some of the types of therapeutic groups include psychoeducational, support, skills, cognitive behavioral, and self-help. Depending upon the needs of the client, the clinician will suggest which group type might be most helpful. Psychoeducational groups offer teaching and can be led by a nurse or a therapist. A support group offers encouragement to clients who have all experienced the same sort of issue, such as a grief support group or a cancer

support group. A skills group is designed for clients who have not developed certain skills needed for optimal functioning. These skills could include coping strategies or socialization (Malhotra & Baker, 2022). Cognitive behavioral groups help clients reframe their thinking to lead to positive behavior changes. Self-help groups, such as Alcoholics Anonymous (AA), are geared for clients motivated to change.

CULTURAL CONTEXT

Overcoming Cultural Barriers

Nurses must recognize that cultural barriers can make or break the effectiveness of therapy. In "Overcoming Cultural Barriers on the Road to Recovery" (2021, October 7), Roselin Dueñas describes going to family therapy to deal with her mental health symptoms. "Being a gay, Latina woman who grew up in a religious household of immigrants, I had to overcome many obstacles in order to get the help that I needed" (para 2). During her attempt at group therapy, she not only had to deal with her parents' backlash for coming out to them as bisexual, but she also faced language and financial barriers. Instead of relying on her therapist to help bring her and her parents together, she had to act as an interpreter, which reinforced the divide. This challenge made her lose confidence in her recovery. Roselin was an immigrant with no documentation; paying for appointments and obtaining medication were difficult without health insurance. These were also learning experiences for her as she continued her road to recovery and shared her story with others. Refer to the NAMI blog (https://openstax.org/r/77nami2) for more information.

5.3 Community Support Systems

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe a therapeutic community
- List conditions that promote a therapeutic community
- Identify members of the interdisciplinary treatment team
- Discuss the nurse's role in milieu therapy

When you think about community support systems, it is important to consider the environments in which care takes place as well as the people providing the care. Interprofessional teams are groups of professionals who work together toward a common goal or outcome when treating clients with mental illness. No two people respond exactly the same to treatment. It is important for people to learn how to develop their own community supports and learn to be their own advocates, through the help of referrals and resources from their primary care providers.

Therapeutic Community

A **therapeutic community** is a socially interactive approach to client treatment for mental health challenges and can include all types of programs, ranging from inpatient to outpatient, short- to longer-term. A therapeutic community works by having the clients interact with other people, make their own decisions, and contribute to decision-making for the community. In doing so, the clients learn new ways to approach/respond to the world around them (Stanborough, 2020). According to the National Institute on Drug Abuse (2015), therapeutic communities were initially developed as long-term residential treatment facilities for people with substance use disorders. Over the years, therapeutic communities have expanded to help people with an array of problems, such as "co-occurring psychiatric disorders [and] homeless individuals" (NIH, 2015, para 3).

Within a therapeutic community, a client strives to be an active participant in group activities, both learning how to achieve positive change and helping others with their recovery. The environment where therapy takes place is also referred to as the milieu. The therapeutic milieu is closely monitored for safety, has a daily routine, and occurs within inpatient and outpatient settings, and meetings (such as AA) or therapeutic groups.

Conditions That Promote Therapeutic Community

The underlying principle of a therapeutic community is that clients can use all the parts of the community in order to take care of themselves individually and collectively (Janeiro et al., 2018). Clients first learn how the community works, what is expected, and the intended goals for treatment. They then begin to interact with both staff and other

clients. Through this process, clients learn to express their emotions safely. Through the education provided in the therapeutic community, the clients begin to see that psychological change is possible (Janeiro et al., 2018). They commit to change and to finding ways to apply the change to their lives.

What are the key components for a therapeutic community? Clients begin to develop a sense of hope for the future. Clients in these communities create a sense of belonging with the connections that form between themselves, staff, and other clients. Through their interactions, clients have opportunities to "develop life skills, and support in areas such as employment, funding and benefits, physical health, and relationship issues" (Wood et al., 2022, p. 7).

Interdisciplinary Treatment Teams

An interdisciplinary treatment team is one that may include psychiatrists, nurses, therapists, social workers, occupational therapists, recreation therapists, mental health technicians, and other team members, all working together toward the individualized goals of each client. This is not an all-inclusive list of interdisciplinary team members, as they may differ from facility to facility. According to Miller et al. (2022), for these teams to work well, there are several conditions. They must first have "material resources" (p. 15) that include being close enough in physical space and having the equipment needed to get the job done. There must be enough staffing to fill all the roles within the team. There must be enough time in the daily schedule to get the work completed. There must be organizational support that includes leaders who are knowledgeable and available to help with any treatment challenges faced by the team members. Lastly, the team members must have an established respect and trust of one another.

The Nurse's Role in Milieu Therapy

Nurses constantly observe the ebb and flow of activity in the unit, quickly jumping into action at any indication of a change that may negatively affect the milieu to ensure the safety and therapeutic benefit of the milieu. The many roles of the registered nurse in milieu therapy include:

- demonstrating caring behaviors to develop therapeutic relationships
- providing care that focuses on the client
- advocating for the needs of diverse populations across the life span
- using critical thinking and technology solutions to implement the nursing process to collect, measure, record, retrieve, trend, and analyze data and information to enhance health-care consumer outcomes and nursing practice
- partnering with the health-care consumers to implement the plan in a safe, effective, efficient, timely, and equitable manner
- engaging with interprofessional team partners to implement the plan through collaboration and communication across the continuum of care
- using evidence-based interventions and strategies to achieve mutually identified goals and outcomes specific to the problem or needs
- delegating tasks according to the health, safety, and welfare of the health-care consumer and after considering the circumstance, person, task, direction or communication, supervision, and evaluation
- knowing the state's nurse practice act, relevant state and local regulations, and institutional policies, and maintaining accountability for the care
- documenting implementation of and any modifications to the identified nursing care plan

LINK TO LEARNING

Watch this video about milieu therapy (https://openstax.org/r/77milieu) for more information. Notice how the environment differs from other settings, yet supports the mental health of the clients.

5.4 Family Support Systems

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the importance of family support in psychiatric-mental health illness recovery
- Define family systems therapy concepts and their benefits related to psychiatric-mental health nursing

Even though the individual client is the focus of therapy, it is vital to remember the importance that family support systems play in the client's treatment and recovery. A thorough client history, including questions about who the client considers their support person(s), must be part of the initial assessment process.

Family Support in PMH Recovery

Recovery is a lifelong process for a person with psychiatric-mental health issues. Piat et al. (2011) state that there are two main parts to recovery: clinical recovery and personal recovery. Clinical recovery involves all the ways the clinicians rate a person's recovery over time, including "diagnosis, objective measures of symptom management and remission, and psychosocial functioning" (p. 3). Personal recovery starts with the person's life experiences and how those experiences shape a person's identity. As a person delves into those aspects of their life, they can begin to reshape their identity in a healthy way. "Key concepts in the recovery process include hope; personal responsibility, self-advocacy and wellness; empowerment and self-determination; and acceptance" (p. 3).

Families can help by expressing a belief that the person can get better. This helps to instill a sense of hope. Family members also protect the person by being advocates for their health care and provide support by trying to keep the client's self-image intact even if they have had negative treatment experiences. Families help the individual see their strengths and ability beyond their mental health diagnosis. Families offer the individual acceptance, trust, a sense of belonging, encouragement, and a place in a community. Remember, however, that "families" may look very different from one another and are defined by the client.

Key Concepts of Family Systems Therapy

Family therapy is a special form of group therapy, consisting of one or more families. Although there are many theoretical orientations in family therapy, one of the most predominant is the systems approach. In this approach, the family is viewed as an organized system, and each individual within the family is a contributing member who creates and maintains processes within the system that shape behavior (Minuchin, 1985). Each member of the family influences and is influenced by the others. The degree to which individuals express or react to life's stressors is based on the way the family of origin reacted to the same. The goal of **family systems therapy** is to enhance the growth of each family member as well as that of the family as a whole. The Bowen family systems theory (BFST) was developed in the 1950s and is one of the main approaches used in marriage and family therapy (Calatrava et al., 2022). The theory is formed around eight main concepts, some of which are detailed more thoroughly here:

- Nuclear family emotional process: Relationship patterns that guide where conflict occurs in the family unit
- Differentiation of self: The difference between the individual and groups to which they belong
- Triangles: The idea of a relationship system of three people
- Emotional cutoff: Ending emotional contact with another in the family
- Family projection process: The way that parents can transfer their emotional issues to their children
- Multigenerational transmission process: The idea that differences between parents and their children grow throughout the generations
- Sibling position: The position in which siblings are born affects behavior and development
- Emotional processes of society: This same system applies to groups within societies beyond families

LINK TO LEARNING

Nurses help clients reach stability by building on the strengths of the family support system and understanding how they are connected to recovery and adapt to change. This video on family systems theory (https://openstax.org/r/77famsystheory) provides an example.

Emotional Triangles

Emotional triangles, one of the components of Bowen's theory, result when parents have a lower level of differentiation of self and project their anxiety onto their children by being overreactive and overprotective. This causes triangulation because it makes the child unable to become differentiated from their parents, reducing their feeling of autonomy and increasing their levels of reactivity and anxiety (Cepukiene, 2021).

Differentiation of Self

Individuals vary in the degree of "self" they develop and this degree does depend, in part, on family dynamics. This trait begins to form in young adulthood when the individual can be emotionally objective in the midst of high anxiety related to other people within their group of belonging. The person begins to be able to have different opinions and values from the rest of the group members, while still being emotionally connected to them. This group could be their family, friends, children, or intimate relationships (Calatrava et al., 2022). The higher the level of differentiation of self, the better the ability of that individual to think for themselves by using intellectual reasoning. Being able to distinguish oneself from the rest of the group can ultimately affect the family's patterns of functioning and their level of interaction.

Family Projection Process

The family projection process was also developed by Bowen to explain the way that stressful life events that happen in childhood shape the attachment that a child has to other members of the family (Palombi, 2016). Depending upon that level of attachment, the child is at risk of needing to have those family members in order to function. The way that the family unit adapted its response during stress shapes each individual within that family.

Multigenerational Transmission Process

The multigenerational transmission process explains "how anxiety is transmitted from generation to generation" (Calatrava et al., 2022, p. 2). Lower levels of anxiety experienced as a child can lead to lower levels of anxiety experienced as an adult based on the person's learned reaction to stressful situations.

Emotional Cutoff

When people have lower levels of differentiation of self, they continue to be connected to their families in a way that creates unclear boundaries within their relationships (Messina et al., 2018). They do not develop their own opinions and values. They seek approval from one another instead of dealing with any tension within their relationships and may be unable to define their own personal values (Messina et al., 2018). People who are emotionally cut off lack the ability to find true autonomy even though they may project the look of independence.

With family therapy, the nuclear family (i.e., parents and children) or the nuclear family plus (whoever lives in the household, e.g., grandparent) come into treatment. Family therapists work with the whole family unit to heal the family. The main benefit of family systems therapy is that the therapist helps family members resolve issues and learn to communicate more effectively.

Summary

5.1 Psychiatric-Mental Health Treatment Settings

There are many types of psychiatric-mental health treatment settings, each with its own advantages and disadvantages. Treatment can happen in the community, in outpatient as well as in inpatient facilities. Clinicians and clients should work together to choose the least restrictive environment that meets the client's needs.

Building a rapport with clients is important in all types of treatment settings. Gaining the client's trust will improve treatment outcomes and provide them with the necessary support to live as independently as possible. Telehealth and teletherapy have become more viable treatment options since COVID-19. Their use extends to rural areas and to homebound clients who might otherwise not have access to mental health services.

There is a wide range of residential care services available to support people with psychiatric-mental illness. These facilities offer 24/7 care by trained health-care workers in a homelike environment. There is no one treatment that is best for all clients. The social, emotional, physical, and spiritual needs of the clients should be considered in choosing a site.

5.2 Group Therapy

Each of the seven factors of group dynamics works together to determine how successful the group will be in reaching its determined outcomes. Possible leadership styles include authoritative leadership, delegative leadership, participative leadership, servant leadership, transactional leadership, and transformational leadership. Transformational leadership is the most effective current leadership style because of the way it supports its members and encourages group cohesiveness, thus establishing norms among group members. Many different types of groups are available, and it is up to the clinician to suggest to the client which group type might be most appropriate to fit their needs.

5.3 Community Support Systems

Therapeutic communities take a socially interactive approach to client treatment for mental health challenges and can include all types of programs, ranging from inpatient to outpatient, short- to longer-term. Milieu therapy provides a safe, structured setting in which people learn to apply healthier ways of thinking and interacting to their lives. Through the relationships and interactions developed in therapeutic communities, clients begin to enjoy a sense of hope, create a sense of belonging, and learn to develop skills to apply to their lives outside of treatment.

An interdisciplinary treatment team works together toward the individualized goals of each client. The role of the nurse within the team includes administering medication, facilitating therapeutic groups, thinking critically to provide a safe environment, and documenting what transpired for each client during a specific time period. Nurses also advocate for their clients to make sure they are getting the treatment they deserve.

5.4 Family Support Systems

Family systems are intended to enhance the growth of each family member and the family unit as a whole. The Bowen family systems theory is the basis of much family therapy that is performed today. The level of attachment that a child has to their parents will shape their future reactions to stress as they become adults. Family therapy allows the family unit to work together on issues within their family structure. The therapist helps all members of the family heal and learn to communicate more effectively.

Key Terms

authoritative leadership type of group in which the leader is in complete control and dictates rules, goals, and norms

delegative leadership relies on the group members to do the work at hand

family systems therapy therapeutic approach that enhances the growth of each family member as well as that of the family as a whole

least restrictive environment treatment setting that places the fewest restrictions on lives

milieu therapy treatment in a structured, safe environment where participation in day-to-day routines, communities, and relationships is the method of therapy

partial hospitalization structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care, allowing clients to return home at night
participative leadership entails listening to group concerns and allowing members to help with decision-making
patient-centered medical home (or medical home model) community center that provides comprehensive, coordinated, client-centered models of primary care
servant leadership serves the greater good of the members of the group
severe mental illness (SMI) mental illness that interferes with a person's ability to function in life
substance use rehabilitation treatment of substance use disorder that is provided in a variety of settings
telehealth use of digital technologies to deliver medical and psychiatric care, health education, and public health services by remotely connecting multiple users in separate locations
therapeutic community socially interactive approach to client treatment for mental health challenges and can include all types of programs, ranging from inpatient to outpatient, short- to longer-term
transactional leadership relies on rewards and punishments to achieve goals
transformational leadership views groups members as valuable and change as positive

Assessments

Review Questions

1. When considering using telehealth services to provide mental health-care treatment to rural or homebound clients, what is the priority client assessment?
   a. the client's ability to use a computer and internet access
   b. the client's access to transportation to get to appointments
   c. whether or not the client is having any thoughts of self-harm
   d. the client's desire to be seen in person

2. A psychiatric RN working on a detox unit is following Prochaska's Stages of Change to determine the client's readiness for substance use rehabilitation after discharge from the hospital. When the client states they have been doing self-reevaluation through group attendance, what stage are they in?
   a. pre-contemplation
   b. contemplation
   c. preparation
   d. action
   e. maintenance

3. A client is preparing for discharge from the hospital after a prolonged stay related to an exacerbation of major depression. The nurse determines that they are having no thoughts of self-harm and are motivated to continue treatment, but worried about symptom management/relapse. For what type of treatment is this client a good candidate?
   a. in-home care
   b. continued inpatient hospitalization
   c. follow-up with a primary care provider
   d. the partial hospitalization program

4. A new nurse working in an inpatient psychiatric unit is teaching a nurse education group about positive coping skills. The participants are all young adults from different backgrounds and with different diagnoses. The nurse asks one of the participants what the benefit is to attend groups. What is a statement the client could make that would indicate that more education is warranted?
   a. "It is to give us something to do while we are in the hospital."
   b. "Groups helps us work with and learn from one another."
   c. "The benefit is that we learn new ways to handle our problems."
   d. "It is helpful to hear about other people's experiences to see if it could help us."

5. A client is attending a depression support group at a community mental health center. The leader listens to the group members and allows them to help make decisions. What type of leadership does this group

demonstrate?
   a. transformational leadership
   b. servant leadership
   c. participative leadership
   d. delegative leadership

6. A psychiatric nurse is working in a community mental health center. Their day begins by seeing a forty-year-old male client diagnosed with schizophrenia. He is due for his monthly injection of a depot medication. The nurse is already running behind and needs some help. Considering the nursing role, how can you decide to delegate tasks?
   a. Just delegate to any technician who is willing and available to help.
   b. Consider whether the delegatee has the ability to do the task according to facility rules.
   c. Consider the circumstance, person, task, direction or communication, supervision, and evaluation.
   d. Never delegate any tasks.

7. A nurse is involved in many layers of the therapeutic community. What benefit does it provide to clients to help them assess their connections to their families?
   a. It helps their ability to adapt to change.
   b. It improves their desire to schedule follow-up appointments.
   c. It helps them become emotionally cut off.
   d. It helps them determine their need to stay in emotional triangles.

8. Family support is an important part of the recovery process for a person with psychiatric-mental health problems. How does having the support of the family increase the individual's recovery?
   a. by constantly reminding the individuals that they have an illness
   b. by hastening their clinical recovery
   c. by providing a source of hope for their personal recovery
   d. by making all treatment decisions for the individual

Check Your Understanding Questions

1. Describe what information a psychiatric RN would provide about the benefits of telehealth home care to a mental health client.
2. For each group leadership style, provide examples of how the leader would approach group decision-making.
3. Describe three components that help to promote a therapeutic community.
4. How is an individual described according to family systems therapy?

Reflection Questions

1. Reflect on a recent clinical experience you have had that involved mental health. Describe the situation. What happened? What was your role in this experience? How did you feel about this experience? If you could repeat the day, what would you do differently?
2. How could age affect group dynamics in a treatment setting? How could age be utilized to create a group? How could age be utilized as an advantage in a therapeutic group setting? How could age be utilized as a disadvantage in a therapeutic group setting?
3. How could culture affect group dynamics in a treatment setting? How could culture be utilized as an advantage in a therapeutic group setting? How could culture be utilized as a disadvantage in a therapeutic group setting?
4. According to the Bowen family systems theory, individuals learn how to deal with stress from the way they saw their parents deal with it. Explain how nursing is connected to this theory and how a nurse would help a client by using knowledge about this theory.

What Should the Nurse Do?

1. Amber, a twenty-two-year-old female, has come to her primary care physician accompanied by her concerned mother. Amber's mother reports that she has been restricting her food intake in the past six months and appears to have lost a lot of weight. She has been avoiding family meals, exercising excessively, and staying home favoring online classes rather than in-person ones. While Amber has not had any medical problems in the past, she does report strong feelings of anxiety. During the initial assessment, Amber's vital signs are as follows: blood pressure of 100/60 mm Hg, heart rate of 50 beats per minute, respiratory rate of 16 breaths per minute, and BMI of 17.5. Amber appears visibly fatigued and demonstrates signs of social withdrawal. She expresses feelings of guilt after eating even small amounts of food and has difficulty concentrating on her studies.
   Identify advantages and disadvantages of each treatment setting. What are the pros and cons of inpatient treatment, intensive outpatient services, and telehealth for treating Amber at this stage and which is best?

2. Lawrence arrives at a community mental health clinic seeking support for persistent symptoms of social anxiety and depression. He reports challenges in forming and maintaining relationships, both personally and professionally. Lawrence, a graphic designer, expresses difficulty collaborating with colleagues and a tendency to avoid social gatherings. He mentions a history of childhood trauma, which he has never addressed in a therapeutic setting. During the initial assessment, vital signs reveal a slightly elevated blood pressure of 130/85 mm Hg, a heart rate of 78 beats per minute, and a respiratory rate of 16 breaths per minute. Lawrence shows signs of restlessness, constantly fidgeting, and displays guarded body language. What verbal and nonverbal cues did Lawrence exhibit during the initial assessment that indicated potential suitability for group therapy?

James, a forty-five-year-old male, visits a psychiatric-mental health clinic accompanied by his wife, Sarah. He presents with symptoms of severe anxiety, insomnia, and emotional withdrawal. James, an accountant, recently lost his job due to the economic downturn, adding financial stress to the existing burden. His medical history reveals a family background of mental health issues, with a sibling diagnosed with bipolar disorder. Vital signs during the initial assessment show an elevated blood pressure of 140/90 mm Hg, a heart rate of 88 beats per minute, and a respiratory rate of 18 breaths per minute.

3. How might James's family history contribute to his symptoms, and in what ways could the recent job loss act as a trigger for his anxiety and emotional withdrawal?
4. What are some potential family-centered interventions that address both James's individual symptoms and the broader family context? How might involving Sarah in the treatment plan contribute to James's recovery?

Competency-Based Assessments

1. The concept of the "least restrictive environment" in mental health refers to providing care and treatment in a setting that imposes the fewest limitations on an individual's freedom and autonomy while still ensuring their safety and well-being. How would you define this concept for a group of parents who are learning about treatment options for their family members with severe mental illnesses?

2. You are a nurse with a client who has a history of noncompliance with treatment plans. What are the advantages and disadvantages of residential, outpatient, and telehealth settings in addressing noncompliance issues?

3. In the context of mental health treatment settings, critically analyze the potential impact of socioeconomic factors on a client's access to and experience within treatment settings.

4. You are a nursing student who has been asked to speak to a group of parents to briefly explain three functions of therapeutic groups in mental health care and to explain how a support group functions differently from a psychoeducational group. Provide brief explanations.

5. You have been asked to name some factors that may influence the effectiveness of group therapy for individuals with social anxiety. As part of your answer, please discuss how cultural factors are relevant and can impact the dynamics of group therapy.

6. You are a nurse who has been asked by a client's family to consider the potential benefits and challenges of

incorporating alternative treatments, such as music or art therapy, into a psychiatric-mental health setting. Consider the client engagement and outcomes.

7. You are a mental health nursing student working on a case study that will require an interdisciplinary treatment team to address. What members should the team include and what skills will they bring to the effort?
8. You are a nurse who has been asked to analyze a situation in which family support is lacking in the treatment of an individual with PMH illness. Explain how this absence impacts the individual's recovery and what interventions could address this deficiency.
9. You are part of a treatment team that is working with a family that is resistant to participating in family systems therapy. Explore potential reasons for this resistance and propose strategies a PMH nurse could employ to engage the family in therapy.

References

Advocates for Human Potential. (2023). *What is WRAP?* https://www.wellnessrecoveryactionplan.com/what-is-wrap/

Agency for Healthcare Research and Quality (AHRQ). (August 2022). *Patient Centered Medical Home (PCMH).* https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/index.html

Agency for Healthcare Research and Quality (AHRQ). (n.d.). *Defining the PCMH.* https://pcmh.ahrq.gov/page/defining-pcmh

American Psychological Association. (2019, October 31). *Psychotherapy: Understanding group therapy.* https://www.apa.org/topics/psychotherapy/group-therapy

Bass, B. M., Avolio, B. J., & Atwater, L. (1996). The transformational and transactional leadership of men and women. *Applied Psychology: An International Review, 45*, 5–34.

Boland, K. M. (2018). Ethical considerations for providing in-home mental health services for homebound individuals. *Ethics & Behavior, 29*(4), 287–304. https://doi.org/10.1080/10508422.2018.1518138

Bryde Christensen, A., Wahrén, S., Reinholt, N., Poulsen, S., Hvenegaard, M., Simonsen, E., & Arnfred, S. (2021). "Despite the differences, we were all the same". Group cohesion in diagnosis-specific and transdiagnostic CBT groups for anxiety and depression: A qualitative study. *International Journal of Environmental Research and Public Health, 18*(10), 5324. https://doi.org/10.3390/ijerph18105324

Budgen, J., & Cantiello, J. (2017). Advantages and disadvantages of the patient-centered medical home. *The Health Care Manager, 36*(4), 357–363. https://doi.org/10.1097/HCM.0000000000000178.

Calatrava, M., Martins, M.V., Schweer-Collins, M., Duch-Ceballos, C. & Rodriguez-Gonzalez, M. (2022). Differentiation of self: A scoping review of Bowen family systems theory's core construct. *Clinical Psychology Review, 91* (102101), 1–13. https://doi.org/10.1016/j.cpr.2021.102101

Cepukiene, V. (2021). Adults' psychological functioning through the lens of Bowen theory: The role of interparental relationship quality, attachment to parents, differentiation of self, and satisfaction with couple relationship. *Journal of Adult Development, 28*, 50–63.

Cherry, K. (2022). How to lead: 6 leadership styles and frameworks. https://www.verywellmind.com/leadership-styles-2795312#toc-authoritarian-leadership-autocratic

Chobanuk J., & James, K. (2015). Leadership special interest group: What is leadership? *Canadian Oncology Nursing Journal. 25*(1):114–117. https://www.canadianoncologynursingjournal.com/index.php/conj/article/view/40

DeCarlo, F., Sociali, A., Picutti, E., Pettorruso, M. Vellante, F. Verrastro, V., Martinotti, G., diGiannantonio, M.. (2020). Telepsychiatry and other cutting-edge technologies in COVID-19 pandemic: Bridging the distance in mental health assistance. *International Journal of Clinical Practice. 75*, 1–9. https://doi.org/10.1111/ijcp.13716

Duenas, R. (2021, October 7). *Overcoming cultural barriers on the road to recovery.* NAMI. https://nami.org/Blogs/

NAMI-Blog/October-2021/Overcoming-Cultural-Barriers-on-the-Road-to-Recovery

Ezhumalai, S., Muralidhar, D., Dhanasekarapandian, & Shanti Nikketha, B. (2018). Group interventions. *Indian J Psychiatry, 60*(4), 514–S521. https://journals.lww.com/indianjpsychiatry/fulltext/2018/60004/group_interventions.20.aspx

Janeiro, L., Ribeiro, E., & Miguel, M. (2018). What is inside the "black box"? Therapeutic community residents' perspectives on each treatment phase. *Addiction Research & Theory, 26*(4), 294–305.

Krebs, P., Norcross, J. C., Nicholson, J. M., Prochaska, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis, *Journal of Clinical Psychology, 74*, 1964–1979.

Kursuncu, M. A., & Bastemur, S. (2019). Family triangulation experiences of Turkish young women. *Educational Policy Analysis and Strategic Research, 14*(3), 312–329. doi: 10.29329/epasr.2019.208.14

Malhotra, A., & Baker, J. (2022, June 11). Group Therapy. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK549812/

Meeussen, L., Agneessens, F., Delvaux, E., & Phalet, K. (2018). Ethnic diversity and value sharing: A longitudinal social network perspective on interactive group processes. *British Journal of Social Psychology*, *57*(2), 428–447. https://doi-org.easydb.angelo.edu/10.1111/bjso.12237

Messina, K. C., Kolbert, J. B., Bundick, M. J., Crothers, L. M., & Strano, D. A. (2018). The impact of counseling on Bowen's differentiation of self. *The Family Journal: Counseling and Therapy for Couples and Families, 26*(2), 150–155. https://doi.org/10.1177/1066480718776197

Miller, C. J., Sullivan, J. L., Harvey, K. L., Williamson, A. K., & Stadnick, N. A. (2022). Promoting high-functioning mental health treatment teams in the context of low staffing ratios. *Health Care Management Review, 47*(1), 12–20.

Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development, 56*(2), 289–302. https://doi.org/10.2307/1129720

National Alliance on Mental Illness (NAMI) Texas. (n.d.). Supportive housing. https://namitexas.org/supportivehousing/

National Institute on Drug Abuse (NIH). (July 2015). What is a therapeutic community's approach? https://archives.nida.nih.gov/publications/research-reports/therapeutic-communities/what-therapeutic-communitys-approach

Palombi, M. (2016). Separations: A personal account of Bowen family systems theory. *Australian and New Zealand Journal of Family Therapy, 37*, 327–339. https://10.1002/anzf.1170

Pappas, S. (2023, March 1). *Group therapy is as effective as individual therapy, and more efficient. Here's how to do it successfully*. American Psychological Association. https://www.apa.org/monitor/2023/03/continuing-education-group-therapy

Petipren, A. (2023). *Hildegard Paplau: Nursing theorist*. Nursing Theory. https://nursing-theory.org/nursing-theorists/Hildegard-Peplau.php

Piat, M., Sabetti, J., Fleury, M. J., Boyer, R., & Lesage, A. (2011). "Who believes most in me and in my recovery": The importance of families for persons with serious mental illness living in structured community housing. *Journal of Social Work in Disability & Rehabilitation*, *10*(1), 49–65. https://doi.org/10.1080/1536710X.2011.546310

Pirotte B. D., & Benson S. (2023). Refusal of care. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560886/

Presbyterian Medical Services. (2023). Comprehensive community support services. https://www.pmsnm.org/programs-services/behavioral-health/comprehensive-community-support-services/

SAMHSA. (n.d.). Tribal Action Plan (TAP). https://www.samhsa.gov/tribal-affairs/tribal-action-plan

Smith, Y., & Spitzmueller, M. C. (2016). Worker perspectives on contemporary milieu therapy: A cross-site

ethnographic study. *Social Work Research*, *40*(2), 105–116. https://doi-org.easydb.angelo.edu/10.1093/swr/svw003

Stanborough, R. (2020, April 10). *What is milieu therapy?* Healthline Media. https://www.healthline.com/health/mental-health/milieu-therapy

Substance Abuse and Mental Health Services Administration & Office of the Surgeon General. (2016). Facing addiction in America: The surgeon general's report on alcohol, drugs, and health. United States Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK424857/

Telehealth.HHS.gov. (2021, July 2). Individual teletherapy. Health Resources & Services Administration. https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/individual-teletherapy/

Venner, K. L., et al. (2018). Future directions for medication assisted treatment for opioid use disorder with American Indian/Alaska Natives. *Addictive Behaviors 86*, 111–117. https://doi.org/10.1016/j.addbeh.2018.05.017

Wood, C. J., Polley, M., Barton, J. L., & Wicks, C. L. (2022). Therapeutic community gardening as a green social prescription for mental ill-health: Impact, barriers, and facilitators from the perspective of multiple stakeholders. *International Journal of Environmental Research and Public Health, 19*(13612), 1–14. https://doi.org/10.3390/ijerph192013612

CHAPTER 6
Therapeutic Relationships

FIGURE 6.1 Group therapy can occur in a variety of settings, such as this session in the woods by a river. (credit: "Men Sitting Talking by River Outdoors" by JourneyPure Rehab/Flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION The therapeutic relationship between the client and the nurse is a foundational element in the provision of good care. This relationship is based on trust, support, engagement, and collaboration to determine a set of goals based on the needs of the client. The nurse acts as a conduit toward better health, not as an authority who makes all the decisions. Support from family and friends is also a factor that determines how quickly the client can recover. Therapeutic relationships and support are protective factors that can decrease the risk of developing or exacerbating mental health issues.

6.1 Nurse-Client Relationship

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the phases of the nurse-client relationship
- Discuss the importance of building trust and rapport between the nurse and client
- Describe boundaries and how to maintain a professional nurse-client relationship

Establishment of the therapeutic nurse-client relationship is vital in nursing care. Nurses engage in compassionate,

supportive, professional relationships with their clients as part of the "art of nursing" (American Nurses Association, 2021). This is especially true in psychiatric care, where the therapeutic relationship is the foundation of client care and healing (Ross & Goldner, 2009). The nurse-client relationship establishes trust and rapport with a specific purpose; it facilitates therapeutic communication and engages the client in partnership for decision-making regarding their plan of care.

Therapeutic nurse-client relationships vary in depth, length, and focus. Brief therapeutic encounters might last only a few minutes and focus on the client's immediate needs, current feelings, or behaviors. For example, in the emergency department setting, a nurse may therapeutically communicate with a client in crisis who recently experienced a situational trauma. In inpatient care settings, nurses work with clients in setting short-term goals and outcomes that are documented in the nursing care plan and evaluated regularly. In long-term care settings, such as residential facilities, the therapeutic nurse-client relationship may last several months and include frequent interactions focusing on behavior modification.

Phases of the Nurse-Client Relationship

Hildegard Peplau is considered the mother of psychiatric nursing through her development of the interpersonal relations theory (see 2.2 Interpersonal Theories and Therapies). This theory helps nurses understand the importance of therapeutic communication with their clients. According to the theory, there are four phases of the nurse-client relationship: pre-orientation, orientation, working, and termination (see link 2.2 Interpersonal Theories and Therapies Peplau's nurse/client relationship phases). This relationship is of a professional nature in which both the client's and the nurse's "feelings, emotions, and behaviors are taken into consideration" (Deane & Fain, 2016, p. 38). This theory is beneficial to nursing students as they learn how to communicate effectively with their clients.

Pre-orientation Phase

The pre-orientation phase is when the nurse prepares to meet the client by reviewing their chart, getting reports from another nurse or department, and planning for the initial assessment that will be performed with this client. This is a time when the nurse mentally readies for the interaction that is about to occur.

Orientation Phase

During the brief orientation phase, clients may realize they need assistance as they adjust to their current health status or condition. Simultaneously, nurses introduce themselves and begin to obtain essential information about clients as individuals with unique needs, values, beliefs, and priorities. During this phase, the nurse and the client begin to establish trust and develop a rapport. Nurses must ensure privacy when talking with the client and providing care and should respect the client's values, beliefs, and personal boundaries.

A common framework used for introductions during the orientation phase of the nurse-client relationship is **AIDET**, a mnemonic for Acknowledge, Introduce, Duration, Explanation, and Thank You.

- Acknowledge: Greet the client by their preferred name, verifying their identity per policy. Make eye contact, smile, and acknowledge any family or friends in the room. Ask the client their preferred way of being addressed (for example, "Mr. Doe," "Jonathon," or "Johnny") and their preferred pronouns (e.g., he/him, she/her, or they/them).
- Introduce: Introduce yourself by name and role. For example, "I'm John Doe, and I am a nursing student working with your nurse to take care of you today."
- Duration: Estimate a timeline for how long it will take to complete the task you are doing. For example, "I am here to perform an admission assessment. This should take about 15 minutes."
- Explanation: Explain step-by-step what to expect next and answer questions. For example, "I will be putting this blood pressure cuff on your arm and inflating it. It will feel as if it is squeezing your arm for a few moments."
- Thank you: At the end of the encounter, thank the client and ask if anything is needed before leaving. In an acute or long-term care setting, ensure the call light is within reach and that the client knows how to use it. If family members are present, thank them for being there to support the client as appropriate. For example, "Thank you for taking time to talk with me today. Is there anything I can get for you before I leave the room? Here is the call light (place within reach). Press the red button if you would like to call the nurse."

It is during the orientation phase that nurses begin to understand the client as a person, while also being self-aware

enough to recognize how the interaction affects them. Acting professionally, asking questions, listening to the client's answers, and setting the tone for the rest of the interaction provides a foundation for a strong nurse-client rapport.

Working Phase

Most of the nurse's time with a client is spent in the working phase. During this phase, nurses use active listening and begin by asking the reason the client is seeking care to determine what is important to them. Nurses use therapeutic communication techniques to facilitate clients' awareness and encourage them to express their thoughts and feelings. They also use this time to develop goals and an individualized plan of care. Nurses provide reflective and nonjudgmental feedback to clients to help them clarify their thoughts, goals, and coping strategies (Hagerty et al., 2018). If a care plan has already been established on admission, nurses use this time to implement interventions targeted to meet short-term objectives and long-term goals. During the working phase, clients begin to accept nurses as health educators, counselors, and care providers. During this phase, the nurse also acts as a resource person who assists the client in gathering more information about their illness (Deane & Fain, 2016).

Resolution/Termination Phase

The final phase of a nurse-client relationship is the termination phase. This phase typically occurs at the end of a shift or on discharge from care. Success in the working phase means that the client, nurses, and interprofessional health-care team members have met the client's needs. The nurse should be aware that the client may try to return to the working phase to avoid termination of the relationship. During the termination phase, the nurse can encourage the client to reflect on progress they have made and review post discharge goals. Even student nurses can be involved in discharge teaching as the client prepares to return to their normal routines (Deane & Fain, 2016). The nurse also makes community referrals for follow-up and continuation of support to meet goals. During this phase, the nurse reviews how well the plan of care worked. They can then apply the knowledge gathered to the care provided to future clients.

Building Trust and Rapport

The theory of interpersonal relations is holistic in the way that it uses both verbal and nonverbal communication skills to assist the client in dealing with their illness (Deane & Fain, 2016). The student nurse can learn a lot about communication by using this theory to guide their interactions with their clients. Deane and Fain (2016) suggest that gaining education about the importance of communication will allow nursing students to develop "empathy, active listening, the use of silence and touch, and *being there*" (p. 37). A nurse develops rapport by offering themselves as a genuine presence, being aware of nonverbal communication, being empathetic, and actively listening. Correct use of these techniques will increase trust and rapport between the student nurse and the client.

Peplau's theory is based on what happens between two people, focusing on feelings, emotions, and behaviors of both the nurse and the client. Having students practice their communication skills through dialogue with their clients not only increases the nursing students' self-confidence, but also helps to grow the level of rapport between the student and the client. Deane and Fain (2016) point out that this interaction encourages the student to have conversations with their clients and not simply concentrate on the tasks at hand. After the interaction has taken place, the instructor can then meet with the student to talk about what did and did not work during the interaction, giving feedback and support as needed to guide the student.

LINK TO LEARNING

Watch the video *The Life and Legacy of Hildegard Peplau* (https://openstax.org/r/77HildePeplau) for more information on Hildegard Peplau's nursing path and work in the field of mental health nursing

Boundaries in the Therapeutic Relationship

The limits people set to define their levels of comfort when interacting with others are called **boundaries**. Personal boundaries include those in the physical, sexual, intellectual, emotional, and financial areas of people's lives. Boundaries promote safety in relationships at work, home, and with partners by protecting one's well-being and limiting the stress response. For example, if an individual comes away from a meeting or conversation with someone

feeling depleted, anxious, or tense, they might consider if something in the meeting crossed their boundaries. It is important to maintain professional boundaries, while also building rapport. For example, you might talk about your family in a general way with a client, but you would not provide specific and personal details to them. You may also have to reinforce professional boundaries if a client attempts to contact you via social media or asks you to continue contact after care is completed. A lack of healthy personal boundaries, or situations that consistently penetrate and cross those boundaries, can lead to emotional and physical fatigue (Pattemore, 2021).

Five major types of boundaries include (Pattemore, 2021):

- Physical: Physical boundaries refer to one's personal space, privacy, and body. For example, some people are comfortable with public displays of affection (hugs, kisses, and hand-holding), while others prefer not to be touched in public.
- Sexual: Sexual boundaries refer to one's comfort level with intimacy and attention of a sexual nature. This can include sexual comments and touch, not just sexual acts.
- Intellectual: Intellectual boundaries refer to one's thoughts and beliefs. When someone dismisses another person's ideas and opinions, they are crossing intellectual boundaries.
- Emotional: Emotional boundaries refer to a person's feelings. For example, an individual might not feel comfortable sharing feelings with another person and may prefer to share information gradually over time.
- Financial: Financial boundaries refer to how one earns money as well as how one prefers to spend or save money.

When caring for clients with mental health disorders, it is common to notice problems with setting appropriate boundaries. For example, a client experiencing bipolar disorder may exhibit a lack of financial and sexual boundaries. When they are experiencing a manic episode, they may spend thousands of dollars on a credit card over a weekend or have sexual relations with someone they just met. Another example of boundary issues is an individual with a depressive disorder who is treated poorly by their partner but does not leave or assert boundaries because they don't feel that they deserve to be treated any better.

Nurses must establish professional boundaries with all clients while also maintaining a respectful and caring relationship. Due to their professional role, nurses have authority and access to sensitive information that can make clients feel vulnerable. *A Nurses Guide to Professional Boundaries* by the National Council of State Boards of Nursing (NCSBN, 2018) states that it is the nurse's responsibility to use clinical judgment to determine and maintain professional boundaries. Nurses should limit self-disclosure of personal information and avoid situations where they have a personal or business relationship with a client. The difference between a caring nurse-client relationship and an overinvolved relationship can be difficult to discern, especially in small communities or in community health nursing where roles may overlap. In these circumstances, it is important for the nurse to openly acknowledge their dual relationship and recognize when they are performing in a professional capacity. Signs of inappropriate boundaries within the nurse-client relationship include the following (National Council of State Boards of Nursing, 2018):

- self-disclosing intimate or personal issues with a client
- engaging in behaviors that could be interpreted as flirting
- keeping secrets with a client
- believing the nurse is the only one who truly understands or can help the client
- spending more time than is necessary with a particular client
- speaking poorly about colleagues or the employment setting with the client and/or their family
- showing favoritism to a particular client
- meeting a client in settings outside of work
- contacting or permitting contact by a client and/or their family members using social media

Several concepts related to therapeutic boundaries of which a nursing student should be aware include transference and countertransference. Transference is when the client reacts emotionally toward the nurse when triggered by memories of a past relationship. This could happen, for example, if the nurse resembles someone from the client's life or if the nurse provides support that the client wishes they were receiving from their significant other and this support makes the client feel extra close to the nurse.

Countertransference occurs when the nurse has these types of triggers toward the client. For example, if the client

reminds the nurse of a previous client who was angry and threatening, those feelings might influence the nurse's attitude toward the current client. It is important for health-care professionals to regularly perform self-reflection exercises to monitor and adjust their reactions to their clients (Prasko et al., 2022). Establishing professional boundaries with clients diagnosed with mental health disorders is essential due to the vulnerability of the client population, as well as the behavioral manifestations of some disorders. For safety purposes, nurses and nursing students should keep their last name, home address, personal telephone number, and social media handles private.

REAL RN STORIES

Nurse: Lenore, MSN, RN-BC
Years in Practice: 19
Clinical Setting: Community mental health center
Geographic Location: New Hampshire

In my years as a psychiatric nurse, I have always been cautious about nurse-client boundaries. In fact, I teach my nursing students the importance of maintaining strict boundaries. Our nursing role is meant to have the client's best interests as the focus of our interactions with them. We cannot muddy the waters by accepting their friend request on Facebook or building a relationship with them after our nursing role is over. Even if we build a strong rapport with a long-term client, it is better to terminate the entire relationship once the nursing relationship has reached the termination phase.

6.2 Family Dynamics

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the role of family dynamics in nursing practice
- Discuss how the family systems model builds collaborative relationships with clients and their families
- Describe collaborative relationships in mental health nursing

With approximately 14.1 million adults and 49.5 percent of adolescents with serious mental illness in the United States needing the help of family caregivers, it is no wonder that family dynamics have a large effect on the outcomes for these clients (National Institute of Mental Health, 2023). The push in more recent years for providing care to individuals with serious mental illness in the least restrictive environments, along with the focus on client-centered care, has increased the need for family members to become caregivers. How does this affect family dynamics and the need for collaborative relationships?

Mental illness does not only affect the individual. It affects the entire family. Nurses can assist family members by educating them about mental illness and disease processes, allowing them to share their feelings, and encouraging open communication between them.

Family Dynamics

The way that the family members interact, communicate, and problem-solve is called **family dynamics**. Functional families work together toward common goals. They support one another and have good communication. Dysfunctional relationships can cause distress and broken ties within the family, leading to poorer mental health outcomes. Even with effective family dynamics, mental illness can cause changes and challenges to the living environment, as well as the family hierarchy (Sanders et al., 2014). Stigma affects families just as it does the person living with the mental health diagnosis. Families can adopt stigmatizing beliefs and feelings about mental illness and this can influence how they perceive and support the person with the mental health diagnosis.

Families today include a variety of combinations that form the family unit (Table 6.1). These combinations include nuclear family, single-parent family, extended family, childless family, grandparent family, and step family. Because mental illness can affect anyone, family members in any combination or type of familial group will have to adapt.

Family Structure	Description
Nuclear family	Two parents with one or more children
Single-parent family	One parent raising one or more children
Extended family	Multiple family members raising one or more children
Childless family	Two partners, married or unmarried, with no children
Grandparent family	Grandparents raising one or more children without the parents
Stepfamily or blended family	Two parents with children forming a combined family unit

TABLE 6.1 **Types of Family Structures**

Nuclear Families

The traditional family, or nuclear, family was mother, father, and children. The current version of this family model includes two parents, regardless of gender or marital status, and one or more children (Meleen, 2021). This family structure can provide stability from having more than one parent to share the care of the child/children. Nuclear families may also have more than one income, providing financial stability for the family unit. Consistency provided by two parents can increase positive behavior patterns in the children. In a functional nuclear family, children learn how to take responsibility and form positive relationships from watching their parents work together to problem-solve and support one another. The opposite is also true. If the parents in a nuclear family have a dysfunctional relationship, for example one that includes arguing or not supporting one another, then children will learn that type of behavior.

Some cons associated with the nuclear family include burnout, especially in mothers, as they often attend to the needs of the entire family while also working outside of the home. Nuclear families are frequently very tightly bonded and may not seek the assistance of extended family members. Without the assistance of extended family, it may be difficult for parents to juggle work, sick children, household chores, and after-school activities, making them more prone to depression and anxiety (Meleen, 2021). Parental stress observed by the children can also impact the children's stress levels and cause anxiety.

Single-Parent Families

The single-parent family is formed by one parent with one or more children. Nearly one in four children is born to a single parent (Blessing, 2023). Family members in single-parent households have a higher risk for developing mental illnesses, such as depression (Behere et al., 2017). The mothers in a single-parent household are also at three times the risk for developing depression and substance use as compared with their married counterparts (Behere et al., 2017). Further, having a parent, particularly the mother, with a mental health problem can increase the chances of the children in that household developing depression (Behere et al., 2017).

One contributing factor is that these households tend to fall at a lower socioeconomic level. It is estimated that poverty levels in single-parent households are as high as 50 percent, whereas in households with two parents, it averages about 5 percent (Behere et al., 2017). Poverty can contribute to dysfunction in parent-child relationships and, like divorce, can cause behavioral problems in the children of those families.

Extended Family

An extended family is multiple family members living together with the common goal of raising the children. This family unit usually has positive family dynamics. According to Mind Help (2023), the advantages of this family unit include sharing duties and finances. Having good communication, being supportive of one another, and working together toward the goals of the family creates a positive influence on the overall mental health of the family (Mind Help, 2023). Some disadvantages are a lack of privacy and interference with other people's relationships within the household. Negative impacts of this family structure include being overinvolved in each other's personal affairs, thus decreasing individual autonomy and increasing feelings of stress (Mind Help, 2023).

Childless Family

The childless family has no children, by choice or circumstance. This family consists of two partners, married or unmarried. These two adults may have a pet instead of a child with no plans to have children. These couples include working couples, couples who feel that children do not fit into their lifestyle (e.g., they enjoy a lot of traveling), and couples who choose to wait to have children (BetterHelp, 2023). The advantages to this type of family are time to enjoy things like travel and quiet time, financial stability, and not having the stress related to taking care of children (BetterHelp, 2023). The disadvantages are that they may experience loneliness and a feeling that they may be missing out by not having children.

Grandparent Family

This type of family unit is formed when grandparents step in to care for the grandchild/children when their parents are unable to do so. Pebley and Rudkin's (n.d.) research has illustrated that split-family households, in which the grandparent is the primary caregiver, form when a parent has financial, mental health, or substance use problems and needs the intervention of grandparents to care for the children. There are about 4.5 million grandparents taking care of their grandchildren (Pebley & Rudkin, n.d.), and a higher percentage of grandparents who have grandchildren living with them occurs in Black families. This can create stressors unique to this family unit, such as physical and medical limitations and complications as an aging grandparent is responsible for children, transportation, and financial issues as well as generational conflict.

Stepfamily

Stepfamilies or blended families occur when two adults with children form a combined family unit. The adults may or may not have biological children together. While this type of family is becoming more common, it is not without its own set of problems (Mayntz, 2019). Conflicting family values, roles, and juggling the care of biological and stepchildren are just a few of the difficulties that may occur. In fact, introduction of a stepparent into a family increases the likelihood of abuse by 30 to 40 percent (Behere et al., 2017).

Families with a Parent with Mental Illness

In families where a parent has mental illness, children have a higher risk for developing a mental illness than those without mental illness in their family because of genetic and environmental risk factors (Sanders et al., 2014). Sanders et al. (2014) describe two types of burden that fall on families with mentally ill members: objective burden and subjective burden. The greater likelihood that a family member will neglect finances and routines, overlook other family members, and endure friction between family members, as a direct result of the ill family member, is called **objective burden**. Feelings related to the family member's illness, including worries and anxiety, resentments, feeling trapped, and fears associated with stigma and with potential interactions and disturbing behaviors, is called **subjective burden** (Sanders et al., 2014). These burdens can make siblings and children become secondary victims as they help with caregiving, support their family member, and struggle with the need to grow up faster.

When considering children whose parents have mental illness, it is important for the nurse to examine the best way to support, educate, and promote resilience in these individuals (Tapias et al., 2021). Nurses should take into consideration the age of the child so that supportive measures meet the child's developmental needs and level of understanding.

CULTURAL CONTEXT

Family Dynamics in Latinx Youth

Family has a high value in the Latinx culture. The strong family bonds should have a protective factor against mental illness. Lazarevic et al. (2021) performed a study testing whether strong family bonds do have a protective factor against mental illness in the context of discrimination faced by Latinx youth. The researchers found that even if the Latinx family had positive family dynamics, it did not protect against the negative effects discrimination had on depression and satisfaction with life in youth. Positive family dynamics only had a positive impact if discrimination levels were low. If the Latinx family had negative family dynamics, it increased the negative effects of discrimination on both depression and life satisfaction. The authors of this study suggested that practitioners working with Latinx families should assess for family conflict and the degree to which discrimination is affecting mental health within

the family unit (Lazarevic et al., 2021).

Family Systems Model

In the 1950s, Murray Bowen developed his family systems theory, which is still the central orientation in family therapy practice (Brown, 1999). The purpose of implementing this theory in practice is to enhance the growth of each family member as well as that of the family as a whole. The main concept in this theory is how much the closeness or distance in the relationship between family members affects anxiety. The major focus in the theory is on **differentiation of self** (Brown, 1999). This is when an individual can feel autonomous and make decisions that help them function independently even within the family group (discussed in greater detail in 5.4 Family Support Systems).

When the nurse or therapist determines that there is fusion among family members, it is their job to teach the family members better ways of coping with stress and anxiety. When a person reacts immediately, without hesitation, to another family member's demands, this is called **fusion**. Fusion of the family members increases the chances of taking things personally and being inflexible to dealing with stress (Brown, 1999). In more recent years, this model has also been used in a wider context to include a look at familial changes related to multigenerational stress, age, gender, and life cycle.

Collaborative Relationships

Interprofessional, collaborative relationships are those that evolve between the interprofessional team and the family. This relationship is a partnership in which all parties listen to one another and respect the perspectives of each person (Ness et al., 2014). Collaboration involves individuals, departments, and hospital systems working together to develop solutions for improving the care they provide to their clients, through sharing information (Howard et al., 2022). The collaborative care model has been developed over the past thirty years to connect behavioral health and health-care professionals and increase client engagement through providing evidence-based care that is based on a shared treatment plan (American Psychiatric Association, 2023).

The relationship between the nurse and the client/family can be a pivotal part of increasing positive outcomes when caring for those with mental illness. The education and support that nurses bring to the interaction help both the individual and the family to have a better understanding about how family dynamics affect each other's mental health. The nurse acts in partnership with the family through learning about the family members, their hopes, their dreams, and how they see their lives unfolding in front of them (Ness et al., 2014). Through this process, they mutually agree on how to collaborate while the nurse teaches the family that working together strengthens the relationships within the family.

CLINICAL JUDGMENT MEASUREMENT MODEL

Generate Solutions: Involve the Client as a Member of the Decision-Making Process

Psychiatric nursing is not about making decisions *for* the client, but *with* the client. Collaborating with the client and the client's family in the decision-making process will help engage the client in the development of goals, outcomes, and interventions (Ness et al., 2014). Through the previous steps in the CJMM, the nurse will have gathered client history, gained information about what is important to the client in the trajectory of their care, and learned about their expectations for recovery. In generating solutions, the nurse's interventions are based on the client's needs and what makes sense to them. The client should have autonomy, the ability to be involved in the decision-making process. Without the client's buy-in, the interventions suggested by the team could be fruitless.

6.3 Peer Support

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe peer support services in psychiatric-mental health
- Discuss the functions of peer support services
- List some examples of peer support services

Living with mental illness can be lonely and isolating. To support those living with mental illness, peer specialists share their experiences of mental illness and recovery with others. This support provides hope and guidance, as well as information on resources that worked for the peer specialist. Peer specialists are able to listen, provide strategies that have been helpful in their recovery, connect people with community resources, and help with overcoming shame and stigma. In this manner, the person who has mental illness learns they do not have to fight the battle alone.

Peer Support Services

Peer support services are those led by a person or persons who have lived experience with mental illness (Muralidharan et al., 2021). A **peer support specialist** is a nonclinical person who uses their experiences with mental illness and recovery to help others (George, 2022). These services can be conducted in an inpatient, outpatient, or group setting, as part of an interdisciplinary treatment team, in a one-to-one format, and in a virtual setting (Fortuna et al., 2022). The original definition for peer support was that it involved services offered to those with a mental health *condition*. Today, the more broadly accepted term is mental health *challenges*, as that covers a wider range of mental health issues, such as "trauma, extreme stress, feelings of loneliness…comorbidities including substance use disorders and chronic medical conditions, criminal justice, and child welfare" (p. 572).

Peer support began as informal self-help groups that offered mutual support. The current model has expanded to focus on the benefit that the client receives from the peer support specialist (Fortuna et al., 2022). It has also grown to be a model that can be paid for and reimbursed through Medicaid. A recent survey found that 25 percent of the time that paid peer specialists spent with their clients was in groups (Muralidharan et al., 2021).

LINK TO LEARNING

This video from Disability Rights Arkansas presents how one client took his experiences with chemical restraints and seclusion to become a peer supervisor (https://openstax.org/r/77chemrestraint) at the Arkansas State Hospital.

Functions of Peer Support Services

Deinstitutionalization, when people with mental illness were discharged from state hospitals and returned to the community, led to peer self-help groups springing up because the clients being discharged into the communities were mistrustful of health professionals and had difficulty even finding outpatient mental health services (Fortuna et al., 2022). These peer services have continued to grow and are available to help clients with psychological, comorbid diagnoses, and social functioning.

Peer support specialists can assist the individual with mental health challenges by helping them, for example, learn how to build better relationships with others. Not only does the development of social skills give the client hope, but it addresses the loneliness that is often part of severe mental illness. Having the support of a person who has gone through some of the same experiences has yielded positive outcomes, such as "decreases in hospitalizations, self-stigma, psychotic symptoms, depression, substance use and fewer feelings of social isolation" (Fortuna et al., 2022, p. 578). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps. They promote self-esteem, self-determination, understanding, coping skills, and resilience through mentoring and service coordination supports.

PSYCHOSOCIAL CONSIDERATIONS

Peer Counseling for College Students

The use of peer-led counseling has become a popular trend on college campuses. According to Mental Health America (2022), a study conducted by a team of people from the Born this Way Foundation, the Mary Christie Institute, and the MassINC Polling Group, one in five college students has used this type of counseling. Peer counseling is especially popular with Black, Transgender, and first-generation college students because they feel more comfortable talking with someone who has similar life experiences. Peer counselors provide support with issues, such as school stress, loneliness, anxiety, depression, and suicidal thoughts. Students who become peer counselors make this choice because they want to help others, want to pay it forward, or have lived experiences that help them relate to what other college students are experiencing.

Examples of Peer Support Services

There are many types of peer support services available as a resource for clients with mental health challenges. What follows is just a small sample of those resources.

- Alcoholics Anonymous (AA) and Narcotics Anonymous (NA): These 12-step programs are examples of peer-led support groups. The main purpose of AA and NA is to help people with substance (alcohol or narcotics) use problems live a sober lifestyle (Alcoholics Anonymous, 2023). The meetings are free to participants and held in a variety of settings, including churches, hospitals, and recovery treatment centers.
- H.E.A.R.T.S. Peer Support Center of Greater Nashua, New Hampshire: This is a free community center for adults living with mental challenges. It offers peer support, crisis respite of seven days/six nights, and step up/step down (H.E.A.R.T.S., n.d.). This support center was formed to help people with mental health challenges stay in the community as much as possible, with the support of others with lived experience.
- NAMI Connection Recovery Support Groups: These are free support groups for adults with mental health conditions. These sixty- to ninety-minute groups are held weekly or every other week and are led by a trained peer with lived experience (NAMI, n.d.).
- NAMI Family Support Groups: These are free, peer-led support groups for adult family members of those with a mental health condition (NAMI, n.d.). These groups are offered either weekly or every other week and usually run sixty to ninety minutes. The groups create a safe space to share experiences with one another. Groups are led by family members of those with mental health conditions.
- The National Association of Peer Supporters (N.A.P.S.): This organization was formed in 2004 by a group of peer specialists in Michigan (N.A.P.S., n.d.). It has since expanded to become an international organization. Its goal is to bring together peer support from around the world through conferences, community resources, and education.
- VA Health Services PACT (Patient-aligned Care Team): This began in 2010 with the purpose of bringing the health-care team together to work collaboratively toward addressing veterans' health-care goals and needs (U.S. Department of Veterans Affairs, n.d.). The inclusion of trained and certified peer specialists adds a more personal layer to the care provided.

Peer support services can be found across the United States in all different formats. Additionally, there are virtual options and apps for on-the-go support. A full list of available apps can be found at the Digital Peer Support (https://openstax.org/r/77DigitalSuppt) website.

LINK TO LEARNING

The TED talk "How your mental health lived experience can heal others" (https://openstax.org/r/77mentalhealth) covers the importance of peer support to the individual with mental illness.

6.4 Client Engagement

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe client engagement in mental health care
- Discuss how client engagement improves outcomes and promotes recovery
- Describe challenges to and strategies for improving client engagement

According to NAMI (2016), 70 percent of people who start mental health-care treatment drop out after the first or second visit. The initiation of a therapeutic relationship and the degree of support that the client feels during the first interaction with a mental health professional can determine the client's level of engagement in the recovery process.

Client Engagement in Mental Health Care

Compliance is the term frequently used when discussing people following their mental health treatment plan. Adherence is a more positive and appropriate term because it does not imply a power imbalance in the clinical provider-client relationship. Alliance is an even better term, focused on recovery and the team approach of client and clinician. Engagement is actually the best term in that it describes the client and the health-care team participating together in the services provided (NAMI, 2016). Client engagement includes having the client at the center of the treatment decision-making process and working in collaboration with the health-care team (Graffign & Barello, 2018). There are factors that can impede an individual's ability to engage with the health-care team. These include: "age, ethnicity, level of education, level of income, personal dispositions and beliefs about the patient's role in managing health care" (p. 1262), as well as the nature of the disease, the details of the therapeutic regimen, and culture. The health-care team should review all of these factors in an effort to have the most information as they collaborate with the client in planning their care.

Engagement Defined

NAMI's (2016) definition for **engagement** is the "strengths-based process through which individuals with mental health conditions form a healing connection with people that support their recovery and wellness within the context of family, culture and community" (p. 6). This definition shows belief in the person, beyond symptom management.

Theories Related to Client Engagement in Mental Health Nursing

Nurses base their care on theories that help guide their knowledge and practice. Nursing theories provide a framework for nurses to understand the how, what, and why of their professional role (Wayne, 2023). There are three types of nursing theories: grand theories, middle-range theories, and practice-level theories (Wayne, 2023). Grand theories provide a broad overview for a general nursing framework. Middle-range theories focus on a particular nursing phenomenon. Practice-level theories are those that are used to form interventions and outcome planning in specific client populations.

As described previously, Hildegard Peplau is a very important part of the process of client engagement. Her theory of interpersonal relations helps nurse to understand the importance of the nurse-client relationship. In psychiatric nursing, this is especially critical as that relationship is what guides practice. Imogene King also had a theory related to the development of the nurse-client relationship. Her theory of goal attainment was based on the nurse and client working together to set goals and the nurse being there to help the client attain those goals (Wayne, 2023). Her theory includes three interacting sections—personal system (perception and self-growth), interpersonal system (interaction and communication), and social system (organization, authority, and decision-making). And Prochaska's transtheoretical model, or stages of change model (see 5.1 Psychiatric-Mental Health Treatment Settings) is focused on the decision-making of the individual and how it occurs in a cyclical manner (LaMorte, 2022). All of these theories help a nurse to assess a client's ability and level of engagement in care.

McAllister et al. (2021) suggest that nurses and other practitioners use the five techniques of the principles of engagement model: "(1) understand the person and their illness; (2) facilitate growth; (3) therapeutic use of self; (4) choose the right approach and; (5) emotional versus restrictive containment" (p. 2). This model was derived from the behavior change theory with the idea that client and provider engagement is influenced by "capability, opportunity and motivation to engage" (Celestine, 2021, p. 2). Nurses need to be able to determine how capable the client is of making a change, if they have the opportunity in their environment to make the change, and whether or

not they have the motivation to perform the change. These components are important in helping a client to change their behavior, thus increasing their engagement.

Client Engagement Improves Mental Health Recovery

According to SAMHSA (n.d.-a), the definition of recovery is a "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (para 2). For recovery to work, the process for achieving it must be appropriate to the individual's age, culture, and stage of life. As discussed in 6.3 Peer Support, peer support is a key component of client engagement in the recovery process. The support and understanding that someone else has had the same experiences assists the individual to engage in treatment choices that are right for them, where they are. Collaboration between the client and the health-care professionals is considered a foundation of recovery because of the trust formed in this relationship as everyone works toward the same goals (Ness et al., 2014).

Reduction of Stigma

A stigma is a cluster of negative attitudes and beliefs that motivates the general public to fear, reject, avoid, and discriminate against people with mental health disorders (Substance Abuse and Mental Health Services Administration, n.d.-b). The general public, relatives of those with mental illness, and even health-care professionals can possess stigmatizing beliefs and attitudes (Zamorano et al., 2023).

Nurses and other health-care professionals need to look for ways they can help to reduce the stigma surrounding mental illness. Zamorano et al. (2023) identified that there are higher levels of stigma in general nursing and medical practice than in psychiatry, and that this resulted in poorer client outcomes, including higher mortality rates. Having contact with people who have mental health concerns actually is one of the best ways to lower stigma. Interactions with people with mental health diagnoses allow nurses to understand and have empathy for the person, seeing beyond the symptoms. It also provides evidence for recovery and hope for people with mental health conditions. Education and training are other effective tools.

Improved Client Outcomes

The World Health Organization (WHO) defines interprofessional collaborative practice as multiple health workers from different professional backgrounds working together with clients, families, caregivers, and communities to deliver the highest quality of care (World Health Organization, 2010). Effective teamwork and communication reduce medical errors, promote a safety culture, and improve client outcomes (AHRQ, 2015). The importance of effective interprofessional collaboration has become even more notable as nurses advocate to reduce health disparities related to social determinants of health (SDOH). In these efforts, nurses work with people from a variety of professions, such as physicians, social workers, educators, policymakers, attorneys, faith leaders, government employees, community advocates, and community members. Nursing students must be prepared to collaborate interprofessionally after graduation (National Academies of Sciences, Engineering, and Medicine, 2021).

Strategies for Improving Client Engagement

Early intervention is one strategy for increasing client engagement (Becker et al., 2017) because if clients are part of the entire process from the start, they will be more likely to understand the nuances of the options and be central to the decision-making process. Moreover, in a study completed by Becker et al. (2017), the most important client points identified that would lead to them having a higher level of engagement were twenty-four-hour crisis services, having a variety of treatment choices, involving family/support people, and availability of addiction services. One intervention that has been studied and found to increase client engagement in mental health care is protected engagement time (PET) (McAllister et al., 2021). PET encourages nurses and other health-care professionals to set aside a specific amount of time to spend engaging with their clients in inpatient units. Research by Ness et al. (2014) found that consumers want their health-care providers to take the time and effort to know them by showing their availability.

One example of a strategy used to keep young adults engaged in their mental health treatment is called "Just Do You." This intervention includes two 90-minute sessions with a licensed clinician and a peer recovery role model (NYU, 2022). The sessions are interactive with music, visual arts, psychoeducation, and peer mentorship. Its design empowers youth in making informed decisions about their mental well-being (Narendorf et al., 2020).

REACH Model

During the assessment phase of the nurse-client interaction, nurses must ask open-ended questions about the client's level of engagement. Do not make assumptions about why clients may seem disinterested in pursuing further treatment. Becker et al. (2021) suggest that providers often project the blame onto client factors instead of realizing the problems may be attributed to their own lack of performance in developing a therapeutic rapport. The REACH model is one that practitioners can use to assess the level of engagement in their clients. There are five parts to this treatment model: relationship, expectancy, attendance, clarity, and homework (Becker, 2021). A trusting therapeutic relationship should be the basis of interactions with clients. What is the expectancy of the interaction? Is the client attending their appointments? Does the nurse ask the client or caregiver to state their understanding/clarity of what is going to happen in treatment? Is the client completing homework or participating in the treatment sessions? Awareness of and meeting each of these steps helps determine the likelihood and strength of engagement.

Barriers to Client Engagement

Some barriers exist that reduce client engagement in their mental health recovery. A **barrier** is anything that blocks the ability of an individual to get the care that is appropriate for their needs. According to NAMI (2016), barriers include outdated policies and procedures, lack of care coordination, negative treatment of people in mental health crisis, lack of respect from the providers, high caseloads, and following very rigid rules when treating a person in crisis. Additional barriers include turnover of providers, lack of transportation, cost of care and treatment, scheduling difficulties, school, work, and implicit bias (Becker et al., 2021). These barriers can make it difficult for clients to access providers in a timely manner, or to be able to continue with a provider once a relationship has been established.

6.5 Trauma-Informed Care

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Apply and define trauma-informed care in child/adolescent populations
- Select nursing interventions incorporating trauma-informed concepts
- Evaluate psychiatric-mental health nursing trauma-informed outcomes of care

In **trauma-informed care** (TIC), health-care providers acknowledge all past and present parts of a person's life situation, including any trauma they have endured (Center for Health Care Strategies, 2021) in an effort to provide treatment that supports the client's autonomy, strength, and control over making health-care decisions. Trauma encompasses three areas: the event, how the individual experiences the event, and the way the event affects the individual's life into the future (Patterson & Troy, 2022). A person who has experienced trauma can develop mental health problems, such as anxiety, depression, and addiction.

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2021) has defined six core principles of TIC:

- Safety: Throughout the organization, clients and staff feel physically and psychologically safe.
- Trustworthiness and transparency: Decisions are made with transparency and with the goal of building and maintaining trust.
- Peer support: Individuals with shared experiences are integrated into the organization and viewed as integral to service delivery.
- Collaboration and mutuality: Power differences between staff and clients and among organizational staff are leveled to support shared decision-making.
- Empowerment voice and choice: Client and staff strengths are recognized, built on, and validated, including a belief in resilience and the ability to heal from trauma.
- Cultural, historical, and gender issues: Biases, stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography), and historical trauma are recognized and addressed.

Organizations focused on providing TIC should consider the addition of trained peer-support workers, individuals who have lived trauma experiences, to the treatment team in an effort to promote a higher level of trust and engagement from the client (Menschner & Maul, 2016). By adopting a trauma-informed care approach, health-care

providers and care settings can ensure that clients feel safe and cared for in a way that encompasses all of their needs.

Application of TIC to Child Development

According to Forkey et al. (2021), more than half of all U.S children under the age of eighteen have experienced some type of trauma in their lifetimes. The American Psychological Association (2023) describes **trauma** as an emotional reaction to a disturbing, distressing, and painful experience. While there is a wide range of events that can be considered traumatic or adverse childhood experiences (ACEs), medical events are high on the list. Keeping this in mind, it is important to point out that pediatric health-care providers are in the spotlight for being able to make a difference in creating safe, stable, and nurturing relationships with their clients.

While all children will experience some type of stress at some point in their lives, it has been found that toxic stress (adverse events that keep activating the stress response) can lead to lifelong impairments "in physical and mental health processes that embed developmental, neurologic, epigenetic, and immunologic changes" (Forkey et al., 2021, p. 3–4). This then leads to a higher risk for having major depressive disorder with a more severe clinical presentation, stress disorders, "feeling sick" due the immunological component, and poor cognitive function. Higher risk populations include children with families living in poverty, a history of child abuse, being an immigrant or refugee, being a victim of bullying, being LGBTQIA+, having obesity, being part of a military family, being born prematurely, and having chronic medical conditions (Forkey et al., 2021).

Toxic stress from ACEs can alter brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse. Children with three or more reported ACEs, compared with children with zero reported ACEs, had higher prevalence of one or more mental, emotional, or behavioral disorders—36.3 percent versus 11.0 percent (Centers for Disease Control and Prevention, 2022, February 24).

Preventing ACEs can help children thrive into adulthood by lowering their risk for chronic health problems and substance misuse, improving their education and employment potential, and stopping ACEs from being passed from one generation to the next (Centers for Disease Control and Prevention, 2022, February 24). Raising awareness about ACEs can help reduce stigma around seeking help for parenting challenges, substance misuse, depression, or suicidal thoughts. Community solutions focus on promoting safe, stable, nurturing relationships and environments where children live, learn, and play. In addition to raising awareness and participating in community solutions, nurses should recognize ACE risk factors and refer clients and their families for effective services and support.

Pediatricians, nurses, and community health-care providers can promote primary prevention through universal screening for such things as poverty, food insecurity, housing needs, language barriers, postpartum depression, and acculturation in immigrant populations (Garner & Yogman, 2021). Using primary prevention techniques is meant to mitigate the stress response by providing interventions to reduce adversity. An example would be that the pediatrician or pediatric nurse screens for food insecurity and finds that the parents do not have adequate funds to provide healthy foods. In response, the pediatrician will educate the parents about community resources that are available.

Pediatric health-care providers who use the relational approach, helping to strengthen relationships, should provide plenty of time to clients and their families, practice cultural competence, and provide interpreter services as needed. Pediatric health-care providers must also be able to recognize barriers to creating safe, stable, nurturing relationships. In some cases, health-care providers will need to work with other community stakeholders in order to educate and train families about how to build strong relationships that provide nurturing environments for child development.

Safety

Ultimately, practitioners must provide care in a manner that does not cause **re-traumatization**, feeling like the past trauma is reoccurring or that the person is in an unsafe situation as they were when the trauma occurred (Substance Abuse and Mental Health Services Administration, 2014). Creating a safe environment is a top priority for organizational client care practices.

There are two areas in which organizations can focus: physical environment and social-emotional environment (Menschner & Maul, 2016). The physical environment encompasses things such as providing good lighting in

parking areas, hallways, waiting rooms, and all treatment areas; reducing noise and distractions; separated seating in waiting areas; welcoming signage throughout the facility; visibility of security; monitoring who enters and exits the building; not allowing people to loiter at the entrance or in the parking lot; and giving clients clear access to exits from examination rooms. The social-emotional environment encompasses providing a welcoming and understanding care environment, giving plenty of notice if scheduling changes, handling conflict appropriately, and acknowledging the role of culturally competent care in reducing the trauma response.

Working with children and adolescents is very different from working with adults. Young people are often reluctant participants who have been brought for care they did not seek on their own. Additionally, their communication skills are limited based on their developmental stage. In addition to gathering information from the child, information must also be obtained from the parent or caregiver (Hilt & Nussbaum, 2016).

The first step to successful care is to create a therapeutic nurse-client relationship. A therapeutic alliance can typically form if the young person feels noticed, heard, and appreciated. It is often helpful to start the conversation with a relatively neutral question like, "Your mom said that you go to [name of school]. What is that school like?" School, friends, family, and favorite activities are low-stress conversation starters. For a very young child, a conversation starter could be a simple observation like what they are wearing. For example, "I see you are wearing blue tennis shoes; did you pick those out yourself?" (Hilt & Nussbaum, 2016).

For young people who seem reluctant to start talking, it may be helpful to describe something you saw that shows you have been paying attention to them. For example, "It looked as though it was hard for you to sit and do nothing while your dad and I were talking. Am I right about that?" (Hilt & Nussbaum, 2016).

When caring for adolescents, it is helpful to gather data from the parent or caregiver, and then ask to speak with the adolescent alone. Reinforce that the conversation is "conditionally confidential" (discussion will remain confidential unless laws require that the provider disclose it, as with, for example, suicidal ideation) and invite the adolescent to sit alone with you to talk. A one-on-one conversation with an adolescent typically creates a better, more honest therapeutic alliance (Hilt & Nussbaum, 2016).

A subtler strategy to build a therapeutic nurse relationship with children and adolescents is to shape how you speak so you are perceived as a responsive problem-solving partner rather than a judgmental authority figure. Building a therapeutic nurse-client relationship with a young person should lead to learning their true chief complaint because the chief complaint of an adolescent may be different from their parents' complaints (Hilt & Nussbaum, 2016).

Family interaction adds another layer of complexity to the care for children or adolescents who have experienced trauma. Family dynamics refers to the patterns of interactions among family members, their roles and relationships, and the various factors that shape their interactions. Because family members typically rely on each other for emotional, physical, and economic support, they are one of the primary sources of relationship security or stress. Secure and supportive family relationships provide love, advice, and care, whereas stressful family relationships may include frequent arguments, critical feedback, and unreasonable demands (Jabbari et al., 2023).

Interpersonal interactions among family members, as a component of safety, have lasting impacts and influence the development and well-being of children. Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. Conflict between parents and adolescents is associated with adolescent aggression, whereas mutuality (cohesion and warmth) is shown to be a protective factor against aggressive behavior (Jabbari et al., 2023). Effectively assessing and addressing a client's family dynamics and its role in a child's or adolescent's mental health disorder requires an interprofessional team of health professionals, including nurses, physicians, social workers, and therapists. Nurses are in a unique position to observe interaction patterns, assess family relationships, and attend to family concerns in clinical settings because they are in frequent contact with family members. Collaboration among interprofessional team members promotes family-centered care and provides clients and families with the necessary resources to develop and maintain healthy family dynamics (Jabbari et al., 2023).

LINK TO LEARNING

The CDC has created a short video that highlights ACEs (https://openstax.org/r/77ACEs) and things that can be done to help prevent them.

Strengths-Based Care and Client Empowerment

Care provided should be person-centered, meaning it focuses on the individual needs and desires of that client (Perrelle et al., 2022). Care should focus on a person's strengths rather than their deficits (UNC School of Medicine, Department of Psychiatry, 2023). Focusing on the client's strengths instead of just looking at what is "wrong" with them should be at the core of trauma-informed care. This approach includes applauding the client for small steps that they take toward their own treatment (Guevara et al., 2021). It helps to empower the client while giving them hope that they can accomplish bigger treatment goals.

LINK TO LEARNING

Watch this video to learn more about culturally competent trauma-informed care (https://openstax.org/r/77culturalcare) and apply the Indigenous Cultural Safety, Cultural Humility, and Anti-racism practice standard.

Nursing and Trauma-Informed Care

Individuals who have a history of trauma may become triggered by engagement with the health-care system. They may experience arousal and reactivity symptoms. As a result of the stimulation of the "fight, flight, or freeze" stress response, the parts of the brain involved in memory, planning, decision-making, and regulation are not engaged. This can impact the client's involvement with health-care services and affect their ability to adhere to treatment plans (Fleishman et al., 2019). Nurses must understand this potential impact of previous trauma and incorporate client-centered, trauma-informed care. Nurses can incorporate trauma-informed care by routinely implementing the following practices with all clients (Fleishman et al., 2019):

- Introduce yourself and your role in every client interaction: Clients might recognize you, but they might not remember your role. This can lead to confusion and misunderstanding. When a client understands who you are and your role in their care, they feel empowered to be actively engaged in their own care. They also feel less threatened because they know your name and why you are interacting with them. When one party is nameless, there can be an automatic power differential in the interaction.
- Use open and nonthreatening body positioning: Be aware of your body position when working with clients. Open body language conveys trust and a sense of value. Trauma survivors often feel powerless and trapped. Health-care situations can trigger past experiences of lack of control or feeling trapped. Using nonthreatening body positioning helps prevent the threat detection areas of the client's brain from taking over and helps clients stay regulated. A trauma-informed approach to body position includes attempting to have your body on the same level as the client, often sitting at or below the client. Additionally, it is important to think about where you and the client are positioned in the room in relation to the door or exit. Both nurse and client should have access to the exit.
- Provide anticipatory guidance: Verbalize what the client can expect during a visit or procedure or what paperwork will cover. Knowing what to expect can reassure clients even if it is something that may cause discomfort. Past trauma is often associated with unexpected and unpredictable events. Knowing what to expect reduces the opportunity for surprises and activation of the sympathetic nervous system symptoms. It also helps clients feel more empowered in the care planning process.
- Ask before touching: For many trauma survivors, inappropriate or unpleasant touch was part of a traumatic experience. Touch, even when appropriate and necessary for providing care, can trigger a "fight, flight, or freeze" response and bring up difficult feelings or memories. This may lead to the individual experiencing increased anxiety and activation of the stress response, resulting in disruptive behaviors and possible dissociation. Nurses are often required to touch clients, and sometimes this touch occurs in sensitive areas. Any touch can be interpreted as unwanted or threatening, so it is important to ask all clients permission to

touch them. Asking permission before you touch clients gives them a choice and empowers them to have control over their body and physical space. Be alert to nonverbal signs, such as eye tearing, flinching, shrinking away, or other body language indicating the person is feeling uncomfortable.
- Protect client privacy: Family members and other members of the medical team may be present when you care for a client. Clients may not feel empowered or safe in asking others to step out. It is crucial that nurses do not put the responsibility on the client to ask others to leave. It is the nurse's role to ask the client (in private) whom they would like to be present during care and ask others to leave the room.
- Provide clear and consistent messaging about services and roles: Care providers who are forthright and honest build trust with their clients. Dependability, reliability, and consistency are important when working with trauma survivors because previous trauma was often unexpected or unpredictable. Providing consistency from the nursing team regarding expectations and/or hospital rules can help clients feel secure and decrease opportunities for unmet expectations that might lead to triggering disruptive behavior. When clients are feeling triggered (i.e., their "fight, flight, or freeze" system is engaged), information processing and learning parts of the brain do not function optimally, and it is hard to remember new information. When providing education, information, or instructions, break information into small chunks and check for understanding. Offer to write important details down so they can accurately recall the information at a later time. Use clear language and "teach back" methods that empower clients with knowledge and understanding about their care.
- Practice universal precaution: Universal precaution means providing TIC to all clients regardless of a trauma history. We cannot know what each person has experienced in their lifetime. Approach every interaction with the understanding that trauma may have occurred and will influence the reaction and emotions of the client. Unless a trauma-focused intervention is needed to amend the impact of trauma, many TIC experts propose universal precaution rather than direct screening.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Nursing Sensitivity During Assessment

When assessing a client, the nurse must always be conscious of the fact that the interaction with the client may in itself be upsetting for the client and could lead to re-traumatization. Therefore, the organization has to be purposive in working with staff in providing trauma-informed care from the time when the client is initially assessed through their period of care and treatment.

This can be achieved by:

- building a workforce that is trauma informed
- communicating with staff about using a trauma-informed approach to the client
- training staff in trauma-specific treatments
- creating a physical and emotional environment that is safe for the client
- preventing secondary traumatic stress in staff
- involving clients in organizational planning
- including clients in the treatment process
- screening for trauma
- engaging referral sources and partner organizations (Center for Health Care Strategies, 2017)

Complexity and Diversity Considerations

A **complex trauma** occurs when an individual is exposed over time to multiple recurring traumatic events (Cenat, 2022). This type of trauma can be sexual, physical, or psychological in nature. Because these traumas reoccur, they have a major impact on an individual's physical and mental health, especially if they begin in childhood. Individuals who have experienced complex traumas are more likely to develop depression, PTSD, anxiety, sleep disorders, suicidal ideation and substance misuse, as well as physical conditions, such as diabetes, hypertension, obesity, and digestive disorders (Cenat, 2022).

Another aspect of complex trauma is racial trauma. This type of trauma is related to racial discrimination that results in threats, humiliation, prejudice, and verbal/physical attacks on an individual. "According to a national survey in the

United States, 50% to 70% of Black, Hispanic, and Asian people stated they had been victims of racial discrimination" (Cenat, 2022, para 3). This type of trauma occurs in neighborhoods, work environments, schools, and health-care environments. If an individual experiences racial trauma as a child or an adolescent, it has the potential to follow them into their adult life, impacting both mental and physical health.

Cognitive Behavioral Therapy

One type of therapy that has been found to help clients (adolescents and older) with PTSD is cognitive behavioral therapy. CBT, combined with exposure therapy, helps people face and control their fear by gradually exposing them to the trauma they experienced in a safe way. It uses imagining, writing, or visiting the place where the event happened to help reduce the intensity of trauma symptoms.

CBT follows several steps (Mayo Clinic, 2019). The first is that the individual identifies the problem areas in their life, and they focus on the emotions and beliefs attached to those problems. The provider helps the individual recognize the thinking patterns that may be contributing to the emotions and beliefs. The individual is encouraged to reshape those thinking patterns in order to reduce negativity associated with them. CBT is a short-term therapy that usually lasts between five to twenty sessions (Mayo, Clinic, 2019).

Outcomes of Care

The overall goal for anyone experiencing trauma-related anxiety is to reduce the frequency and intensity of the anxiety symptoms. SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) outcomes are individualized to the client's diagnosed conditions, situational factors, and current status. Planning outcomes in small, attainable steps can help a client gain a sense of control over their anxiety (SAMHSA, 2021). Examples of SMART outcomes include:

- The client's vital signs will return to baseline within one hour.
- The client will identify and verbalize symptoms of anxiety by the end of the shift.
- The client will verbalize three preferred stress management and coping strategies for controlling their anxiety by the end of week one.

In addition to keeping the client and others safe, priority nursing interventions for a client experiencing severe anxiety focus on the client's physical needs, such as fluids to prevent dehydration, blankets for warmth, and rest to prevent exhaustion.

Support During Recovery and Post-Traumatic Growth

It is very important to get support during the recovery process. Support can be found in a variety of ways/places, including friends, family, coworkers, mental health professionals, religious professionals, and support groups (Patterson & Troy, 2022). Support can be as simple as an individual asking a friend to sit with them when they are feeling anxious. For some people, taking the step to ask for help is the most difficult part of the process.

Positive changes in a person's outlook after experiencing a trauma is called **post-traumatic growth** (Mehraban et al., 2022). Trauma can cause a person to ruminate on the traumatic event. That rumination can cause the person to have an increase in stress. It can also make them take a look at how they react to things and become able to reframe their thoughts (Shin et al., 2023). One thing that has a significant effect on post-traumatic growth is a person's perception of social support from their friends and family (Mehraban et al., 2022). A person who has the support of others is more likely able to adapt to stressful situations and improve their coping mechanisms.

Summary

6.1 Nurse-Client Relationship

Therapeutic nurse-client relationships vary in depth, length, and focus. Some may be brief and others will be longer, depending upon the environment and the client's needs. Regardless of length or client need, there are four stages to Peplau's nurse-client relationship: pre-orientation, orientation, working, and termination. Each stage builds upon the one before it. These stages, as well as the boundaries placed and upheld by the nurse, help to build the rapport and trust between the client and the nurse.

6.2 Family Dynamics

Family dynamics have a large impact on a child's emotional development. Some things that can affect family dynamics are being a single-parent family, divorce, poverty, addition of a stepparent, and parental mental health. Using Bowen's family systems theory, mental health nurses can educate families on positive ways to interact and cope with mental illness in the family. Collaboration between the nurse, the client, the client's family, and the interdisciplinary team increases the chances of positive outcomes.

6.3 Peer Support

Peer support services are led by a person or persons who have lived experience with mental illness. These services can be conducted in an inpatient, outpatient, or group setting, as part of an interdisciplinary treatment team, in a one-to-one format, and in a virtual setting. Peer support specialists can assist the individual with mental illness by helping them learn how to build better relationships with others, grow their self-esteem, increase their self-determination, access resources, empower themselves, and feel less lonely in their illness.

6.4 Client Engagement

Engagement is a term that describes both the client and the health-care team participating in the services provided. For recovery to work, clients must be engaged, so treatment options must be client-centered and appropriate based on age, culture, and stage of life. Nurses should assess clients for their potential level of engagement by looking at their therapeutic relationship, expectancy, attendance, clarity, and homework.

6.5 Trauma-Informed Care

According to Forkey et al. (2021), more than half of all U.S children under the age of eighteen have experienced some type of trauma in their lifetimes. Toxic stress (adverse events that keep activating the stress response) can lead to lifelong impairments. Focusing on the client's strengths instead of just looking at what is "wrong" with them should be at the core of trauma-informed care. Involving the client in their own care provides them with a sense of autonomy and control over the treatment process. The first step to successful care is to create a safe, therapeutic nurse-client relationship. Effectively assessing and addressing a client's family dynamics and its role in a child's or adolescent's mental health disorder requires an interprofessional team of health professionals, including nurses, physicians, social workers, and therapists. One type of therapy that has been found to help clients with PTSD is cognitive behavioral therapy. Support is critical during the trauma recovery process in order to achieve optimal outcomes of care.

Key Terms

AIDET mnemonic for Acknowledge, Introduce, Duration, Explanation, and Thank You
barrier anything that blocks the ability of an individual to get the care that is appropriate for their needs
boundaries limits set as individuals that define levels of comfort when interacting with others
complex trauma when an individual is exposed over time to multiple recurring traumatic events
differentiation of self when an individual is able to feel autonomous and make decisions that help them function independently within the family group
engagement describes the client and the health-care team collaborating on treatment and participating together in the services provided
family dynamics way that the family members interact, communicate, and problem-solve
fusion family members reacting immediately, without hesitation, to another family member's demands
objective burden person's distraction, caused by the ill family member, to things such as finances, routines, and

other family members

peer support specialist nonclinical person who uses their experiences with mental illness and recovery to help others

post-traumatic growth positive changes in a person's outlook after experiencing a trauma

re-traumatization feeling like the past trauma is reoccurring or that the person is in an unsafe situation as they were when the trauma occurred

subjective burden feelings, such as stigma, fears about interactions, disturbing behaviors, feeling trapped, feeling resentful, and being anxious about the future

trauma emotional reaction to a terrible experience

trauma-informed care health-care providers acknowledge all past and present parts of a person's life situation, including any trauma they have endured, in an effort to provide treatment that supports the client's autonomy, strength, and control over health-care decisions

Assessments

Review Questions

1. A nurse working with a client for a long time has developed a strong rapport with the client. When the nurse gets home from work, she is looking at Facebook and notices a friend request from the client. The nurse really likes this client. How does the nurse show that she understands professional boundaries?
    a. She eagerly accepts the friend request and later thanks the client.
    b. She denies the friend request and then explains to the client why they cannot be friends on social media.
    c. She ignores the friend request and doesn't say anything to the client.
    d. She emails the client to say she cannot accept the friend request.

2. Building a rapport with a client is the foundation of the therapeutic relationship. Nurse Tom is caring for a thirty-two-year-old mother of three who just had her first anxiety attack. Following AIDET, what is one of the first things Tom could say to make her feel more relaxed after acknowledging her?
    a. "My name is Tom and I will be taking good care of you today."
    b. "Thank you for coming in today. Please let me know if there is anything you need."
    c. "I will be asking you a series of questions during my assessment. It should take about 20 minutes."
    d. "Next, I am going to tell you three words and I would like you to say them and then memorize them as I will ask you to recall them in a few minutes."

3. Nurse Alena is caring for a ten-year-old client, Lu, whose mother recently married a man with two teenage sons. Nurse Alena asks Lu if she is having any difficulties with the transition to a new family structure. In this family style, how might children feel?
    a. Children may initially feel conflicted.
    b. Children feel extra love.
    c. Children feel the effects of poverty.
    d. Children may be more likely to grow up quickly.

4. A nursing instructor is teaching a group of nursing students about the role that collaboration plays in the nurse-client relationship. One of the students raises their hand to ask a question. What is one question a student might ask that demonstrates understanding of the concept?
    a. "If I am talking with my client, it is a good idea to ask what they want from the treatment, right?"
    b. "When my client's family wants to share information with me, I should tell them that I can only listen to the client."
    c. "If my client doesn't want to try the intervention I am providing, I should tell them they have to do it."
    d. "So, to promote the most trust, I should tell my client that all questions should only be directed to me?"

5. An adult son whose mother is having an exacerbation of her mental health condition immediately does whatever his mother suggests, without asking questions or saying that he is busy with other things in his own life. According to Bowen's family systems theory, what is the son experiencing?

a. self-differentiation
b. autonomy
c. fusion
d. justification

6. A community mental health nurse is caring for a client who smokes a pack a day. The nurse is reviewing healthy living choices with the client and suggests that the client attend a smoking cessation group facilitated by a peer specialist who used to smoke. What is the best reason the nurse would make this referral?
a. The nurse is not a smoker and has no knowledge of what it is like to quit.
b. Peer specialists are people with lived experience who can offer support.
c. Smoking is unhealthy.
d. The nurse needs to fill openings within this group.

7. Tom has just been discharged from the inpatient behavioral health unit after a two-week stay for depression. Part of his follow-up care plan is to attend a peer support aftercare program at the local community mental health center. How might peer support help Tom? Select all that apply.

a. improves individuals' social skills
b. decreases the possibility of readmission
c. decreases loneliness
d. increases the possibility of self-stigma

8. A client in a recovery center is learning how to be more engaged in their treatment journey. How would the nurse describe the benefit of being engaged?
a. "Being engaged means that you can make all your treatment decisions."
b. "Being engaged means that you will never miss another therapy appointment."
c. "Being engaged means you will collaborate with your health-care team."
d. "Being engaged means that once you are done with treatment, you will be cured."

9. Recovery is a journey that will include ups and downs for the client. The nurse taking care of clients in recovery realizes that client engagement can improve client outcomes. As the nurse introduces topics during a sobriety discussion group, she prioritizes addressing what two important client factors to help increase engagement?
a. age and culture
b. income and education
c. wealth and occupation
d. diagnosis and insurance coverage

10. Nurse Mary is caring for six-year-old Sally who lives with her single mother. As Nurse Mary asks Sally what she likes to eat for breakfast, Sally states that she rarely eats breakfast because her mother cannot afford a lot of food. What is an important intervention for this child?
a. providing a snack while the child waits to see the doctor
b. educating the child's mother about community resources for obtaining free food
c. calling the Department of Children and Youth Services to report neglect
d. informing the doctor that this child may be undernourished

11. You work in a pediatric office and have just begun talking to an adolescent client who is being seen for increased anxiety related to recent physical abuse from a family member. What is the most important aspect of TIC that you can use in this situation?
a. Tell the client to undress and sit on the examination table.
b. Ask the client several questions in a row and wait for his response.
c. Explain to the client that you need to touch his arm to take his blood pressure.
d. Invite the client's mother into the room without asking his permission.

12. A student nurse is learning about TIC. What is an example of a statement that demonstrates the student's learning?
    a. "Trauma-informed care occurs only when the provider suspects that trauma has happened."
    b. "Trauma-informed care begins in the pediatric office."
    c. "Trauma-informed care involves primary prevention."
    d. "Trauma-informed care involves both the physical environment and social-emotional environment."

Check Your Understanding Questions

1. Think about the five types of personal boundaries that should not be crossed when taking care of a client. Give an example of two of those boundaries.
2. A nursing student is studying for an exam that includes Bowen's family systems theory. What are two important terms related to this theory, and how are they distinguished?
3. Describe areas where a peer support specialist may work or volunteer.
4. Identify and describe the five parts of the REACH model.
5. Describe three ways that you, as a nurse, can use TIC when caring for a client.

Reflection Questions

1. What does the orientation stage of the nurse-client relationship entail and how does it help to build trust and rapport between the nurse and client?
2. Discuss how family dynamics might interfere with a client assessment being performed by a psychiatric nurse making a monthly visit to a client in their home.
3. In caring for a client with substance use problems, what would be the role of the peer support person? What would you expect them to assist with and how would the client benefit?

What Should the Nurse Do?

1. Nurse Georgia, who works at a community mental health center, is talking with Susan, a sixteen-year-old female, who she has often seen in the waiting room when her mother has an appointment with the psychiatrist. Nurse Georgia notices how mature Susan is as she says that she is worried that she may get a parking ticket because the appointment is taking longer than expected. Nurse Georgia asks Susan how long she has been driving. Susan explains that she has had her driver's license for six months but learned how to drive when she was fourteen just so she could get her mom to the hospital if there was an emergency. She also provides transportation for her younger siblings who both play sports after school. Susan explains that her dad left when her mom got really sick four years ago, and they do not see him very often. She says that she often prepares meals for her siblings and helps with the household chores. She is a junior in high school who does well in school, but is beginning to feel the pressure of her classes and has noticed her grades slipping recently.
   Based on this conversation, what actions should Nurse Georgia take to ensure the safety and well-being of this client's children, most specifically Susan?

Competency-Based Assessments

1. As a nursing student, it is important to understand therapeutic communication and the effect it has on developing a rapport with the client. Draw a concept map to describe the benefits to the client of developing a rapport with the psychiatric nurse.
2. Perform an internet search of local peer support services, and make a list of ten places where you could refer a client for a mental health challenge.
3. Design a plan for a ten-minute nurse education group that includes strategies for improving client engagement.
4. Develop a five-minute public service announcement video that describes the community services available to

treat children who have experienced trauma.

References

AHRQ. (2015, July). *TeamSTEPPS: National implementation research/evidence base.* https://www.ahrq.gov/teamstepps/evidence-base/safety-culture-improvement.html

Alcoholics Anonymous (AA). (2023). *What is AA?* https://www.aa.org/what-is-aa

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

American Psychiatric Association. (2023). *Learn about the collaborative care model.* https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

American Psychological Association. (2023). *Trauma.* https://www.apa.org/topics/trauma

Becker, K. D., Wu, E. G., Hukill, A., Brandt, N., & Chorpita, B. F. (2021). How do mental health providers assess treatment engagement of youth and caregivers? *Journal of Child & Family Studies, 30*(10), 2527–2538. https://doi-org.easydb.angelo.edu/10.1007/s10826-021-02042-x

Becker, M., Cunningham, C., Christensen, B. K., Furimsky, I., Rimas, H., Wilson, F., Jeffs, L., Madsen, V., Bieling, P., Chen, Y., Mielko, S., & Zipursky, R. B. (2017). Investigating service features to sustain engagement in early intervention mental health services. *Early Intervention in Psychiatry, 13*, 241–250. https://doi.org/10.1111/eip.12470

Behere, A. P., Basnet, P., & Campbell, P. (2017). Effects of family structure on mental health of children: A preliminary study. *Indian Journal of Psychological Medicine, 39*(4), 457–463.

BetterHelp. (2023, July 12). *6 family types and their unique dynamics.* https://www.betterhelp.com/advice/family/there-are-6-different-family-types-and-each-one-has-a-unique-family-dynamic/

Blessing, M. (2023, March 16). *6 types of family structures common in 2023.* https://www.lovetoknow.com/life/relationships/types-family-structures

Brown, J. (1999). Bowen family systems theory and practice: Illustration and critique. *Australian and New Zealand Journal of Family Therapy, 20*(2), 94–103.

Celestine, N. (2021, August 14). What is behavior change in psychology? 5 models and theories. Positive Psychology.com. Retrieved from https://positivepsychology.com/behavior-change/

Cénat, J. M. (2022). Complex racial trauma: Evidence, theory, assessment, and treatment. *Perspectives on Psychological Science, 18*(3), 675–687. https://doi.org/10.1177/17456916221120428

Center for Health Care Strategies. (2017). *10 Key ingredients for trauma-informed care.* https://www.chcs.org/resource/10-key-ingredients-trauma-informed-care/

Center for Health Care Strategies. (2021). *What is trauma-informed care?* Retrieved from https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

Centers for Disease Control and Prevention. (2022, February 24). *Data and statistics on children's mental health.* https://www.cdc.gov/childrensmentalhealth/data.html

Deane, W. H., & Fain, J. A. (2016). Incorporating Peplau's theory of interpersonal relations to promote holistic communication between older adults and nursing students. *Journal of Holistic Nursing, 34*(1), 35–41.

Fleishman, J., Kamsky, H., & Sundborg, S. (2019, May 31). Trauma-informed nursing practice. OJIN: *The Online Journal of Issues in Nursing, 24*(2). https://doi.org/10.3912/OJIN.Vol24No02Man03

Forkey, H., Szilagyi, M., Kelly, E. T., & Dufee, J. (2021). Trauma-informed care. *Pediatrics 148*(2), e2021052580. https://doi.org/10.1542/peds.2021-052580

Fortuna, K. L., Solomon, P., & Rivera, J. (2022). An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Quarterly, 93*, 571–586. https://doi.org/10.1007/

s11126-022-09971-w

Fosco, G. M., & Grych, J. H. (2012). Capturing the family context of emotion regulation: A family systems model comparison approach, *Journal of Family Issues, 34*(4) 557–578.

Garner, A., & Yogman, M. (2021). Preventing childhood toxic stress: Partnering with families and communities to promote relational health. *Pediatrics, 148*(2): e2021052582. https://doi.org/10.1542/peds.2021-052582

George, K. (2022, June 7). Peer support specialists: Connections to mental health care. *National Conference of State Legislators*. https://www.ncsl.org/state-legislatures-news/details/peer-support-specialists-connections-to-mental-health-care

Graffigna, G., & Barello, S. (2018). Spotlight on the Patient Health Engagement model (PHE model): a psychosocial theory to understand people's meaningful engagement in their own health care. *Patient Preference and Adherence, 12*, 1261–1271. http://dx.doi.org/10.2147/PPA.S145646

Guevara, A. M. M., Johnson, S. L., Elam, K., Rivas, T., Berendzen, H., & Gal-Szabo, D. E. (2021). What does it mean to be trauma-informed? A multi-system perspective from practitioners serving the community. *Journal of Child & Family Studies*, *30*(11), 2860–2876. https://doi-org.easydb.angelo.edu/10.1007/s10826-021-02094-z

H.E.A.R.T.S. of Greater Nashua. (n.d.). *What we do*. https://www.heartspsa.org/

Hagerty, T. A., Samuels, W., Norcini-Pala, A., & Gigliotti, E. (2018). Peplau's theory of interpersonal relations: An alternate factor structure for patient experience data? *Nursing Science Quarterly, 30*(2), 160–167. https://dx.doi.org/10.1177%2F0894318417693286

Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. https://doi.org/10.1176/appi.books.9781615370511

Horgan, A., Donovan, M. O., Manning, F., Doody, R., Savage, E., Dorrity, C., O'Sullivan, H., Goodwin, J., Greaney, S., Bierine, P., Bjornsson, E., Bocking, J., Russell, S., MacGabhann, L., Jan van der Vaart, K., Allon, J., Granerud, A., Halls, E., Pulli, J., Vatula, A., Ellila, H., Lahti, M., & Happell, B. (2021), "Meet me where I am": Mental health service users' perspectives on the desirable qualities of a mental health nurse. *International Journal of Mental Health Nursing, 30*, 136–147. https://doi-org.easydb.angelo.edu/10.1111/inm.12768

Howard, R., Leyden, T., & Englesbe. (2022, March 16). How collaboration can drastically improve U.S. health care. *Harvard Business Review*. https://hbr.org/2022/03/how-collaboration-can-drastically-improve-u-s-health-care

Jabbari, B., Schoo, C., & Rouster, A. (2023, September 16). Family dynamics. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK560487/

LaMorte, W. (2022). The transtheoretical model (stages of change). Boston University School of Public Health. https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/behavioralchangetheories6.html

Lazarevic, V., Crovetto, F., Shapiro, A., & Nguyen, S. (2021). Family dynamics moderate the impact of discrimination on wellbeing for Latino young adults, *American Psychological Association, 27*(2), 214–226.

Mayntz, M. (2019, July 29). *Definition of a blended family: Understanding the dynamic*. https://www.lovetoknow.com/parenting/parenthood/definition-blended-family

Mayo Clinic. (2019). *Cognitive behavioral therapy*. https://www.mayoclinic.org/tests-procedures/cognitive-behavioral-therapy/about/pac-20384610

McAllister, S., Simpson, A., Tsianakas, V., Canham, N., De Meo, V., Stone, C., & Robert, G. (2021). Developing a theory-informed complex intervention to improve nurse–patient therapeutic engagement employing experience-based co-design and the behaviour change wheel: An acute mental health ward case study. *BMJ Open 2021*, *11*(047114). https://doi.org/10.1136/bmjopen-2020-047114

Mehraban, E. D., Farhangi, A., & Abolghasemi, S. (2022). The relationship between mental health and perceived social support with the post traumatic growth model through the mediating role of coping strategies in COVID-19 recovered patients. *Journal of Shahrekord University of Medical Sciences*, *24*(4), 182–188. https://doi-org.easydb.angelo.edu/10.34172/jsums.2022.30

Meleen, M. (2021, September 30). *Pros and cons of the nuclear family*. https://www.lovetoknow.com/life/relationships/advantages-disadvantages-nuclear-family

Menschner, C., & Maul, A. (2016). Issue brief: Key ingredients for successful trauma-informed care implementation. SAMHSA. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Mental Health America. (2022, January). Peer counseling in college mental health. https://drive.google.com/file/d/1bpb2KJdNAtLGoUJpHtZaS9JvovOHWI1w/view?pli=1

Mind Help. (2023) *Family dynamics*. https://mind.help/topic/family-dynamics/

Muralidharan, A., Peeples, A. D., Hack, S. M., Fortuna, K. L., Klingaman, E. A., Stahl, N. A., Phalen, P., Lucksted, A., & Goldberg, R. W. (2021). Peer and non-peer co-facilitation of a health and wellness intervention for adults with serious mental illness. *Psychiatric Quarterly, 92*, 431–442. https://doi.org/10.1007/s11126-020-09818-2

Narendorf, S. C., Glaude, M., Munson, M. R., Minott, K., & Young, B. (2022). Adaptation of a mental health treatment engagement intervention for older foster youth. *Child and Adolescent Social Work Journal, 38*, 27–41. https://doi.org/10.1007/s10560-020-00664-6

National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020–2030: Charting a path to achieve health equity.* The National Academies Press. https://doi.org/10.17226/25982

National Alliance on Mental Illness (NAMI). (2016). *Engagement. A new standard for mental health care.* https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care

National Alliance on Mental Illness (NAMI). (n.d.). *NAMI family support group*. https://www.nami.org/Support-Education/Support-Groups/NAMI-Family-Support-Group

National Association of Peer Supports (N.A.P.S.). (n.d.). *The history of N.A.P.S.* https://www.peersupportworks.org/about/our-mission-vision-and-history/

National Center for PTSD. (2023). *Understanding PTSD and PTSD treatment. 1–16*. https://www.ptsd.va.gov/publications/print/understandingptsd_booklet.pdf

National Council of State Boards of Nursing. (2018). *A nurse's guide to professional boundaries*. https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf

National Institute of Mental Health. (March 2023). *Mental health information*. https://www.nimh.nih.gov/health/statistics/mental-illness

Neelambari B. (2019, October 26). *Understanding family dynamics meaning and family types.* The MindFool. https://themindfool.com/understanding-family-dynamics-meaning-and-family-types/

Ness, O., Borg, M., Semb, R., & Karlsson, B. (2014). "Walking alongside:" Collaborative practices in mental health and substance use care. *International Journal of Mental Health Systems, 8*(55), 1–8. https://doi.org/10.1186/1752-4458-8-55

New York University (NYU). (2022, March 8). *NYU researchers see promise in orientation intervention designed to keep young adults connected to mental health treatment.* https://www.nyu.edu/about/news-publications/news/2022/march/n-206--2021-22--just-do-you-intervention.html

Pattemore, C. (2021, June 2). *10 ways to build and preserve better boundaries.* PsychCentral. https://psychcentral.com/lib/10-way-to-build-and-preserve-better-boundaries#types

Patterson, E., & Troy, B. (2022, September 19). *10 tips on how to heal from trauma*. Choosing Therapy, Inc. https://www.choosingtherapy.com/healing-from-trauma/

Pebley, A. R., & Rudkin L. L. (n.d.). *Grandparents caring for grandchildren. What do we know?* https://www.rand.org/pubs/research_briefs/RB5030.html

Perrelle, L., Klinge, N., Windsor, T., Low, L., Laver, K., & Cations, M. (2022). Characterizing trauma- informed aged

care: An appreciative inquiry approach. *International Journal of Geriatric Psychiatry,* p. 1–10. https://doi.org/10.1002/gps.5802

Prasko, J., Ociskova, M., Vanek, J., Burkauskas, J., Slepecky, M., Bite, I., Krone, I., Sollar, T., & Juskiene, A. (2022). Managing transference and countertransference in cognitive behavioral supervision: Theoretical framework and clinical application. *Psychology research and behavior management*, *15*, 2129–2155. https://doi.org/10.2147/PRBM.S369294

Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558–567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

Sanders, A., Szymanski, K., & Fiori, K. (2014). The family roles of siblings of people diagnosed with a mental disorder: Heroes and lost children. *International Journal of Psychology, 49*(4), 257–262. https://doi.org/10.1002/ijop.12020

Shin, Y., Nam, J. K., Lee, A., & Kim, Y. (2023). Latent profile analysis of post-traumatic stress and post-traumatic growth among firefighters. *European Journal of Psychotraumatology*, *14*(1). https://doi-org.easydb.angelo.edu/10.1080/20008066.2022.2159048

Substance Abuse and Mental Health Services Administration. (2014). Trauma-informed care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. *HHS Publication No. (SMA)* 13-4801. Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2021). *Trauma-informed care.* https://www.samhsa.gov/resource/dbhis/trauma-informed-care-webpage

Substance Abuse and Mental Health Services Administration. (2023, April 24). *Find support.* https://www.samhsa.gov/find-support/how-to-cope

Substance Abuse and Mental Health Services Administration. (n.d.-a). *Recovery and recovery support.* https://www.samhsa.gov/find-help/recovery

Substance Abuse and Mental Health Services Administration. (n.d.-b) *School materials for a mental health friendly classroom: training package.* https://www.prevention.org/Resources/2e2ba6ce-1e47-40ec-b49d-f7952b1f95a1/School%20Materials%20for%20a%20Mental%20Health%20Friendly%20Classroom.pdf

Tapias, E., Coromina, M., Grases, N., & Ochoa, S. (2021). Psychological treatments with children of parents with mental illness: A systematic review. *Child & Youth Care Forum, 50*, 1107–1130. https://doi.org/10.1007/s10566-021-09608-2

U.S. Department of Veterans Affairs. (n.d.). *Peer support specialists' unique contribution to veterans' health.* https://www.hsrd.research.va.gov/publications/vets_perspectives/1803_peer_support_specialists_contribution_to_veterans_health.cfm

UNC School of Medicine, Department of Psychiatry. (2023). *Strengths-based person-centered planning.* https://www.med.unc.edu/psych/cecmh/education-and-training/unc-institute-for-best-practices/individual-placement-and-support-ips/resources/strengths-based-person-centered-planning/

Wayne, G. (2023, January 12). *Nursing theories and theorists: The definitive guide for nurses.* https://nurseslabs.com/nursing-theories/

World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice.* https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice

Zamorano, S., Saéz-Alonso, M., Gonzaález-Sanguino, C., and Muñoz, M. (2023). Social stigma towards mental health problems in Spain: A systematic review. *Clīnica y Salud, 34*(1), 23–34. https://doi.org/10.5093/clysa2023a5

CHAPTER 7
Interprofessional Care

FIGURE 7.1 Group therapy can occur in a variety of settings. (credit: "Men Sitting Talking by River Outdoors" by JourneyPure Rehab/flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION Imagine building a house. One person would not do everything, right? It would take a team of professionals—architects, builders, electricians, plumbers—to ensure that each part is done correctly and efficiently. Mental health care is the same way. Each health-care professional involved in a client's care brings their own unique skills and knowledge to the team.

What is interprofessional care? It's when health-care professionals from different fields work together as a team to provide the best possible care for a client. This can include doctors, nurses, therapists, social workers, and many others. Interprofessional care is important because mental health challenges are complex and multifaceted and require a variety of perspectives and expertise to address. It isn't just about having a bunch of people in the same room. Interprofessional care requires effective communication, collaboration, and respect for each other's expertise. By working together, health-care professionals can provide a more holistic and comprehensive approach to mental health care, leading to more personalized care and better outcomes for their clients.

7.1 Collaboration and Coordination of Care

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe four evidenced-based case management service models
- Discuss the role of the nurse as case manager
- Explain how virtual health care is useful in coordination of care

Case management developed as a way to coordinate and manage the care of clients with increasingly complex health-care needs, and it has evolved over the decades as a response to an increasingly complex health-care system (American Case Management Association, n.d.-b). The practice brings together health-care workers from different disciplines to provide coordinated, comprehensive, and client-centered care. It aims to address the physical, psychological, social, and environmental needs of clients and improve the quality of care while simultaneously reducing health-care costs and improving outcomes.

Case Management Service Models

The collaborative and organized approach to client care that involves assessing, planning, coordinating, and monitoring services and resources to meet the needs of individuals or groups, often in complex or challenging situations is called **case management** (American Case Management Association, n.d.-a). It is a multifaceted process that provides health care, mental health support, and social assistance across multiple disciplines and settings.

Case management aims to promote health equity by prioritizing needs, ensuring access to appropriate resources and services, addressing social determinants of health, and facilitating safe care transitions. Professional case managers develop plans to help each client move smoothly through the health-care system. They are instrumental in navigating complex systems to achieve shared goals; advocating for their clients; and upholding their personal dignity, autonomy, and right to self-determination.

The practice of case management is not a new one; it encompasses a range of strategies and services that have evolved over decades. The case management system originally evolved in the early 1900s to assist institutionalized people with severe and persistent mental illness (Kersbergen, 1996). A deinstitutionalization movement occurred in the 1950s and 1960s, leading to significant changes in mental health-care delivery as clients were diverted into community-based services (Smith et al.,1993). This resulted in a major increase in psychiatric hospital discharges and an increasing demand for community assistance. People with major needs and requirements found it challenging to navigate complex, community-based care systems and obtain psychiatric services.

Through the years, case management began to encompass the medical needs of clients in addition to the psychiatric ones. The introduction of Medicaid and Medicare in 1965 created two vast new government health-care programs that needed navigating. Health care has only continued to grow more complex in the decades since, due to new laws, technology, and cultural changes. Different models of case management have evolved along with these changes in order to address the specific needs of different communities.

The Brokerage Case Management Model

In the brokerage case management model, a case manager acts as a "broker" or intermediary between a client and the various services and resources that the client needs (Substance Abuse and Mental Health Services of America [SAMHSA], 2021a). This case manager is typically a social worker or nurse. The case manager helps the client to identify their needs, access appropriate services, and coordinate care among multiple providers.

In this model, the case manager is responsible for assessing the client's needs, developing a care plan, identifying appropriate service providers, providing referrals, and coordinating care among the different providers. The case manager may also provide ongoing monitoring and support to ensure that the client's needs are being met and that services are delivered effectively. Interactions between the case manager and client tend to be relatively brief, so the brokerage model is better suited to clients with minimal needs.

The Clinical Case Management Model

In the clinical case management model, one of the client's clinicians, such as a nurse or therapist, serves as case manager (SAMHSA, 2021a). Because the case manager is also the client's clinician, they are more closely involved

with individual clients than in the brokerage model. With a closer knowledge of their clients' care plans, wants, and needs, clinical case managers are able to focus on executing the entire care plan for each client.

Clinical case managers can encourage clients to interact with their family, friends, and peers while also assisting them in overcoming social, emotional, and mental barriers to services. An additional benefit of this model includes increased one-on-one time between the case manager and client, which, when the case manager is a nurse, strengthens the nurse-client relationship and helps clients feel motivated and supported. Due to the intense, comprehensive nature of the relationship with each client, however, clinical case managers see fewer clients.

The Intensive Case Management Model

The intensive case management model (ICM) is intended for severely mentally ill clients. The purpose of the ICM is to provide high-quality, coordinated care to individuals with complex health and social needs in a short amount of time (Ponka et al., 2020). Individuals who may benefit from the ICM model are typically those with multiple chronic conditions, complex medical and social needs, and high utilization of health care. These individuals often require intensive and ongoing care coordination and support to manage their conditions effectively.

Under an intensive case management model, the client receives much more individual attention from the case manager than in other models, ideally resulting in a stronger relationship between the case manager and the client. This strong relationship, along with the higher degree of the case manager's involvement with the client, results in faster, more thorough results and gives clients with severe mental illness the resources and support they need to live independently, manage their symptoms, and improve their quality of life.

ICM does have its drawbacks. As with the clinical case management model, the ICM is resource-intensive. Each case manager carries a relatively small caseload. It is also time- and cost-consuming.

The Strengths-Based Case Management Model

The strengths-based case management model (SBCM) developed in response to concerns that case management models were focusing mainly on clients' limitations and impairments. In contrast, the SBCM model aims to build on the strengths and abilities of individuals with mental illness (SAMHSA, 2021a). By recognizing and utilizing each individual's unique strengths and skills, case managers promote recovery and improve outcomes more effectively.

The SBCM model is challenging because it requires a highly personalized plan for each client, with an eye on cultural sensitivity. With its focus on positivity, there is a possibility of overlooking serious issues or challenges. It has numerous benefits, however, including the following:

- Individualized and person-centered: The SBCM model is tailored to the needs and preferences of each client. The approach recognizes that every person has their own unique strengths and challenges and works to identify and build on those strengths to achieve recovery goals.
- Collaborative and empowering: In the SBCM model, the person with mental illness is an active participant in their own care. The approach empowers individuals to take an active role in their recovery process, working in partnership with their care team to set goals and make decisions about their treatment.
- Holistic and comprehensive: The SBCM model recognizes that mental health is influenced by a wide range of factors, including social, economic, and environmental ones. The approach addresses not only the individual's mental health symptoms but also their broader health and social needs.
- Strengths-focused and solution-oriented: The SBCM model focuses on identifying and building on the individual's strengths and abilities, rather than highlighting their weaknesses. The approach also emphasizes finding solutions to problems rather than simply identifying them.
- Outcome-driven and evidence-based: The SBCM model focuses on achieving measurable improvements to the individual's mental health and overall well-being. The approach is grounded in scientific research and has been proven to be effective at improving outcomes for individuals with mental illness.

Figure 7.2 shows the degree of closeness between the client and the case manager in each of the service models.

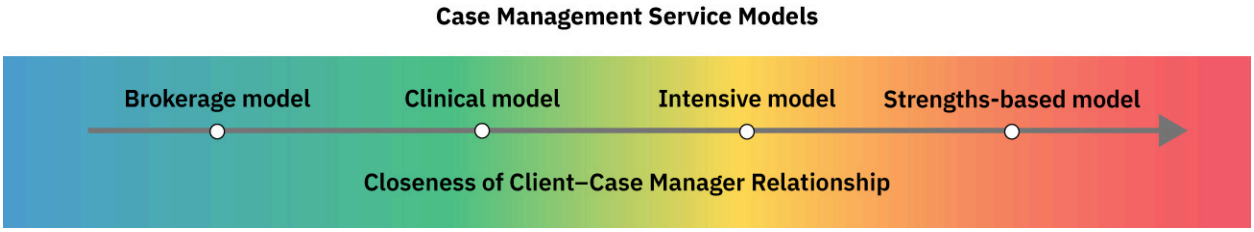


FIGURE 7.2 The case manager in the brokerage model is the least familiar with the client, whereas in the strengths-based model, the case manager is the closest to the client. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The Nurse's Role as a Case Manager

Case management is a practice used by and including many disciplines. Because the discipline of nursing focuses on the whole person, however, nursing is the predominant field practicing case management. Nurses play a critical role in care for clients, serving as both care providers and care coordinators. Consequently, the role of case manager often falls to the nurse.

Nurses often have extensive clinical experience and knowledge of the health-care system, which makes them well-suited for this role. Additionally, nurses are often involved in the care of clients from admission to discharge, which allows them to have a comprehensive understanding of the client's needs, preferences, and goals. Furthermore, nurses are trained to coordinate care across multiple disciplines and to communicate effectively with clients, families, and other health-care providers. This makes them valuable members of a care team and capable of overseeing the coordination of care for clients with complex mental and other health conditions.

Virtual Health and Care Coordination

Virtual health and care coordination are two interrelated concepts that are increasingly important in modern health care. Nursing plays a central role. Virtual health, or telehealth, is the application of electronic information and communication technologies to facilitate remote clinical health care, education for both clients and health-care professionals, and activities related to public health and health-care administration (SAMHSA, 2021b). Telehealth utilizes digital technologies, such as telemedicine, remote monitoring, and mobile health apps to deliver health-care services and information remotely. This can help to improve access to care, reduce costs, and provide more personalized and convenient care for clients. Telehealth can also enable better care coordination by allowing health-care providers to share information and collaborate more easily (Mechanic et al., 2022).

The organization and distribution of health-care services across different providers and settings in order to ensure that clients receive the right care at the right time is called **care coordination**. This can involve coordinating appointments, tests, and treatments, as well as managing transitions between different health-care settings, such as hospitals, primary care clinics, and home care. Care coordination is important for ensuring that clients receive high-quality care and avoid unnecessary complications and hospitalizations.

Telehealth and care coordination are closely linked because telehealth technologies truly facilitate care coordination. For example, virtual visits can enable primary care providers and specialists to consult with each other and coordinate care for clients with complex conditions. Remote monitoring technologies can also help to ensure that clients receive appropriate follow-up care after a hospitalization or procedure, and mobile health apps can provide clients with personalized information and support to help them manage their health and navigate the health-care system.

PSYCHOSOCIAL CONSIDERATIONS

Telehealth, Mental Health Needs, and COVID-19

During the COVID-19 pandemic that began in 2020, there was a rapid increase in the use of telemedicine, especially among clients with a mental health or substance misuse diagnosis. Many private insurance companies, along with Medicaid, increased their coverage for mental health and substance misuse–related telehealth services (Rae et al., 2022). People seeking assistance for mental health and substance use in particular have continued to utilize telehealth for their needs. Younger populations are more likely to use telehealth due to their comfort with

technology; rural populations are also more likely to use telehealth due to issues with physically accessing care. Telehealth represented less than 1 percent of outpatient care for both mental health and substance use prior to the pandemic; however, at its peak during the pandemic, telehealth represented 40 percent of mental health and substance use outpatient visits. As of March 2022, telehealth still represented 36 percent of these outpatient visits. Due to its convenience, cost-effectiveness, and popularity, telemedicine will continue to play a major part in delivering mental health care to a large percentage of the population in the future.

7.2 Recovery and Rehabilitative Needs

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss four dimensions of recovery
- Provide examples of rehabilitative treatments in PMH nursing
- Provide examples of rehabilitative resources in PMH nursing

Recovery and rehabilitation from mental illness are not isolated events, but a process. Depending on each client's severity of illness and level of functioning, they will need different types of assistance during their recovery. It is a complex journey requiring support from an interdisciplinary team, including nurses, physicians and advanced practice providers, social workers, therapists, behavioral health technicians, peer support, and more. It is up to the nurse to assess the client for their recovery needs and help them develop a plan of care likely to lead to the best outcomes.

Dimensions of Recovery

The process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential is called recovery (SAMHSA, n.d.). The concept of recovery is hopeful and empowering; it is based on the belief that people with mental health conditions have the potential to lead fulfilling lives, and that recovery is possible with the right support and resources. Recovery-oriented treatment approaches focus on the person's strengths and abilities, rather than on their limitations or diagnosis, and aim to empower individuals to take an active role in their own recovery process.

Recovery is a road that is unique to each individual, involving various factors, such as personal growth, resilience, and self-determination. It does not necessarily mean the absence of symptoms or the return to a previous state of functioning. Instead, it is a holistic and ongoing process that involves addressing physical, emotional, and social needs. Recovery can involve medication, therapy, peer support, and lifestyle changes. It is important to note that recovery is not a linear process, and often involves setbacks. With the right support, though, people with mental health conditions can learn to manage their symptoms and achieve their goals.

The Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.) identifies four major dimensions of recovery in a mental health context: health, home, purpose, and community. These dimensions are interconnected and can have a significant impact on an individual's overall well-being. By addressing each dimension, individuals can work toward achieving a balanced and fulfilling life in recovery. It's important to remember that mental health recovery is a unique journey for each individual, so these dimensions may look different for each person.

Health

This dimension emphasizes the importance of maintaining physical and mental health through activities, such as exercise, healthy eating, and self-care. It also involves managing any medical conditions or mental health symptoms through medication, therapy, and other interventions.

Home

This dimension refers to having a stable and safe living environment, whether that be through independent living, supported housing, or other arrangements that meet the individual's needs. It also includes having access to basic necessities, such as food, clothing, and transportation.

Purpose

This dimension involves finding meaning and purpose in life, such as through work, education, volunteering, or creative pursuits. It also means setting and achieving goals and having a sense of direction and motivation.

Community

This dimension emphasizes the importance of social connections and support systems, whether through family, friends, peers, or formal support networks. It entails building and maintaining positive relationships, as well as contributing to one's community through social engagement and advocacy.

Rehabilitative Treatments

The holistic and structured process aimed at assisting individuals with mental health challenges to regain or enhance their functional abilities, independence, and quality of life through therapeutic interventions and support is called **rehabilitation** (World Health Organization [WHO], 2023). Rehabilitation promotes recovery.

Rehabilitative treatments are designed to help individuals with mental health conditions manage their symptoms and improve their functioning. These treatments may include therapies, such as cognitive behavioral therapy, or medication management, as well as other types of interventions, such as group therapy or art therapy. The goal of rehabilitative treatments is to help individuals regain independence and improve their quality of life. In essence, rehabilitative treatments consist of the clinical interventions that are used to address mental health symptoms and take clients on the journey to recovery.

Medication Management

Effective medication management involves careful monitoring of the client's symptoms, side effects, and medication adherence, as well as adjustments to the medication regimen as needed. Clients attend regular check-ins with health-care providers and receive education and support to ensure they understand the importance of taking their medication as prescribed.

Psychological Support

Psychological support is an essential component of rehabilitative treatment for individuals with mental health conditions. This type of treatment is aimed at improving mental health and overall well-being by addressing the psychological and emotional needs of the client. Psychological support can be effective for a range of mental health conditions, including depression, anxiety, bipolar disorder, personality disorders, and post-traumatic stress disorder (PTSD). It can also be helpful for individuals who have experienced trauma, grief, or other life challenges that may be affecting their mental health.

Psychological support comes in various forms, including individual therapy, group therapy, and family therapy. It involves working with a mental health professional to explore thoughts, feelings, and behaviors that may be contributing to the individual's mental health challenges. The goal of psychological support is to help clients learn coping skills and strategies to manage symptoms, improve their mood and emotions, and enhance their quality of life.

Rehabilitative Resources

The various programs, services, and interventions that aim to support people with mental health conditions in their recovery and return to their previous level of functioning, or the highest level of function possible for them, are called **rehabilitative resources**. Mental health professionals, community organizations, or other health-care providers may offer these resources. Nurses should expect to collaborate with those in the health-care field as well as those in the community.

Housing

Stable and safe housing is essential for individuals with mental health diagnoses. A variety of programs aim to provide access to safe and affordable housing, which can help people maintain stability and support their recovery. Federal laws prohibit housing discrimination based on mental illness. Many states offer subsidized housing to low-income and vulnerable populations, such as the chronically mentally ill. These programs include supportive housing, which provides additional services, such as case management, counseling, and medication management. These subsidized and supportive housing programs are often limited by lack of funding and other resources, and can have complex application processes combined with long waits for housing resources.

Job Coaching

Job coaching programs can provide clients with mental health conditions with the training, skills, and support they need to find and maintain employment. This can include help with résumé writing, job searching, and interview

skills, as well as ongoing support to help individuals succeed in their jobs.

Educational Assistance

Education and training can provide individuals with mental health conditions with the skills they need to achieve their goals and improve their overall quality of life. These programs include access to training, vocational programs, and educational opportunities that can help people build new skills and increase their employability.

Social Support

Social support programs can provide individuals with mental health conditions access to peer support, counseling, and other services that can help them build social connections and develop a sense of community. This can include support groups, peer mentoring programs, and other resources that can help people connect with others who have had similar experiences.

CULTURAL CONTEXT

Cultural Barriers to Mental Health Treatment

Cultural factors can affect a client's support system. Existing stigma can cause clients of different ethnicities to be left to find mental health treatment and support alone. Cultural barriers also may result in confusion and misunderstanding between providers and clients. Lack of cultural understanding can lead to suboptimal care, such as misdiagnoses and/or unsuccessful treatment plans.

One example of a situation where lack of cultural knowledge can lead to misunderstandings involves the Hispanic/Latinx community. This population is 50 percent less likely to receive mental health treatment than the White non-Hispanic population (National Alliance on Mental Illness [NAMI], n.d.). One in four individuals in the Hispanic/Latinx community who reported having a mental health condition were categorized as having a serious mental illness, such as schizophrenia, bipolar disorder, or major depressive disorder.

NAMI Compartiendo Esperanza is an initiative founded by and for Hispanic/Latinx communities in order to help address disparities in mental health treatment. It offers resources for individuals, families, and youth on mental health treatment, breaking down mental health stigma among individuals and communities, and incorporating understanding in a culturally relevant and sensitive manner (NAMI, n.d.).

7.3 Discharge and Transfer

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the role of discharge planning in psychiatric-mental health nursing
- Describe the procedure for transfer of a client
- Describe the procedure for transfer of client health information

Discharge and transfer are crucial times in the treatment process for mental health clients. Both transfer and discharge require careful planning to ensure the client's safe transition to another level of care, another facility, or their home. Each client must receive appropriate education and follow-up services in order to maximize their likelihood of adhering to their plan and achieving positive outcomes.

Discharge Planning

Discharge planning is a critical aspect of psychiatric-mental health nursing. It involves developing a comprehensive and individualized plan for a client's safe and successful transition from an inpatient psychiatric facility or unit to their home or community or to another facility. The primary goal of discharge planning is to ensure that clients receive continuity of care and support after leaving the hospital, which can help to prevent relapse, reduce hospital readmissions, and promote overall recovery. This process involves collaboration between the client, nurse, family members, other health-care providers, and community resources to identify the client's needs, strengths, and resources, and develop a plan that addresses their unique needs. Some of the key components of discharge planning include assessing the client's mental health status, identifying potential risk factors, evaluating the client's support system, coordinating with community resources, and ensuring that the client has access to appropriate

medication, therapy, housing, and other resources.

Psychiatric-mental health nurses play a vital role in discharge planning by facilitating communication and coordination between clients, families, and health-care providers; advocating for the client's needs and preferences; and providing education and support to promote successful community reintegration. Effective discharge planning can help clients with mental health conditions achieve their treatment goals, improve their quality of life, and minimize the risk of relapse or hospital readmission.

When clients with mental health disorders are hospitalized, their admission status may affect their rights related to discharge. Voluntary and involuntary admission statuses will influence discharge considerations and legal constraints. There are four main types of discharge:

- Unconditional discharge: Unconditional discharge refers to unconditional termination of the legal client and institution relationship. Discharge may be ordered by a psychiatrist, advanced practice provider, or the court.
- Release against medical advice (AMA): Clients who were admitted voluntarily may elect to leave an institution against the advice of the health-care provider.
- Conditional release: Conditional release means the client is discharged from inpatient care but requires outpatient treatment for a specified period of time. If the client was involuntarily admitted, they can be readmitted based on the original commitment order if they don't participate in outpatient treatment. These laws vary by state and are not uniform throughout the country.
- Assisted outpatient treatment: Assisted outpatient treatment (AOT) means the conditional release is court-ordered. This treatment is tied to services and goods provided by social welfare agencies, such as disability benefits and housing. As with conditional releases, these laws are not available in every state.

Transfer of a Client

Like discharge, transferring a client with mental illness into or out of a mental health unit or between departments can be a complex and sensitive process that requires careful planning and consideration. Client safety is paramount when transferring clients with psychiatric needs. It is important to evaluate the client's condition, including their mental state, physical health, and potential risks, to determine the safest mode of transportation and level of supervision required during the transfer. The client may be transferring between medical units, from a medical unit to a behavioral health unit, from a medical or behavioral health unit to a corrections facility, or to an outside facility.

Transferring clients with mental illness requires adherence to legal and ethical guidelines. It is critical to respect clients' rights, and obtain all necessary consents and permissions. Additionally, client confidentiality and privacy are paramount throughout the transfer process. Whenever possible, take clients' preferences into account when transferring them. This includes considering the client's choice of destination, mode of transportation, and any other preferences they may have. Clients should receive appropriate care throughout the transfer process, and their treatment plan should be communicated to the receiving facility or care team. This ensures continuity of care and minimizes the risk of adverse events.

The staff involved in the transfer process must be trained and competent in handling clients with mental illness. Such staff may include nursing, nursing assistants, security, law enforcement, and others. They must be aware of the unique challenges and potential risks involved in the transfer of such clients and know how to respond to emergencies. Effective communication is essential when transferring clients with mental illness. Clear and concise communication between all parties involved in the transfer process, including the client, their family, health-care providers, and transportation staff, is crucial for a successful transfer.

Protective Placement

Guardianships and protective orders are legal methods in states for appointing an alternative decision-maker and identifying required services for individuals who are legally incompetent. Legally incompetent individuals may have developmental disabilities, chronic and serious mental illness, severe substance use disorders, or other conditions that limit their decision-making ability. A court can issue orders for a person who has a guardian to be placed protectively. The legal standard basically states that without the protective placement, the individual is so incapable of providing for their own care and well-being that it creates a substantial risk of serious harm to themselves or others. Protective services may include case management, in-home care, nursing services, adult day care, or inpatient treatment. Protective placements must be the least restrictive setting necessary to meet the individual's

needs and must be reviewed annually by the court.

EMTALA

The **Emergency Medical Treatment and Active Labor Act (EMTALA)** was passed by the U.S. Congress in 1986 and requires hospitals to provide emergency medical treatment to clients regardless of their ability to pay or their insurance status (Warby & Borger, 2023). The law also prohibits hospitals from transferring clients with emergency medical conditions to other facilities without stabilizing them first, or without the client's consent.

With regard to mental health client transfers, EMTALA requires that clients with emergency mental health conditions receive the same level of care as those with emergency medical conditions. This means that if a client is brought to the emergency department with a mental health crisis, the hospital is required to provide a medical screening examination to determine the nature and severity of the client's condition. If the examination determines that the client has an emergency mental health condition, the hospital is required to provide stabilizing treatment before transferring the client to another facility.

EMTALA also requires that any client transfer must be done in compliance with applicable state and federal laws, and that the receiving facility must be able to provide the appropriate level of care to meet the client's unique needs. This is particularly important for mental health clients who may require specialized care and treatment that may not be available at all hospitals. Overall, EMTALA helps ensure that mental health clients receive appropriate care and treatment, regardless of their ability to pay or their insurance status.

Transfer of Client Health Information

Transferring a psychiatric client's health information is a sensitive process that requires careful attention to privacy and confidentiality. There are several important considerations to keep in mind.

Privacy Concerns

The Health Insurance Portability and Accountability Act (HIPAA) outlines specific rules for handling and transferring protected health information (PHI). All parties involved in the transfer of psychiatric client health information must adhere to HIPAA regulations to protect the privacy and confidentiality of the client's information. It is crucial to ensure the security of the client's health information during the transfer process. This includes, for example, using encrypted electronic communication methods and secure faxes or mailing hard copies of the information in a sealed envelope.

Informed Consent

Before transferring any health information, the client must provide informed consent, which includes information about the purpose of the transfer, who will receive the information, and any potential risks or benefits. The client's mental state should be taken into account when transferring their health information. If they are in crisis or experiencing acute symptoms, the transfer may need to be delayed; otherwise, the legal guardian or proxy may give consent. A legal guardian will need to consent for the transfer of a minor's health information.

Communication

It is essential to ensure continuity of care for the client during and after the transfer process. This may include providing the receiving nurse with the client's treatment plan, medication list, and contact information for their treatment team. Effective communication is crucial during the transfer process to ensure that all parties involved understand the purpose of the transfer, who will receive the information, and any special considerations that need to be taken into account.

LINK TO LEARNING

The video *Family Attend Discharge* (https://openstax.org/r/77famdischarge) presents important information regarding the discharge process.

7.4 Continued Support

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe follow-up care for psychiatric-mental health clients after hospitalization
- Explain what mental health and psychosocial support (MHPSS) entails and provide examples

Follow-up care is critical for the successful recovery and overall mental health of clients who have been discharged from a hospital for psychiatric care. The transition from the hospital back to the community can be challenging for clients, and the nurse's role in follow-up care is crucial in providing continuity of care and helping clients navigate their recovery journey.

Follow-Up Care after Hospitalization

Mental health care for an acute episode does not stop when the client is discharged from the hospital; follow-up care after hospitalization is a critical component of ensuring successful recovery and reducing the risk of relapse. Often, providers recommend that the client follow up with a mental health provider within thirty days of discharge; ideally, they would follow up within seven days (Medicaid, n.d.).

As coordinator of care for the client, the nurse plays a vital role in assisting with this follow-up care, collaborating with other health-care professionals to provide comprehensive care for clients with mental health concerns. The nurse's central role in the interdisciplinary team entails addressing a client's overall health needs after discharge. Nurses can provide updates on the client's mental health status and collaborate with the team regarding any changes that should be made to the care plan to address the client's physical and mental health concerns. Nurses can also support clients in a number of other aspects of follow-up care.

Medication Management

One of the most important aspects of follow-up care for mental health clients is medication management. Nurses can help clients understand the importance of taking their medication as prescribed, monitor side effects, and work with the client's providers to make adjustments as necessary. Nurses can assess barriers to medication adherence, such as the ability to access pharmacies and locations to fill prescriptions and the high cost of some medications. The nurse can also ensure that the client's follow-up appointments with their providers are made prior to discharge in order to increase ease of access to medication.

Counseling and Psychotherapy

Counseling and psychotherapy are other crucial components of follow-up care for clients after discharge. Nurses can provide emotional support, monitor progress, and help clients identify and address any ongoing concerns or challenges related to their therapy. They can also help clients identify and manage triggers for their mental health concerns, such as stress or certain situations, and provide support in developing coping strategies to address these triggers. Nurses may also facilitate group therapy sessions or provide referrals to specialized therapists, depending on the client's individual needs. The nurse should ensure that the client's follow-up appointments with relevant providers are made prior to discharge.

Family and Friends

Family and friends serve a basic human need for companionship and support. The support of loved ones can help reduce the feelings of isolation and stigma that clients may experience and provide practical support, such as transportation to appointments or assistance with daily activities. Nurses can encourage family and friends to provide emotional support, offering encouragement, empathy, and listening without judgment. Additionally, loved ones can help identify triggers for the client's mental health concerns and assist in developing coping strategies to manage these triggers. Nurses can support the involvement of family and friends as support persons by including them in the discharge planning process, with the client's permission. Caring for a loved one with a mental illness can be stressful and overwhelming. Nurses provide support for family and friends as well as the client. Educating and promoting self-care and appropriate boundary-setting will help support persons avoid burnout when caring for someone with a mental illness.

Community Resources

Support groups and other community resources are also important aspects of follow-up care for mental health

clients. Nurses can provide clients with information about available support groups or community resources, such as vocational training programs or housing assistance programs, and help connect them to these resources as needed. This can help clients build a support network and improve their overall well-being. There are many organizations that facilitate support groups for families and clients. These support groups may be educational in nature, or peer-led, and help to foster a sense of community and caring for people in recovery and their support network.

REAL RN STORIES

Nurse: Ryan, BSN
Years in Practice: 7
Clinical Setting: Inpatient dual diagnosis unit
Geographic Location: Large midwestern city

Claire was admitted to our inpatient dual diagnosis unit for treatment for major depressive disorder and alcohol use disorder (AUD). She required medication-assisted detox for her AUD and was put on antidepressant medication to stabilize her depression. Part of our inpatient treatment for our dual diagnosis clients includes daily twelve-step group sessions, mostly Alcoholics Anonymous (AA), which has a long and established history and good reputation in the recovery community. Our clients are encouraged to continue with this peer-based treatment as outpatients. Continuing to learn from and socializing with peers who are clean and sober is not just helpful, but necessary for clients with a substance use disorder, including AUD. Because twelve-step programs like AA are commonly available in the community, we like to familiarize our clients with them while they're in the hospital, then encourage them to continue to participate after discharge so that they have the community support.

Claire told me that she had tried AA several times in the past but that she didn't feel like it worked for her. She had objections to certain aspects of the program, such as the emphasis on spirituality, and did not like being constantly told that she must label herself "an alcoholic." She didn't feel that continuing to attend AA after discharge would help her and admitted that she probably wouldn't go to any meetings due to her past experience.

As ongoing community support is crucial for clients with AUD, I decided to help research other peer support groups in the community. I found two abstinence-based peer support programs, Self-Management and Recovery Training (SMART Recovery) and Women for Sobriety (WFS), that are available in our area. I discussed these programs with Claire and together we identified meeting days and times that would work for her schedule. She was excited to find alternatives to AA that still offered the element of peer support. I was happy to find that abstinence-based peer support groups exist as alternatives to twelve-step programs. Having alternatives for clients like Claire helps encourage the recovery process as it continues long after discharge, and as the nurse, it is part of my job to ensure that our clients are set up for success after their hospitalization is done.

Personalized Safety Plan

When clients are discharged from a psychiatric hospital, they are still vulnerable to experiencing a relapse or other mental health crises. Knowing how to respond in such situations can help clients manage their symptoms and prevent a potential relapse. One of the best ways to provide clients with information on how to respond in a mental health crisis is by creating a **personalized safety plan** with them. This document outlines the client's specific warning signs, coping strategies, support systems, and emergency contacts. Safety planning can begin at admission and should be reviewed and updated at discharge. A personalized safety plan can help clients feel more in control of their mental health and provide them with a clear road map for what to do in case of an emergency. The nurse can also provide the client with information on crisis hotlines, mobile applications, online platforms, and other resources for crisis situations.

LINK TO LEARNING

Georgetown Behavioral Hospital provides five tips for a healthy transition (https://openstax.org/r/77afterpsychhos) following a stay in a psychiatric hospital.

Mental Health and Psychosocial Support (MHPSS)

The range of interventions and services that promote mental health, prevent and treat mental health disorders, and support individuals and communities affected by crises and disasters is called **mental health and psychosocial support (MHPSS)** (U.S. Agency for International Development, 2022). It is a critical component of overall health care and well-being.

MHPSS interventions can include individual and group counseling, psychoeducation, peer support programs, and community-based activities aimed at promoting resilience and improving mental health outcomes (Figure 7.3). The role of health-care professionals, particularly nurses, is critical in providing MHPSS services to individuals in need. Nurses play a key role in assessing and identifying mental health concerns and in providing emotional support, counseling, and education to people with mental health concerns. Nurses also administer medications, collaborate with other health-care professionals, advocate for the rights and needs of individuals with mental health challenges, and promote mental health awareness and education within their communities.

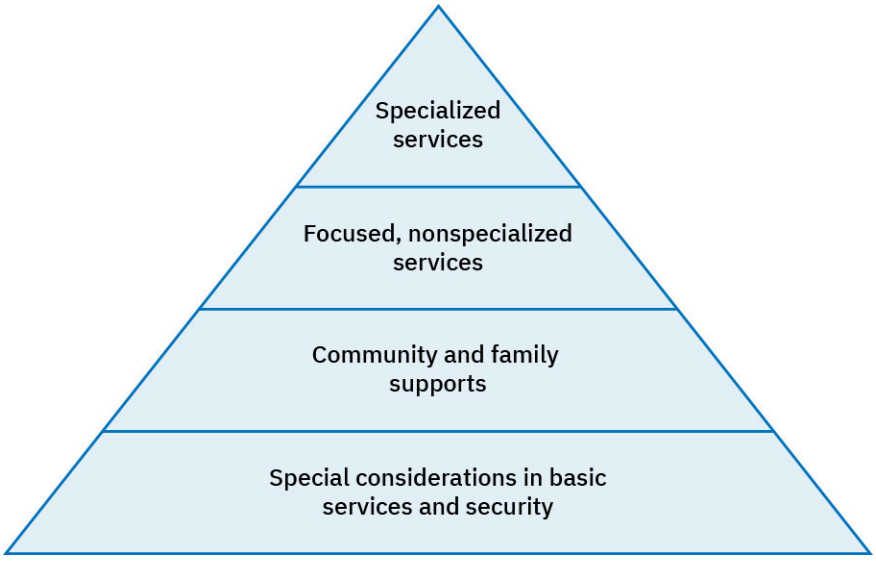


FIGURE 7.3 This pyramid represents MHPSS guidelines. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Mental health and psychosocial support (MHPSS) is used by organizations worldwide. Table 7.1 identifies groups that provide MHPSS services.

Organization	How It Utilizes MHPSS
United Nations Refugee Agency	Supports local health staff and communities and the management of mental, neurological, and substance use conditions in health facilities. Emphasizes issues particularly relevant to the refugee population, including community-based protection, child protection, and gender-based violence protection and response.
UNICEF	Uses the MHPSS model to support children, their families, and the community around them using a holistic approach. The guidelines are used to assist "UNICEF staff and partners support and promote safe, nurturing environments for children's recovery, psychosocial wellbeing and protection" (Snider, 2018, p. 8).

TABLE 7.1 MHPSS Organizations

Organization	How It Utilizes MHPSS
International Organization for Migration	IOM's MHPSS initiatives encompass a range of activities, such as conducting individual and group counseling sessions, and facilitating art, informal learning, and recreational activities for individuals impacted by crises. Additionally, IOM establishes temporary psychosocial support hubs in both camps and host communities, implements referral systems for severe mental disorders, aids in interpretation and mediation, strengthens national mental health systems, and engages in advocacy work while developing policy documents, guidelines, and manuals to enhance the effectiveness of MHPSS programming (International Organization for Migration, 2023).
International Medical Corps	The International Medical Corps provides worldwide disaster relief. It has put extra effort into expanding remote services for its clients using technology, such as internet, mobile units, hotlines, and radio and TV broadcasts. These remote services help bypass issues, such as travel-related dangers, restrictions, or expenses; physical disabilities limiting travel options; and stigma and other cultural barriers (International Medical Corps, 2023).

TABLE 7.1 MHPSS Organizations

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN: Client-Centered Care Competency

The QSEN client-centered care competency recognizes the client as the source of control and a full partner in providing compassionate and coordinated care that respects the client's preferences, values, and needs.

Care for PMH clients following discharge is an example of client-centered care. Follow-up care improves the transition of health care from inpatient to the home/community setting and facilitates continuity of care. The following is a sample KSA created for follow-up PMH care.

Knowledge	Skills	Attitude
Understands client needs and includes client preferences that enable client control and participation in care. Develops individualized plan of follow-up care.	Communicates with an interprofessional team to coordinate follow-up care. Communicates therapeutically with the client/significant others. Encourages client to actively participate in decision-making, which empowers the client.	Caring, supportive, knowledgeable, available, a good listener

7.5 Online Self-Help and Therapy

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the types of online self-help and therapy options and their benefits
- Describe the special considerations for online platforms for psychiatric-mental health nurses and clients
- Explain the role of the PMH nurse in promoting online self-help and therapy

Online therapy, also known as teletherapy, has skyrocketed in popularity in recent years as a viable option for mental health treatment. Increased convenience has driven its popularity, as has the COVID-19 pandemic, which accelerated the adoption of online therapy as mental health treatment. Ongoing changes to telehealth policy and reimbursement will address this increased need in the future. The explosion in popularity of online mental health treatment has brought with it special considerations and concerns that professionals must address when using these platforms to work with clients.

Understanding Online Self-Help and Therapy

Online self-help and therapy offer individuals new avenues to address their emotional well-being. These virtual platforms provide a range of resources, tools, and therapeutic interventions that empower users to navigate their mental health challenges from the comfort of their own spaces. Understanding the dynamics and potential benefits of online self-help and therapy is essential for anyone seeking accessible and flexible ways to enhance their mental health resilience and seek support.

Definition and Types

There are several types of online self-help and therapy available today. Here are some common ones:

- Online support groups are moderated groups where people can come together to discuss common challenges and provide emotional support to each other.
- Self-guided therapy uses online programs that provide structured activities and exercises to help individuals address specific mental health concerns, such as anxiety or depression.
- Therapy or counseling that happens remotely instead of in-person, called **teletherapy**, is performed by licensed therapists and mental health providers who offer treatment for various mental health concerns.
- Self-help technology, or **online self-help**, refers to the use of internet-based resources, such as websites, forums, mobile applications, and digital tools, to address personal mental health issues and challenges. These include self-help apps that offer a range of features, including CBT exercises, mindfulness techniques, and guided meditations.
- Online coaching: These are online sessions with life coaches or other professionals who provide guidance on how to achieve personal or professional goals (APA, 2023).

Benefits of Online Self-Help and Therapy

There are multiple advantages to online self-help and therapy that have helped make it such a popular choice in recent years. One of the biggest advantages is accessibility. Online self-help and therapy are extremely convenient and can be accessed from anywhere and at any time, thereby eliminating the barriers to traditional in-person therapy due to location or scheduling conflicts. As access to care is a challenge in health care in both rural and urban settings, online options are providing services to more individuals.

Another major benefit is affordability: online self-help and therapy can be less costly than traditional in-person therapy, increasing access for clients with lower incomes. Additionally, some self-help materials are available online for free, requiring only an internet connection. Local public libraries are often a great resource for people who need access to free internet.

There are other benefits. For example, some clients believe online therapy offers greater anonymity and privacy and prefer it to discussing their problems face-to-face with a therapist. Additionally, online self-help and therapy can provide access to a wide range of resources, including forums, videos, and articles, that can supplement therapy and help individuals develop coping mechanisms for their mental health issues.

Common Features of Platforms

In today's digital era, reputable online self-help and therapy platforms have emerged as valuable resources in the realm of mental health and well-being. These platforms offer individuals convenient access to a variety of therapeutic tools, resources, and guidance, providing a means to address their emotional challenges and personal growth at their own pace and on their own terms. Exploring the world of reputable online self-help and therapy platforms opens up opportunities for individuals to engage in evidence-based practices and connect with professional support, all within the comfort and privacy of their digital environments. Reputable online self-help and therapy platforms share several features in common:

- Accessibility: Online self-help and therapy platforms offer easy access to mental health resources for individuals who may not have access to traditional in-person therapy due to various reasons, such as financial constraints, distance, or scheduling conflicts. They also offer different communication channels, including messaging, videoconferencing, and phone calls, to enable individuals to connect with therapists and access support.
- Confidentiality: Most online self-help and therapy platforms ensure the privacy and confidentiality of user information and conversations with licensed therapists. Clients should be discouraged from using those that

do not.
- Personalization: These platforms often use algorithms or assessments to match individuals with therapists or self-help resources that are tailored to their specific needs and concerns.

Special Considerations for Online Platforms

Online mental health platforms have several challenges and limitations. To begin with, not everyone has access to reliable internet or possesses the equipment and technical skills required to use online mental health platforms. This can limit the reach and accessibility of these services, particularly for older adults and people in low-income or rural areas. When it comes to client care, online mental health platforms often have a standardized approach to mental health treatment that may not be tailored to the individual needs of the client. This lack of personalization may not be suitable for people with certain complex or severe mental health issues. If someone is expressing thoughts or demonstrating behaviors indicating that they may be a harm to themselves or others, they should be seen in person immediately.

Other limitations relate to communication. Online mental health platforms rely on video, written, or typed communication, which can be limiting in terms of conveying emotions, tone, and nonverbal cues when compared with in-person interactions. This can make it difficult for the therapist and client to build trust and rapport. Also, online mental health platforms may not provide the same level of continuity and follow-up care as traditional in-person therapy. Clients may discontinue treatment or switch to another provider without adequate transition planning, leading to discontinuity of care.

As online mental health platforms have increased in popularity, specific ethical considerations have evolved to protect clients and provide the safest, most secure experience. The top ethical concerns for online platforms are privacy and confidentiality (Stoll et al., 2020). The safeguarding of an individual's personal and sensitive health information from unauthorized access, use, or disclosure, ensuring confidentiality and maintaining the individual's control over their health data is called **privacy**. The ethical obligation to protect and keep private a client's personal health information, preventing its disclosure to unauthorized individuals or entities, is called **confidentiality**. Online platforms must ensure the privacy and confidentiality of their users. This includes providing highly secure transmission and storage of personal and sensitive information. Data breaches can occur, however, because of security or technology issues that are beyond the control of the clinician. Clients should read and understand terms and conditions clearly when entering personal information on websites and ensure the site uses appropriate privacy practices. The legal terms and conditions concerning privacy can be long and dense, making it challenging for clients to comprehend.

Another top ethical concern for online platforms is informed consent. Informed consent for online services is slightly different due to different ethical and legal concerns that may vary by service or by state. Users should be informed about the nature and limitations of online mental health services and have the right to give or withhold consent for treatment. It can be difficult, however, for the provider to assess if the client is mentally or legally able to give consent online without first having evaluated the client.

Online mental health providers must have appropriate training, credentials, and licensure to provide services. Therapeutic techniques for online therapy may differ from those that are used for in-person therapy and require special training. Online providers must adhere to the same ethical and professional standards as in-person providers, such as avoiding dual relationships, maintaining appropriate boundaries, and avoiding conflicts of interest. Additionally, online mental health platforms must ensure that their services meet accepted standards of quality of care. This includes regular assessment of client outcomes, ongoing professional development, and adherence to evidence-based practices.

The Role of Nursing Online

As telehealth has expanded, so has the role of the nurse in providing telehealth services for clients with mental health issues. The role of nursing in online self-help and therapy platforms can vary depending on the specific platform and the services it offers. Nevertheless, nurses play valuable roles in supporting individuals who are seeking help or therapy online.

One important role for nurses is providing health education and information to individuals who are using online self-help and therapy platforms. Nurses can use their expertise to help individuals better understand their health

conditions, medications, and treatment options. This can be particularly helpful for individuals who are seeking information about mental health conditions, such as depression or anxiety. Nurses can also provide education to clients on how to look for the best online platform to suit their own particular wants and needs.

Ethical and Legal Considerations

It is the nurse's duty to deliver ethical, evidence-based, high-quality, individualized care that is based on the Code of Ethics for Nurses (American Nurses Association [ANA], 2015). With online platforms, privacy is of the utmost concern. Nurses should have knowledge of the different telehealth technologies that are available—particularly which telehealth platforms are considered secure. For example, no Zoom platform may be entirely HIPAA secure, and FaceTime is not considered secure in most facilities. Organizations often have designated platforms that meet privacy, confidentiality, and security requirements.

Nurses must also be aware of legal and regulatory issues, that vary from state to state, and remain current on applicable laws. For example, licensure requirements for a nurse providing care to clients in other states may differ from requirements in the nurse's home state and are subject to change at any time (Telehealth.HHS.gov, 2023). The details of telehealth consents vary between states as well. If the nurse is providing care in multiple states, they must follow the Board of Nursing guidelines for each state. The telehealth nurse must also be trained in the proper delegation of non-RN tasks to unlicensed staff and licensed practical nurses (LPNs). For example, an LPN can schedule appointments and referrals to other providers.

Nursing Interventions

Even though telehealth leads to a much more independent, client-driven experience, it is still important to follow up and evaluate the effectiveness of the treatment plan. One important nursing intervention is to educate clients about the benefits and limitations of using online platforms. By discussing the various platforms available and their effectiveness, clients can make informed decisions about which platform would suit them best. Another important intervention is to assess whether clients are suitable candidates for online self-help and therapy platforms. Factors, such as the severity of a client's mental health condition, their access to technology, and their computer literacy levels, can determine if online self-help and therapy platforms are appropriate.

Nurses also help monitor clients' progress and adherence to their treatment plan, including their use of online self-help and therapy platforms. By tracking their usage, nurses can identify any issues or barriers to treatment, such as problems with the client navigating the website or difficulties understanding certain concepts. Nurses can also collaborate with other health-care professionals, such as psychologists or psychiatrists, to provide a holistic approach to the client's mental health. This collaboration can ensure that the client's treatment plan is comprehensive and that it addresses all aspects of their mental health.

Finally, nurses can provide emotional support to clients who are using online self-help and therapy platforms. They can discuss clients' concerns or fears about using these platforms, address any feelings of isolation or disconnection, and provide reassurance and encouragement.

REAL RN STORIES

Nurse: Lenore, RN
Years in Practice: 20
Clinical Setting: Community mental health center
Geographic Location: Midwest

In rural areas, there can be a lack of both psychiatrists and psychiatric nurses available to care for clients in the inpatient setting. One thing that hospitals do to combat this is use contract providers through a telehealth company to provide ER psych assessments and to cover daily rounds, especially on weekends. Even though this is provided within the hospital setting, it does require that the client feel comfortable talking to a doctor on a computer screen and the assistance of the RN to bring the clients to the examination room to support both the client and the doctor during the appointment. Sometimes, the clients are hesitant to talk to a doctor who is not physically present, so the nurse can provide the client with support during the intervention. The doctor can also ask the nurse questions after the client has left the room and this helps to facilitate continuity of care. This particular hospital gets admissions

from as far away as a five-hour drive. There is an online tracking system used throughout the state to find beds for clients in need. The availability of online providers to support the in-person psychiatrists is beneficial to the department and the clients.

During the pandemic, many therapy offices switched to online appointments with their licensed professional counselors. Clients became comfortable with the convenience and flexibility of this type of service. I am familiar with several local offices that continue to offer online appointments to meet the needs of their clients.

Online Approaches and Theories for Self-Help and Therapy

Several different approaches are well-suited for online self-help and therapy. Here are some of the most commonly utilized.

Cognitive Behavioral Therapy

One of the most widely used and well-known forms of psychotherapy (NAMI, 2017), CBT is based on the idea that thoughts, feelings, and behaviors are interconnected, and that by changing thoughts and behaviors, people can improve their emotional well-being. Research shows that CBT delivered through telehealth can be just as effective as traditional CBT, especially for anxiety and depression (NAMI, 2017).

Mentalization-Based Therapy

Used to treat personality disorders, such as borderline personality disorder, **mentalization-based therapy (MBT)** encourages clients to consider how their thoughts influence their behaviors and their relationships with others.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is a type of psychotherapy that aims to help individuals develop psychological flexibility and improve their overall well-being. The core principle of ACT is to accept difficult thoughts and feelings, rather than try to avoid or eliminate them, and to focus instead on taking action toward living a meaningful and fulfilling life.

Dialectical Behavioral Therapy

DBT is a form of therapy based in CBT that is meant for clients who have difficulty regulating and expressing their emotions. It was originally designed to assist clients with borderline personality disorder, but is now used to treat a variety of mental illnesses. DBT emphasizes the importance of balancing acceptance of reality and change of unhelpful behaviors in order to improve emotional regulation.

Online Support Groups

In **online support groups**, clients can find a community of individuals who share similar experiences and can offer advice and support to one another. Examples include groups for individuals with anxiety, depression, or addiction.

CLINICAL JUDGMENT MEASUREMENT MODEL

Generate Solutions: Helping Clients Find Options for Online Mental Health Assistance

Generating solutions involves the identification of the measures, interventions, or actions necessary to address a particular problem or issue. Part of this process involves differentiating between solutions that are appropriate, and those that are unnecessary, unneeded, or contraindicated (*Introduction to Health Assessment for the Nursing Professional—Part I*, 2021). When assisting clients with finding the most appropriate forms of online therapy, there are multiple factors that the nurse must take into account:

- Diagnosis: Consider the client's specific mental health diagnosis. Certain therapeutic modalities may be more effective for particular issues, such as CBT for anxiety or depression, or DBT for borderline personality disorder.
- Severity of symptoms: Some individuals may require more intensive support or specialized interventions than may be offered through online care. For example, online therapy would not be appropriate for a client experiencing active suicidal ideation or psychosis.
- Technological accessibility: Ensure that the client has access to the necessary computer technology and internet connection to participate in online therapy sessions. Determine if they are comfortable enough

with technology to effectively participate in regular online treatment.
- Privacy and security: Ensure that the proposed online therapy platform complies with relevant health-care regulations and provides secure, confidential communication channels to protect the client's sensitive information.
- Cost and insurance coverage: Discuss the cost of online therapy sessions and whether they are covered by the client's insurance. Consider the financial aspects and explore options that are affordable for the client.
- Client preference: Involve the client in the decision-making process. Understand their preferences regarding the format of therapy, communication style, and therapeutic goals. Some individuals may prefer traditional talk therapy, while others might benefit from approaches like mindfulness-based therapies or dialectical behavior therapy. Others may prefer therapists who specialize in certain culturally sensitive care, such as those who provide therapy specific to LGBTQIA+ individuals.

7.6 Challenges to Continuity of Care

LEARNING OBJECTIVES

By the end of this section, you will be able to:
- Describe the complexity of mental health care and providing continuity of care
- Explain how communication helps or hinders continuity of care for clients
- Describe the nurse's role in providing continuity of care

The nature of mental illness, as well as the variety of treatments offered, contribute to the complexity of mental health services. This makes quality care coordination a top priority when caring for clients with mental illness. Excellent communication is particularly important when dealing with multiple professions and agencies in order to prevent fragmentation of care. As always, the nurse plays an important role as care coordinator, removing boundaries and ensuring smooth communication.

Complexity of Mental Health Services

The complexity of mental health services can be seen in the types of services available, the variability of the conditions that mental health professionals treat, and the challenges in accessing these services. One of the nurse's central roles in providing mental health services is care coordination. As previously mentioned, care coordination refers to the organization and distribution of health-care services across different providers and settings in order to ensure that clients receive the right care at the right time.

One key factor contributing to the complexity of mental health services is the wide range of conditions that fall under the category of "mental illness." Mental health professionals may work with individuals experiencing depression, anxiety, bipolar disorder, schizophrenia, eating disorders, addiction, and many other conditions, each with its own set of symptoms and treatment approaches. Mental health services often involve a multidisciplinary team of professionals, including psychiatrists, psychologists, social workers, nurses, and other specialists, who must work together to provide the most effective care possible. This coordination can be challenging, particularly when working with clients who may have multiple health issues or complex treatment needs.

Another factor that contributes to the complexity of mental health services is the difficulty in accessing care. In most parts of the world, mental health services are not as widely available or affordable as they need to be, and individuals may face long wait times or significant physical or financial barriers to accessing care. Additionally, mental health services are often delivered in a variety of settings, including hospitals, clinics, community centers, schools, and even online. This diversity of settings means that mental health professionals must be adaptable and able to work effectively across different environments. The complexity of mental health services requires specialization of health-care services, communication, and continuity to ensure access and utilization of the care continuum.

Specialization of Health-Care Services

Specialization in mental health-care services refers to the process of focusing on specific areas of mental health practice to provide more targeted and effective care for individuals with specific mental health needs. There are many reasons why mental health-care services may become specialized, including the need to provide more individualized care, the desire to improve outcomes, and the recognition that different mental health conditions

require different types of care.

Specialization is commonly seen in the treatment of specific mental health disorders. For example, there are specialized treatment programs for individuals with eating disorders, substance use disorders, and post-traumatic stress disorder (PTSD). These programs often involve a multidisciplinary team of health-care providers who have extensive training and expertise in treating the specific disorder.

Another area where specialization is increasingly common is in the delivery of telehealth services. With the increasing use of technology in mental health care, providers can now offer specialized services to individuals in remote or underserved areas. Telehealth services can include online counseling, virtual therapy sessions, and remote monitoring of mental health symptoms.

Specialization in mental health-care services can also extend to specific populations, such as children, adolescents, or older adults. For example, providers may specialize in working with children and adolescents with autism spectrum disorder or older adults with dementia. Specializing in a particular population allows providers to better understand the unique mental health needs of that group and tailor their care accordingly.

Overall, the specialization of mental health-care services can lead to more targeted and effective care for individuals with specific mental health needs. By focusing on specific areas of practice, providers can gain the expertise needed to deliver high-quality care and improve outcomes for their clients. The specialization of care can lead to clients having to see multiple providers to address all of their needs. This can lead to fragmentation of communication and care across a continuum. The nurse has a role in care coordination, ensuring continuity throughout all health services.

Communication along the Continuum of Care

The **continuum of care** refers to the different stages of care that a person may receive, from prevention and early intervention to treatment and recovery. Effective communication is crucial for providing high-quality mental health care across all these stages. Communication involves the exchange of information, ideas, and emotions between mental health professionals, clients, their families, and other health-care providers involved in the client's care.

At the prevention and early intervention stage, communication involves educating the public about mental health, reducing the stigma associated with mental illness, and promoting awareness of the signs and symptoms of mental health problems. This may include providing educational materials, conducting community outreach programs, and promoting mental health screenings.

In the assessment and diagnosis stage, communication involves the exchange of information between the client and their health-care provider to gather information about the client's mental health history, symptoms, and other relevant information. Effective communication at this stage is essential for making an accurate diagnosis and developing a treatment plan that meets the client's needs.

In the treatment and recovery stage, communication involves ongoing collaboration between nurses, clients, other providers, and their families to meet treatment goals and monitor progress. This may involve regular check-ins with the client, medication management, therapy sessions, and support groups. Effective communication at this stage is essential for promoting client engagement, adherence to treatment, and positive outcomes.

Throughout the continuum of care, communication also involves coordination and collaboration between mental health professionals and other health-care providers involved in the client's care. This may include primary care physicians, social workers, case managers, and other specialists. Effective communication between these providers is essential for ensuring that clients receive comprehensive and coordinated care that addresses all of their mental health needs.

Communication Hindering or Helping Continuity of Care

What contributes to more comprehensive and better health care through the coordination and quality of health-care services a client receives over time from various health-care providers or care settings is **continuity of care**. When employed effectively, communication is the most effective tool for providing continuity of care for clients. When incomplete or inconsistent, communication can hinder continuity of care. Missing or incorrect information can have a particularly negative effect on client outcomes.

Communication Helping with Continuity of Care

The communication skills of nurses are essential for delivering effective care and promoting positive health outcomes. By communicating effectively with clients, nurses establish a trusting relationship, which is important for promoting client engagement and involvement in the care process. Nurses can also help to identify potential barriers to treatment, such as medication side effects or lack of social support, and work to address them. Furthermore, regular communication between nurses and clients can help ensure that clients receive consistent care, even when they see different providers at different times. Good nurse communication also involves collaboration and coordination with other health-care providers, such as physicians and mental health specialists, to ensure that clients receive appropriate and timely care. By working together, health-care providers can ensure that clients receive consistent and comprehensive care.

Communication Hindering Continuity of Care

Just as good communication can ensure continuity of care for clients, communication barriers can cause significant problems with continuity of care for mental health clients. When communication is inadequate, it may lead to a lack of information, or misinformation, being exchanged between health-care professionals. If nurse-client communication is poor, clients may struggle to communicate their symptoms or concerns, leading to missed diagnoses, inadequate treatment, or medication errors. Communication barriers can contribute to misunderstandings between clients and health-care providers, leading to a lack of trust, poor client engagement, and a lack of follow-up.

The Nurse's Role in Promoting Continuity of Care

The nurse's role in promoting continuity of care in mental health services is central. The nurse works as a liaison between different mental health-care providers and coordinates care to ensure that clients receive comprehensive and consistent care. The nurse can also maintain open and ongoing communication with the client and their family to ensure that everyone is informed about the client's progress and any changes to their care plan.

The nurse should advocate for clients by ensuring that their rights are respected, their needs are addressed, and their voices are heard in the decision-making process. Additionally, the nurse can provide clients with information about their mental health condition and treatment options, as well as coping strategies and resources to support their recovery. This increases compliance and follow-up.

Finally, the nurse can follow up with clients after they have received treatment to ensure that they are following their care plan, taking their medications, and attending any necessary appointments. If clients are not reaching goals, the nurse should evaluate why, and make any necessary changes to the client's nursing care plan.

Summary

7.1 Collaboration and Coordination of Care

The four evidence-based case management service models are the brokerage model, the intensive case management model, the clinical case management model, and the strengths-based case management model. They differ in who serves as the case manager and in the degree of closeness and interaction between the case manager and client. The nurse as case manager helps plan and coordinate care for each client to address their unique needs. Virtual health care may be used in coordination of care as a way to more easily access and exchange information and navigate the health-care system.

7.2 Recovery and Rehabilitative Needs

Recovery is a journey throughout which clients improve their mental and physical health and wellness, and try to live a fulfilling, self-directed life. The four dimensions of recovery are health, home, purpose, and community. Rehabilitative treatments, which support recovery, include medication management and therapy. Examples of rehabilitative resources, which also support recovery, include housing assistance, job coaching, educational assistance, and social support.

7.3 Discharge and Transfer

Discharge planning is a critical aspect of psychiatric-mental health nursing. It involves developing a comprehensive and individualized plan for a client's safe and successful transition from an inpatient psychiatric facility or unit to their home or community or to another facility. Transferring a client with mental illness into or out of a mental health unit or between departments can be a complex and sensitive process that requires careful planning and, above all, consideration for client safety. Transferring a psychiatric client's health information is also a sensitive process, requiring informed consent, effective communication, and careful attention to privacy and confidentiality concerns.

7.4 Continued Support

Discharge and transfer of clients are critical times in client care. Clients should follow up with a mental health provider within thirty (preferably seven) days of discharge. As coordinator of care for the client, the nurse plays a vital role in assisting with this follow-up care in collaboration with other health-care professionals. Mental health and psychosocial support (MHPSS) is a critical component of overall health care and well-being. It refers to a range of interventions and services that promote and treat mental health and health care after disasters and crises.

7.5 Online Self-Help and Therapy

Types of online therapy include online support groups, self-guided therapy, teletherapy, online self-help, and online coaching. Benefits include accessibility, cost, anonymity, and access to resources. There are other considerations involved in the decision to use online mental health applications, such as access, communication, quality, legal and licensing issues, and ethical concerns like privacy. Nurses play a valuable role in supporting individuals who are seeking help or therapy online, though the specific role can vary depending on the platform and the services it offers.

7.6 Challenges to Continuity of Care

The complexity of mental health involves the types of services available, the challenges in accessing these services, and the variability of the conditions that mental health professionals treat. Effective communication helps to ensure that clients continue to receive consistent, comprehensive care that is tailored to their individual needs and preferences even as they move between health-care providers. When communication is inadequate, it can contribute to misunderstandings between nurses and clients; it may also lead to a lack of information, or misinformation being exchanged between health-care professionals. The nurse's role in promoting continuity of care in mental health services is crucial. The nurse works as a liaison between different mental health-care providers and coordinates care to ensure that clients receive comprehensive and consistent care.

Key Terms

care coordination organization and distribution of health-care services across different providers and settings in order to ensure that clients receive the right care at the right time

case management collaborative and organized approach that involves assessing, planning, coordinating, and monitoring services and resources to meet the needs of individuals or groups, often in complex or challenging situations

confidentiality ethical obligation to protect and keep private a client's personal health information, preventing its disclosure to unauthorized individuals or entities

continuity of care coordination of care and consistent care at regular intervals by mental health specialists and the primary care provider

continuum of care different stages of care that a person may receive, from prevention and early intervention to treatment and recovery

Emergency Medical Treatment and Active Labor Act (EMTALA) federal law regulating how hospitals provide emergency medical treatment to clients; the law also prohibits hospitals from transferring clients with emergency medical conditions to other facilities without stabilizing them first, or without the client's consent

mental health and psychosocial support (MHPSS) range of interventions and services that promote mental health, prevent and treat mental health disorders, and support individuals and communities affected by crises and disasters

mentalization-based therapy (MBT) encourages clients to think about how their thoughts influence their behaviors and relationships with other people

online self-help use of internet-based resources, such as websites, forums, mobile applications, and digital tools, to address personal mental health issues and challenges

online support group online community of individuals who share similar experiences and can offer advice and support to one another

personalized safety plan document that outlines the client's specific warning signs, coping strategies, support systems, and emergency contacts

privacy safeguarding an individual's personal and sensitive health information from unauthorized access, use, or disclosure, ensuring confidentiality and maintaining the individual's control over their health data

rehabilitation holistic and structured process aimed at assisting individuals with mental health challenges in regaining or enhancing their functional abilities, independence, and quality of life

rehabilitative resources various programs, services, and interventions that aim to support people with mental health conditions in their recovery and return to their highest level of functioning

teletherapy therapy or counseling that happens remotely instead of in-person

Assessments

Review Questions

1. What model has the purpose of providing high-quality, coordinated care to individuals with complex health and social needs in a short amount of time?
    a. brokerage case management model
    b. intensive case management model
    c. clinical case management model
    d. strengths-based case management model

2. What is a benefit of telehealth that has helped to increase access to care for clients with a mental health diagnosis?
    a. Telehealth is easy for those with limited technological skills.
    b. Telehealth is more convenient for many rural clients.
    c. Telehealth is cheaper than in-person care.
    d. Telehealth enables clients to manage and change their own medical records remotely.

3. What is the purpose of the four dimensions of recovery?
    a. to help the client lead a balanced and fulfilling life in recovery
    b. to provide a strict framework that is generalizable to every client
    c. to provide specific recommendations to each client
    d. to prevent relapse

4. What is an example of a rehabilitative treatment?
   a. medication management
   b. vocational services
   c. job coaching
   d. housing assistance

5. What is the primary purpose of discharge planning?
   a. to ensure that clients receive continuity of care and support after leaving the hospital
   b. to ensure that clients never need to be readmitted to the hospital
   c. to ensure that clients have been given the correct diagnosis
   d. to ensure that clients are able to live independently

6. After discharge for hospitalization for a mental illness, how soon should clients follow up?
   a. six months
   b. one year
   c. thirty days
   d. three months

7. What is the purpose of mental health and psychosocial support (MHPSS)?
   a. to provide interventions and services that promote mental health, prevent and treat mental health disorders, and support individuals and communities
   b. to provide general community-wide social services for mental health
   c. to provide individualized services to telehealth clients for mental health needs
   d. to provide specialized care to diverse cultural groups needing support for mental health disorders

8. What is the term for the use of internet-based resources, such as websites, forums, mobile applications, and digital tools, to address personal mental health issues and challenges?
   a. an online support group
   b. online self-help
   c. teletherapy
   d. telemedicine

9. In what type of therapy might a nurse encourage the client to focus on accepting difficult thoughts and feelings rather than trying to avoid or eliminate them, and to focus instead on taking action?
   a. acceptance and commitment therapy
   b. cognitive behavioral therapy
   c. dialectical behavioral therapy
   d. mentalization-based therapy

10. What is one factor that can complicate efforts to provide continuity of care in mental health?
   a. confidentiality of client information
   b. ineffective communication along the continuum of care
   c. an excess of funding for community programs
   d. family involvement

11. What term represents the coordination and quality of health-care services a client receives over time from various health-care providers or care settings?
   a. transitions
   b. care coordination
   c. continuity of care
   d. case management

Check Your Understanding Questions

1. What characteristics make case manager an ideal role for a nurse?
2. Compare and contrast the brokerage case management model and the clinical case management model. What are the key differences, and in what client scenarios would each model be most effective?
3. Provide examples of how telehealth technologies, such as virtual visits and remote monitoring, can enhance care coordination and improve client outcomes.
4. What is the difference between recovery and rehabilitation?
5. What is the procedure for transferring clients with mental health needs from an emergency room? How does EMTALA affect the transfer process?
6. Describe three interventions offered by MHPSS.
7. Identify and discuss specific organizations, as mentioned in the chapter, that provide mental health and psychosocial support (MHPSS) services. How can these organizations contribute to the broader goal of promoting mental health and well-being on a global scale?
8. Describe the role of the PMH nurse in promoting online self-help and therapy. Discuss nursing interventions related to client education, assessing client suitability for online platforms, monitoring progress, and providing emotional support. Highlight the importance of collaboration with other health-care professionals and the role of the nurse in addressing potential barriers to online mental health treatment.

Reflection Questions

1. Describe what characteristics you should consider in order to determine the best case management model to use when working with a client.
2. Explain the significance of the "social connections and support systems" dimension in mental health recovery. How can building and maintaining positive relationships contribute to an individual's overall well-being?
3. Discuss the role of psychological support as a rehabilitative treatment in psychiatric and mental health nursing. How does psychological support contribute to improving mental health and overall well-being?
4. Explain the significance of stable and safe housing as a rehabilitative resource in psychiatric and mental health nursing. How does access to stable housing support the recovery of individuals with mental health diagnoses?
5. Discuss the primary goal of discharge planning in psychiatric-mental health nursing and its impact on client outcomes. How does effective discharge planning contribute to preventing relapse and promoting overall recovery?
6. Discuss the importance of adherence to HIPAA regulations in the transfer of psychiatric client health information. What considerations should be taken into account to protect the privacy and confidentiality of the client's information during the transfer process?
7. What kinds of organizations or agencies are likely to use MHPSS?
8. What are the differences between privacy and confidentiality?
9. What is the nurse's role in helping with care transitions for people with mental health needs?

What Should the Nurse Do?

Elena is a thirty-two-year-old female who presents to the psychiatric outpatient clinic for a follow-up appointment. Elena has a complex medical and psychiatric history, contributing to her ongoing mental health challenges. She was diagnosed with bipolar disorder at the age of twenty-one and has experienced multiple episodes of both mania and depression since then. Her medical history also includes hypothyroidism, for which she takes levothyroxine. Elena reports a recent exacerbation of depressive symptoms, including persistent low mood, fatigue, and feelings of

hopelessness. She mentions difficulty concentrating, changes in appetite with unintended weight loss, and disrupted sleep patterns. During the assessment, she reveals a history of trauma, which she acknowledges has played a role in her mental health struggles. Additionally, Elena has a past history of substance use disorder, particularly alcohol misuse, but reports being in recovery for the past three years. She attends regular Alcoholics Anonymous meetings as part of her ongoing support network.

1. Considering Elena's complex medical and psychiatric history, which case management model(s) might be most suitable for her situation, and why?
2. How might the strengths-based case management model (SBCM) be applied to Elena's case, considering her history of trauma and ongoing mental health challenges?
3. Discuss the role of nurses in case management and how it aligns with Elena's needs.
4. Explain how virtual health care would be helpful in the coordination of care for a client like Elena.
5. Considering the various models discussed, how might the drawbacks of the intensive case management model (ICM) impact its applicability to clients like Elena?

Sarah is a forty-two-year-old female who arrives at the psychiatric clinic seeking assistance for a complex set of mental health challenges. Sarah's history reveals a long-standing struggle with bipolar disorder, which was initially diagnosed during her early twenties. Over the years, she has encountered recurrent episodes of both manic and depressive states, impacting her overall quality of life. Recently, Sarah has been grappling with intensified symptoms of depression, including persistent feelings of hopelessness, a diminished interest in activities she once enjoyed, disrupted sleep patterns, and noticeable changes in her appetite leading to unintentional weight loss. In addition to her psychiatric history, Sarah reports a significant life event that triggered this latest episode—a recent divorce after a fifteen-year marriage. The stressors associated with this major life change have exacerbated her bipolar symptoms, leading her to seek professional help. Sarah's vital signs upon arrival indicate a heightened level of physiological distress, with an increased heart rate of 105 bpm and elevated blood pressure reading at 140/90 mmHg. During the initial assessment, she expresses difficulties in concentrating at work, which has led to a decline in her professional performance and an increasing sense of inadequacy. Sarah also admits to struggling with social isolation, finding it challenging to connect with friends and family members, exacerbating her feelings of loneliness.

6. How can the four dimensions of recovery (health, home, purpose, and community) be incorporated into Sarah's care plan, considering her current mental health challenges and recent major life event? Provide specific examples for each dimension.
7. Based on Sarah's symptoms and history, discuss two rehabilitative treatments that could be beneficial for her, explaining how each treatment addresses specific aspects of her mental health challenges.
8. Identify and discuss two rehabilitative resources that could support Sarah in her recovery journey. How might these resources address her specific needs, and what role can nurses play in facilitating access to these resources?

Rodney is a forty-five-year-old male who presents at the psychiatric inpatient unit following a referral from the emergency department due to an acute exacerbation of schizophrenia. Rodney appears disheveled, with poor eye contact and a guarded demeanor. He is oriented to person, place, and time, but is preoccupied with auditory hallucinations, reporting command hallucinations instructing him to harm himself. He exhibits paranoid delusions, expressing a belief that he is being followed and persecuted. Rodney has a complex psychiatric history, dating back to his early twenties when he was initially diagnosed with schizophrenia. He has a history of multiple psychiatric hospitalizations, often precipitated by medication noncompliance. His medical history includes hypertension, for which he takes amlodipine, a medication that has been well-tolerated. In the current episode, Rodney's family reports a recent decline in his overall functioning. They noticed increased social withdrawal, decreased self-care, and disrupted sleep patterns. He denies any recent substance use or changes in medications. His vital signs on admission are within normal limits, and initial laboratory workup, including a complete blood count and comprehensive metabolic panel, is unremarkable.

9. Discuss the key components of a comprehensive discharge plan for Rodney, considering his complex psychiatric history, recent exacerbation of schizophrenia, and the goal of preventing relapse. How can psychiatric-mental health nurses facilitate effective discharge planning?
10. Rodney may require a transfer between units or facilities. Outline the procedure for transferring a client with acute exacerbation of schizophrenia, emphasizing legal and ethical considerations, client safety, and staff training. How can nurses ensure a smooth and safe transfer process?

11. Rodney's health information needs to be transferred between health-care facilities while adhering to privacy regulations. Explain the considerations and steps involved in the transfer of psychiatric client health information. How can nurses ensure client confidentiality and informed consent during this process?

Emily is a thirty-two-year-old female who arrives at the psychiatric outpatient clinic for follow-up care after a recent hospitalization for a major depressive episode with suicidal ideation. Emily reports a two-month history of persistent low mood, anhedonia, feelings of hopelessness, and changes in sleep and appetite. During her hospitalization, she was started on a therapeutic dose of sertraline and engaged in individual and group therapy sessions. Emily has a history of recurrent depressive episodes since her early twenties, with intermittent periods of stability. She has a family history of mood disorders, and her past psychiatric treatments have included various antidepressant medications and psychotherapy. Emily's medical history is notable for hypothyroidism, managed with levothyroxine, and there is no reported history of substance use. During her initial assessment, Emily's vital signs are within normal limits, and she expresses a commitment to continue with her medication regimen and follow-up appointments.

12. Discuss the role of the nurse in facilitating follow-up care for Emily after her recent hospitalization for a major depressive episode. What specific actions can the nurse take to ensure a smooth transition from the hospital to the community, emphasizing medication management, counseling, and involving family and support groups?

13. Explain the concept of mental health and psychosocial support (MHPSS) and how it can be applied in the context of Emily's ongoing care. How can MHPSS interventions, such as counseling, psychoeducation, and community-based activities, contribute to Emily's overall mental health and recovery?

Aarav, a twenty-eight-year-old nonbinary individual, seeks care at the psychiatric outpatient clinic due to escalating symptoms of anxiety and panic attacks. Aarav provides a comprehensive account of the distress, linking it to heightened stress levels arising from work-related pressures and challenges in personal relationships. Aarav describes the anxiety as pervasive, affecting both day-to-day functioning and overall well-being. The reported symptoms encompass various dimensions. Aarav mentions experiencing disrupted sleep patterns, characterized by frequent awakenings and difficulty falling asleep due to intrusive thoughts. Racing thoughts dominate waking hours, contributing to a heightened sense of unease. Physical manifestations during panic attacks include palpitations, a racing heartbeat, and shortness of breath, further intensifying the emotional distress. A thorough exploration of Aarav's medical history reveals no significant health issues or prior engagements with mental health services. This marks Aarav's first encounter with seeking professional support for mental health concerns. The absence of a mental health treatment history prompts the nurse to gather additional information about Aarav's coping mechanisms, support systems, and any past strategies employed to manage stress. Aarav's social history unveils a dynamic and supportive network of friends and family. However, recent challenges in personal relationships have strained these support systems, contributing to Aarav's sense of isolation and exacerbating the anxiety symptoms.

14. Given Aarav's presentation of anxiety and panic attacks, discuss the potential benefits of specific online self-help and therapy options mentioned in the chapter, such as teletherapy, self-guided therapy, and online support groups. How can these options contribute to Aarav's mental health resilience, considering the reported symptoms and challenges in personal relationships?

15. Identify and discuss the special considerations and concerns that PMH nurses need to address when recommending or providing online self-help and therapy options to individuals like Aarav. How can nurses ensure the privacy, confidentiality, and ethical considerations of online mental health platforms while promoting client education and informed consent?

16. Explain the role of the PMH nurse in promoting online self-help and therapy for individuals like Aarav. How can nurses provide health education, assess the suitability of online platforms for specific clients, and monitor progress while maintaining ethical standards and addressing potential challenges associated with online mental health services?

Riya is a thirty-five-year-old female, who presents at the mental health clinic reporting persistent symptoms of depression and anxiety. Riya expresses a sense of overwhelming sadness, loss of interest in previously enjoyable activities, and pervasive worry about the future. The nurse notes vital signs, revealing an increased heart rate and slightly elevated blood pressure. Riya's medical history indicates a previous diagnosis of hypothyroidism, managed with medication. Her psychiatric history unveils that Riya has a history of recurrent depressive episodes, with the current episode marked by increased severity. Riya has engaged in therapy intermittently but has struggled to maintain consistent follow-ups due to various barriers, including financial constraints and limited accessibility to

mental health services. Communication challenges emerge as Riya highlights difficulties in expressing her emotions verbally, contributing to a sense of isolation.

17. Riya has a history of recurrent depressive episodes, and barriers, such as financial constraints and limited accessibility, hinder consistent therapy follow-ups. Discuss the complexity of providing continuity of care for Riya, considering her recurrent depressive episodes and the identified barriers. How can the nurse address these challenges to ensure Riya receives consistent and comprehensive mental health care?
18. Riya faces communication challenges, finding it difficult to express her emotions verbally, contributing to a sense of isolation. How does effective communication play a crucial role in promoting continuity of care for Riya? Discuss specific communication strategies the nurse can employ to overcome Riya's communication challenges and enhance the overall continuity of care.
19. Financial constraints and limited accessibility to mental health services are barriers for Riya. Explain the nurse's role in removing these barriers to promote continuity of care. What specific interventions can the nurse implement to address financial constraints and improve Riya's access to mental health services, ensuring a more seamless continuity of care?

Competency-Based Assessments

1. Compare and contrast the brokerage model and the clinical case management model. What are the key differences, and in what client scenarios would each model be most effective?
2. How does the comprehensive understanding of client needs, preferences, and goals, combined with effective communication skills, make nurses well-suited for the role of case managers?
3. Provide examples of how telehealth technologies, such as virtual visits and remote monitoring, can enhance care coordination and improve client outcomes.
4. Explain the significance of the community dimension in mental health recovery. How can building and maintaining positive relationships contribute to an individual's overall well-being?
5. Discuss the role of psychological support as a rehabilitative treatment in psychiatric-mental health nursing. How does psychological support contribute to improving mental health and overall well-being?
6. Explain the significance of stable and safe housing as a rehabilitative resource in psychiatric and mental health nursing. How does access to stable housing support the recovery of individuals with mental health diagnoses?
7. Discuss the primary goal of discharge planning in psychiatric-mental health nursing and its impact on client outcomes. How does effective discharge planning contribute to preventing relapse and promoting overall recovery?
8. Explain the considerations and legal aspects involved in the transfer of a psychiatric client between facilities. How can health-care providers ensure client safety and adherence to ethical guidelines during the transfer process?
9. Discuss the importance of adherence to HIPAA regulations in the transfer of psychiatric client health information. What considerations should be taken into account to protect the privacy and confidentiality of the client's information during the transfer process?
10. Outline the key components of follow-up care for mental health clients after hospitalization. How does the nurse's role in medication management and counseling contribute to the successful recovery of clients? Create a plan to include family and friends in the follow-up care process.
11. Define Mental Health and Psychosocial Support (MHPSS) and explain its significance in promoting mental health and treating mental health disorders. How do health-care professionals, particularly nurses, contribute to MHPSS interventions, and what are the key components of MHPSS services?
12. Identify organizations that utilize Mental Health and Psychosocial Support (MHPSS) services. How do these organizations implement MHPSS models to address mental health needs in specific populations or crisis situations?

13. Explain the various types of online self-help and therapy options available, highlighting their benefits. Provide examples of actual online self-help and therapy options and their potential advantages for individuals seeking mental health support.
14. Assess three online platforms using the special considerations and challenges associated with online mental health platforms for PMH nurses and clients. Consider ethical concerns, privacy and confidentiality issues, and the role of PMH nurses in ensuring secure and effective online therapy.
15. Describe the role of the PMH nurse in promoting online self-help and therapy. Discuss nursing interventions related to client education, assessing client suitability for online platforms, monitoring progress, and providing emotional support. Highlight the importance of collaboration with other health-care professionals and the role of the nurse in addressing potential barriers to online mental health treatment.
16. Explain the factors contributing to the complexity of providing continuity of care in mental health. Discuss the challenges related to the wide range of mental health conditions, the multidisciplinary nature of mental health services, and the difficulties in accessing care. Highlight the nurse's role as a care coordinator in addressing these complexities and ensuring clients receive appropriate care across different providers and settings.
17. Elaborate on the role of communication in promoting or hindering continuity of care for mental health clients. Discuss the stages of the care continuum, emphasizing how effective communication contributes to prevention, early intervention, assessment, diagnosis, treatment, and recovery. Provide examples of how good nurse-client communication fosters client engagement in each stage.
18. Outline the nurse's role in removing barriers to continuity of care in mental health. Discuss how nurses act as advocates for clients, ensuring their rights are respected and their voices are heard. Emphasize the nurse's role in follow-up care, evaluating client progress, and making necessary adjustments to the care plan.

References

Agency for Healthcare Research and Quality. (n.d.). *Care coordination*. Retrieved April 23, 2023, from https://www.ahrq.gov/ncepcr/care/coordination.html

American Case Management Association. (n.d.-a). *About ACMA*. Retrieved April 23, 2023, from https://www.acmaweb.org/section.aspx?sID=4

American Case Management Association. (n.d.-b). *Scope of Services*. Retrieved April 22, 2023, from https://www.acmaweb.org/section.aspx?sID=136

American Institutes for Research. (2011, March). *Step by step: A comprehensive approach to case management*. Retrieved April 22, 2023, from https://www.air.org/sites/default/files/March%202011%20-%20%20by%20Step%20-%20A%20Comprehensive%20Approach%20to%20Case%20Management.pdf

American Nurses Association (ANA). (2015). *Code of ethics for nurses with interpretive statements.* Retrieved April 22, 2023, from https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

American Psychological Association. (2023, March 21). *What you need to know before choosing online therapy*. Retrieved April 22, 2023, from https://www.apa.org/topics/telehealth/online-therapy

Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *Schizophrenia Bulletin*, *43*(4), 698–700. https://doi.org/10.1093/schbul/sbx061

HealthIT.gov. (2019, October 17). *What is telehealth? How is telehealth different from telemedicine?* Retrieved April 19, 2023, from https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine

International Medical Corps. (2023, July 26). *Guidelines for remote MHPSS programming in Humanitarian Settings*. https://internationalmedicalcorps.org/remotemhpssguidelines/

International Organization for Migration. (2023). *Mental health and psychosocial support in crisis*. https://www.iom.int/mental-health-and-psychosocial-support-crisis

Introduction to Health Assessment for the Nursing Professional—Part I (2021, December). https://pressbooks.library.torontomu.ca/assessmentnursing/

Kersbergen, A. L. (1996). Case management: A rich history of coordinating care to control costs. *Nursing Outlook*, *44*(4), 169–172. https://doi.org/10.1016/s0029-6554(96)80037-6

Mechanic, O. J., Persaud, Y., & Kimball, A. B. (2022, September 12). *Telehealth Systems*. National Center for Biotechnology Information. Retrieved April 22, 2023, from https://pubmed.ncbi.nlm.nih.gov/29083614/

Medicaid. (n.d.). *Follow-up after hospitalization for mental illness: Age 18 and older*. Retrieved April 25, 2023, from https://www.medicaid.gov/state-overviews/scorecard/follow-up-after-hospitalization-mental-illness-age-18/index.html

National Alliance on Mental Illness. (2017, December). *Anxiety disorders*. Retrieved April 23, 2023, from https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Anxiety-Disorders/Treatment

National Alliance on Mental Illness. (n.d.). *NAMI Compartiendo Esperanza: Mental wellness in Hispanic/Latin American community*. https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Compartiendo-Esperanza-Mental-Wellness-in-Hispanic-Latin-American-Community

Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A. H., Arya, N., Hannigan, T., Thavorn, K., Andermann, A., Tugwell, P., & Pottie, K. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PLOS ONE*, *15*(4). https://doi.org/10.1371/journal.pone.0230896

Rae, M., Lo, J., Miller, B. F., Panchal, N., Cox, C., & Amin, K. (2022, March 22). *Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic*. Kaiser Family Foundation. Retrieved April 23, 2023, from https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

Rutledge, C., & Gustin, T. (2021). Preparing nurses for roles in telehealth: Now is the time! *OJIN: The Online Journal of Issues in Nursing*, *26*(1). https://doi.org/10.3912/ojin.vol26no01man03

Smith, G. B., Schwebel, A. I., Dunn, R. L., & McIver, S. D. (1993). The role of psychologists in the treatment, management, and prevention of chronic mental illness. *American Psychologist*, *48*(9), 966–971. https://doi.org/10.1037/0003-066x.48.9.966

Snider, L. (2018). *Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families*. UNICEF. https://www.unicef.org/media/52171/file

Stoll, J., Müller, J. A., & Trachsel, M. (2020, February 11). *Ethical issues in online psychotherapy: A narrative review*. Frontiers in psychiatry. Retrieved April 21, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7026245/

Substance Abuse and Mental Health Services Administration. (2021a). *Comprehensive Case Management for Substance Use Disorder Treatment*. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-013.pdf

Substance Abuse and Mental Health Services Administration. (2021b). *Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders*. https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf

Substance Abuse and Mental Health Services Administration. (n.d.). *Recovery and recovery support*. U.S. Department of Health and Human Services. Retrieved April 26, 2023, from https://www.samhsa.gov/find-help/recovery

Telehealth.HHS.gov. (2023, February 4). *Licensure*. Retrieved April 26, 2023, from https://telehealth.hhs.gov/licensure

The UN Refugee Agency. (n.d.). *Mental Health and Psychosocial Support*. https://www.unhcr.org/mental-health-and-psychosocial-support

U.S. Agency for International Development. (2022, December 10). *Mental Health and Psychosocial Support: Basic Page*. Retrieved April 22, 2023, from https://www.usaid.gov/inclusivedevelopment/mental-health

Warby, R., & Borger, J. (2023, February 13). *EMTALA and transfers*. National Center for Biotechnology Information. Retrieved April 22, 2023, from https://pubmed.ncbi.nlm.nih.gov/32491744/

Wong, E., Collins, R., McBain, R., Breslau, J., Burnam, M., Cefalu, M., & Roth, E. (2021, March 11). Racial-Ethnic differences in mental health stigma and changes over the course of a statewide campaign. *Psychiatry Online*. https://doi.org/10.1176/appi.ps.201900630

World Health Organization. (2023, January 30). *Rehabilitation*. Retrieved April 22, 2023, from https://www.who.int/news-room/fact-sheets/detail/rehabilitation

CHAPTER 8
Cultural Considerations

FIGURE 8.1 Group therapy can occur in a variety of settings, such as this session in the woods by a river. (credit: modification of "Men Sitting by River Outdoors" by JourneyPure Rehab/Flickr, CC by 2.0)

CHAPTER OUTLINE

INTRODUCTION Every person in the world belongs to a culture. For the purposes of this chapter, culture is the learned and customary way of life in human societies, unique to each. Culture helps give people an identity and shapes their values, beliefs, and practices. Culture plays a significant role in health and wellness because it can affect what types of medicines and treatments to use, who is allowed to provide care, and beliefs about what causes illness and injury.

The United States has long had a reputation as a multicultural nation and, according to the United States Census Bureau, it continues to grow even more racially and ethnically diverse every year (Jensen, 2022). In health care, nurses will encounter clients with different cultures from each other and different cultures from themselves. It is imperative that nurses are able to understand and adapt to cultural differences in order to provide the best possible care for all clients, regardless of culture. This chapter discusses how to gain a better understanding of cultural differences among the clients nurses serve and how to incorporate diversity and inclusion as best practice.

8.1 Understanding Cultural Differences

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify cultural influences on beliefs regarding health and illness
- Recognize health disparities among different cultural groups
- Describe various types of healing in different cultures
- Explain how to recognize and address unconscious or implicit bias

Nurses encounter clients from a variety of backgrounds; therefore, it is essential that nurses provide culturally appropriate care. Cultural competence, in the context of nursing care, does not assume mastery. It means being open to learn and grow and practicing toward success. The skill of applying evidence-based nursing care in agreement with the cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes is called **cultural competency**. It is one component of providing client-centered, holistic nursing care.

A nurse who provides holistic care to clients will focus on healing the person as a whole, rather than on one specific problem. Holistic care means to think about and care for physical, cognitive, social, emotional, and spiritual health. When an individual's cultural beliefs are integrated into their health care, it is called **culturally responsive care**. Culturally responsive care is required for a trusting, effective relationship with the client, and this skill begins with cultural awareness. Throughout care delivery, nurses partner with clients and families to become aware of their preferences and values. This awareness can come through structured interviews, therapeutic interactions, and inclusion of the clients' significant others in care, as permitted.

Cultural Influences on Health and Illness

The United States is a country of various ethnic and cultural groups that grows more diverse every day. The set of beliefs, attitudes, and practices shared by a group of people or community that is accepted, followed, and passed down to other members of the group is called **culture**. Some cultures have beliefs that explain what causes illness, how illnesses can be treated or cured, and who should be involved in the process. Culture also affects how people communicate with health-care team members in terms of language or eye contact, or what can be discussed in terms of the person's body, health, or illness. A person's culture affects everything from how they think and feel about health and illness, to how receptive they are to treatment recommendations, to how, when, and from whom they receive care.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Competency: Client-Centered Care

Definition: Recognize the client as a full partner in control of all decisions when providing compassionate and coordinated care based on respect for the client's preferences, values, and needs.

Knowledge: Describe how diverse cultural, ethnic, and social backgrounds function as sources of client, family, and community values.

Skill: Communicate client values, preferences, and expressed needs to other members of the health-care team.

Attitude: Respect and encourage individual expression of client values, preferences, and expressed needs.

Best practice standards include the nurse providing competent, effective care with each client interaction. Conducting a cultural assessment is one way to ensure meeting the client's preferences and cultural needs.

(QSEN Institute, n.d.)

Individualism versus Collectivism

One main psychological distinction between cultures that affects how people think and make decisions is individualism versus collectivism. Cultures that follow **individualism** focus on the individual. They are encouraged to make choices for their own benefit with an emphasis on independence and self-reliance, and health care tends to be viewed as a personal responsibility. Most Western countries, such as the United States, United Kingdom, and other

parts of Western Europe are considered to have individualistic cultures (Fatehi et al., 2020).

In contrast, cultures that follow **collectivism** emphasize community and cooperation. Decisions are made for the benefit of the collective. These cultures believe that it is best for society when everyone works together as a group, and the needs of the individual come secondary to the needs of the greater good. A client from a collectivistic culture might defer treatment decisions to their family, for example. Some countries that practice cultural collectivism include China, Japan, Indonesia, and several other Eastern Asian or South Asian countries.

Cultural Influences on Pain

Pain management can be a challenging task and can be made more complex by the cultural considerations particular to each client. Different cultures have varying views on pain, including how to express it, how to treat it, and what it means. Pain is a universal physical experience, but it also involves emotions and behaviors that are colored by the client's cultural viewpoint (Givler & Bhatt, 2022). For instance, Black, Japanese, Hispanic, and East Asian cultures tend to appear stoic about pain and may keep an unexpressive face or believe that requesting pain medication is a sign of weakness (Givler & Bhatt, 2022). This does not mean that they are not experiencing pain, or that they have a higher pain tolerance than people who may appear more emotional when experiencing pain. Others, such as those who are part of Muslim or Christian communities, can view pain as the plan of a higher power. Chinese clients may view pain as an imbalance between yin and yang (Perreira et al., 2019). Take care to avoid misunderstandings about pain due to cultural differences because they can result in overtreatment or undertreatment of the client's pain.

CLINICAL JUDGMENT MEASUREMENT MODEL

Take Action: Culturally Sensitive Nursing Interventions for Pain

Even though the ways in which clients experience and express pain are influenced by their cultural background, pain is an individual experience. It is important for the nurse to be aware of cultural differences so that they can treat the individual in a way that best suits their pain and their preferences. Culturally sensitive nursing interventions for pain include (Givler & Bhatt, 2022):

- Providing an interpreter for clients with limited verbal or written English skills.
- Asking the client about their ideas and understanding of the concept of pain. Their beliefs may be representative of their cultural background, or they may not—be careful not to make generalizations without listening to the client.
- Providing thorough education to the client on pain assessment and the importance of reporting pain. Rely on these assessments rather than on behaviors.
- Being sensitive to traditional healing remedies, such as prayer or use of certain foods. Allow the client to incorporate traditional remedies whenever possible. Make sure to gather a thorough history of all medicines, herbs, plants, and foods to avoid any possible interactions.
- Assuring the client that the health-care team is there to help treat their pain in a way that is the most appropriate and suitable for them.
- Adjusting the client's care plan to reflect their cultural needs.

Health Disparities Related to Cultural Differences

The nonbiological factors that influence health outcomes, including conditions in which people are born, grow, work, live, and age, and the wider sets of forces and systems shaping the conditions of daily life are called social determinants of health. Health outcomes that are influenced by these social determinants of health and therefore represent preventable differences experienced by underrepresented individuals are called **health disparities**.

Various factors contribute to health disparities among different cultural groups. Socioeconomic status, race, educational level, and physical proximity to health-care facilities are all factors that contribute to health disparities. For instance, distrust of mainstream Western medicine in Black and American Indian communities due to a long history of systemic discrimination can further health disparities by preventing community members from seeking preventative care. Black and American Indian populations experience increased stress levels of systemic discrimination and have higher rates of obesity, diabetes, hypertension, and heart disease when compared with

White populations (Perreira et al., 2019; Weinstein et al., 2017). This represents one example of why it is important for the nurse to provide culturally sensitive care to all groups and foster a trusting relationship with the client.

Healer Variations among Different Cultures

Every culture develops its own ways of dealing with health and illness. Some use **traditional healing**, the various medicines and healing practices around the world that differ from the modern, Western health-care system (World Health Organization, n.d.) (Table 8.1). The term encompasses a vast range of traditions and practices that differ across different regions and cultures.

Traditional healing has long been used to promote health and fight disease and is still used today by many people around the world because traditional healers tend to be accessible, affordable, familiar, and knowledgeable of the language and culture. Some people rely on traditional healers instead of Western medicine, while others choose to incorporate traditional healing practices into Western medical care.

Healing Tradition	Chief Characteristics
Traditional Chinese Medicine (TCM)	Belief in the idea of balance as the root of health; based on concepts of qi and yin and yang; practices include acupuncture, cupping, herbs, tai chi
Ayurveda	Hindu form of medicine from India, based on the idea that disease is caused by imbalance; seeks to cure imbalances using Ayurvedic medicine, including diet, herbal medicines, yoga, and meditation
African Traditional Healing	Extremely diverse and varies by tribe; belief that ancestral spirits are closely involved in the lives of the living, offer spiritual education and care, and function as counselors and social workers
American Indian Traditions	Belief in spiritual and physical health as intertwined; the healer's role is to help the individual as they help themselves; ritual and ceremony have key roles in healing
Hispanic Traditions	Curanderismo is a holistic practice rooted in beliefs that health is achieved through the right balance of mind, body, and spirit; healers focus not only on the individual's physical health, but also on their mental health, diet, personal/social relationships, and more; use various healing methods, including prayer, oils, herbs, special diets, massage, and other spiritual rituals
Western European Traditions	Role of client at the center of the client-healer relationship is crucial; strong foundation in using medicines created from natural elements, including herbs, plants, minerals, and animals

TABLE 8.1 **Healing Traditions**

Asian Traditions

Asian healing traditions are rooted in the concept of balance. Two of the more well-known traditions are Traditional Chinese Medicine and Ayurveda. Both Traditional Chinese Medicine and Ayurveda have become increasingly popular in recent years as complementary therapies to Western medicine.

Traditional Chinese Medicine (TCM) is an ancient practice based on the ideas of qi and yin and yang. Qi is the life force that runs through one's body; yin and yang are the opposite qualities of qi that must be in balance for optimal health (Johns Hopkins Medicine, 2019b). TCM consists of such practices as acupuncture, acupressure, cupping, herbs, tai chi, and others (Figure 8.2). The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is a federally recognized organization that accredits schools in the United States that teach acupuncture

and TCM.

FIGURE 8.2 Various herbs shown here are used in Traditional Chinese Medicine. ("Chinese prescriptions" by Tim Wilson/Flickr, CC BY 2.0)

Ayurveda is the traditional Hindu form of medicine from India that is based on the idea that disease is caused by an imbalance in the body. Ayurvedic medicine seeks to cure this imbalance through a combination of diet, herbal medicines, yoga, and meditation. In India, Ayurvedic medicine is considered equivalent to conventional Western medicine, and providers receive formal training, but there is no licensing process for Ayurvedic practitioners in the United States (Johns Hopkins Medicine, 2019a). Ayurvedic medicine consists of herbs, spices, minerals, and other substances that can interfere with conventional drugs; a thorough list of all medicines and supplements is an important part of the nursing assessment for this reason.

African Traditions

African healing traditions have their foundations in practices dating back thousands of years. Although specific religious traditions vary from tribe to tribe, traditional African healing is rooted in the idea that ancestral spirits are closely involved in the lives of the living, and act as “mediators” between the living and God (Mokgobi, 2014). As Christianity and Islam began to spread across the continent, many people converted from traditional religions, but continued the use of traditional practices while also using Westernized health care.

Different tribes have different types of healers; for example, the Bapedi tribe has diviners (*Ngaka ya ditaola*), Sanusi (or *Sedupe*), traditional surgeons, and traditional birth attendants. Diviners and Sanusi can diagnose and prescribe treatment for mental, physical, and spiritual afflictions (Zuma et al., 2016). Surgeons have been trained to perform circumcisions on boys, along with the duties of diviners and Sanusi. Older women who have experience assisting with births over many years become traditional birth attendants. African traditional healers do more than help with physical illness and injury, however. They also offer spiritual education and care and have special knowledge of traditional culture, which allows them to function as counselors and social workers.

Native American Traditions

In Native American and Alaska Native cultures, physical and spiritual health are interconnected. The belief is that in order for the body to heal, the soul must heal as well. Native American healers believe that the individual is the source of most of the healing, and is responsible for their own health, wellness, and behavior. The healer's role is to help the individual as they heal themselves, although the individual's family and community play an important part as well (National Institutes of Health (NIH), n.d.).

LINK TO LEARNING

Visit the IHS Mental Health Programs (https://openstax.org/r/77ihsmenheal) to find federally operated programs, many conducted by individual tribes, that provide mental health services.

Ritual and ceremony hold a key role in traditional Native American healing. Purifying and cleansing the body, whether through sweating or purging, is an important practice in some Native American healing rituals. Smudging is another practice that involves cleansing a place or person with the smoke of certain sacred plants. Some healing ceremonies can involve whole communities. These ceremonies can include music, painting bodies, dancing, exorcisms, sand paintings, stories, and use of mind-altering substances. These ceremonies are a way to seek spiritual assistance and physical healing (NIH, n.d.). Researchers call for mentorship and outreach in nursing education to incorporate culture and tradition into academic programs (Moore, 2023).

LINK TO LEARNING

Visit this HHS.gov site of the Office of Minority Health (https://openstax.org/r/77omh) to find statistics on the mental health status and death rates for Native American/Alaska Native adults and adolescents and access to care in the United States.

Members of the Native American Church are legally allowed to use peyote, a hallucinogen, during religious ceremonies. It can cause hallucinations and alterations in perceptions of space, time, and self. Physical symptoms include nausea, vomiting, dilated pupils, increased heart rate, elevated blood pressure, perspiration, headaches, muscle weakness, and impaired motor coordination. In rare cases, large doses have been reported to cause bradycardia, hypotension, and respiratory depression (Department of Justice, 2020). Peyote has been used for centuries by American Indians and is considered a sacred plant.

LINK TO LEARNING

This video from the Harvard Divinity School features a discussion with Native American Church leaders about the Sacrament of Peyote (https://openstax.org/r/77NACpeyote) and its history in the indigenous medicine world.

Hispanic Traditions

Traditional Hispanic medicine is performed by healers called *curandera* (women) or *curandero* (men). The practice is called **curanderismo**, a holistic practice rooted in beliefs that health is achieved through the right balance of mind, body, and spirit. A curandero focuses not only on the individual's physical health, but also on their mental health, diet, personal relationships, and more. Curanderos use various healing methods, including prayer, oils, herbs, special diets, and other spiritual rituals. They also act as counselors and social workers, listening to individuals talk about their problems and helping them build an emotional support network (Cruz et al., 2022).

Western European Traditions

The central role of the client in the healer-client relationship is foundational to modern Western European healing culture. There is also a strong emphasis on technology and scientific evidence of healing practices.

Traditional European medicine has a strong foundation in using medicines created from natural elements, including herbs, plants, minerals, and animals (Firenzuoli & Gori, 2007). Homeopathy and naturopathy both have roots in

European tradition. Individuals who rely on herbal and plant-based remedies tend to either use them in conjunction with conventional Western medicine or view them as alternatives to harsher methods of treatment. Examples are discussed later in this chapter. Nurses should provide quality education to their clients about clinical evidence of the effectiveness of these complementary and alternative therapies (Leonti & Verpoorte, 2017).

Counteracting Implicit Bias

Everyone holds biases that reflect their own personal belief systems. One type of bias is called explicit bias, a consciously held set of beliefs about a particular group of people based on characteristics. Explicit bias is what we typically think of when we see or hear the word *bias*. A person might be openly biased against someone due to their age, gender, race, sexuality, or another reason. An overtly racist comment is an example of explicit bias (Sabin, 2022).

In comparison, implicit bias refers to unconscious biases. Implicit bias is an automatic reaction toward a group of people involving subconscious feelings, perceptions, attitudes, and stereotypes. People may hold conscious beliefs about equality and fairness while still having unconscious, implicit biases that contradict these beliefs.

Bias negatively affects the client-provider relationship, leading to poorer quality care and worse outcomes for certain groups. For example, research studies have shown that implicit bias regularly leads to the undertreatment of pain in Black individuals (Sabin, 2022). Implicit bias can be difficult to change. The first step in overcoming implicit biases is to become aware of them; training in diversity and inclusiveness can also help identify problematic feelings, thoughts, and behaviors.

LINK TO LEARNING

Take this test to learn more about your own implicit biases (https://openstax.org/r/77impbias) and how they can affect your worldview.

8.2 Ethical Practice in Culture and Diversity

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify ways to accommodate different cultural practices
- Explain ethical ways to engage in cultural diversity practices
- Define how nurses can be responsive to diversity and inclusion

As discussed in 8.1 Understanding Cultural Differences, the concept of culturally responsive care, which involves integrating an individual's cultural beliefs into their health care, is an important foundation of cultural competence. Providing culturally competent care requires attention to diversity and inclusion and a willingness to accommodate the cultural differences of others. According to the American Psychological Association (APA, n.d.), **cultural diversity** means a variety of communities that are very different from one another. Nurturing a community that acknowledges, respects, and has regard for people from all different cultures is called **inclusion**.

According to the Centers for Disease Control and Prevention (2024), there are eight principles of cultural competence:

1. Define culture broadly.
2. Value clients' cultural beliefs.
3. Recognize complexity in language interpretation.
4. Facilitate learning between providers and communities.
5. Involve the community in defining and addressing service needs.
6. Collaborate with other agencies.
7. Professionalize staff hiring and training.
8. Institutionalize cultural competence.

Note that it is the responsibility of the health-care professional to seek out, understand, and integrate the client's beliefs into their care. Ultimately, the goal is to build cultural competence into the permanent framework of health

care.

Accommodating Cultural Practices

According to the American Nurses Association (ANA) Code of Ethics (2018), nurses must practice with cultural humility and inclusiveness. Culture is constantly changing and evolving, so true cultural competence requires a lifetime of learning with these changes. Respecting and learning about the cultures of others while exploring one's own cultural biases is considered **cultural humility**.

There are both intrapersonal and interpersonal components to cultural humility (Table 8.2) (Hughes et al., 2020). The **intrapersonal** component consists of a personal awareness of one's own limited knowledge of the client's culture. The **interpersonal** component involves a respect for the client's culture and openness to their beliefs and experiences. By focusing on developing partnerships with clients, the nurse can create a space that encourages learning and appreciation for other cultures. It is a client-centered way of providing culturally sensitive care.

Interpersonal Skills	Intrapersonal Skills
Involves relations between people	Occurs within the individual mind or self
Two or more parties involved	No external parties involved
Feedback comes from the parties involved	Feedback comes in the form of self-analysis
Important to building and maintaining relationships; must develop self-awareness	Continuous flow of thought; one's own thoughts, views, opinions, and attitudes are developed

TABLE 8.2 Interpersonal versus Intrapersonal Skills

Avoid Forcing Change

Cultural humility involves inclusion. Inclusion means taking into account the client's own cultural preferences and involving them in the process as much as possible. Forcing a client to accept a treatment plan that conflicts with their cultural practices and beliefs is rarely effective and can damage the relationship of trust between the nurse and the client. The process where the client and nurse seek a mutually acceptable way to deal with competing interests of nursing care, prescribed medical care, and the client's cultural needs is called **cultural negotiation**. It is reciprocal and collaborative. When the client's cultural needs do not significantly or adversely affect their treatment plan, the cultural needs can and should factor into the plan.

Seek Cultural Assistance

Having respectful, curious, in-depth conversations with clients is the best way to learn about their individual cultural practices. When seeking ways to accommodate different cultural practices, approach clients with cultural humility to learn how best to care for them. Cultural guides from different local communities may also be available for cultural dialogue (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Collaboration between clients from diverse cultures and nurses is an excellent way to produce culturally sensitive, client-centered care plans (Hughes et al., 2020). Examples of seeking cultural assistance include researching assistance from different organizations, discovering available resources, or developing initiatives for unit-based councils.

Ethical Engagement in Cultural Diversity

As a nurse, it is necessary to actively engage with the client and their culture. Cultural negotiation is mutual; the nurse and the client must gain an understanding of each other's perspective. There are many ways a nurse can actively take part in learning about different cultures to best serve diverse client populations. Some examples include encouraging the client to bring traditional or culturally important food from home that is compatible with dietary orders and needs or involving the family in medical decision-making.

Active Learning

One of the first steps in engaging in cultural diversity is to get to know your community—what ethnic groups are most prevalent, what languages are most widely spoken, what religions are most popular? Use sources, such as

newspapers, journal or book articles, and cultural training seminars or courses to research cultural issues that are relevant to your area. At the same time, do not stereotype or generalize clients. Make sure to ask clients' personal preferences when it comes to their cultural background and beliefs (Stubbe, 2020).

Learning about cultural diversity also includes becoming aware of your own practices and implicit biases. There are various implicit bias inventories available to help you identify unconsciously held beliefs. Journaling or reflective practice is another way to help identify and reflect upon personal thoughts and feelings toward working with diverse groups. Awareness of your own practices can help identify and address issues with practices observed in the workplace. For example, your area may have a large Arabic-speaking population, but your clinic does not have consent forms in Arabic. You decide to advocate for your clients and ask the clinic to provide consent forms in Arabic. Another example would be your clinic hosts educational workshops so employees can actively learn about the populations they serve. Learning about the culture of your client population leads to better client outcomes.

Exploring

Immersing yourself in different cultural communities can be an engaging and fun way to learn more about your clients. Attending local cultural events, such as festivals and dances, exploring art and music scenes, and even joining religious ceremonies (may require special permission) are all ways to experience cultural practices firsthand (Figure 8.3).

FIGURE 8.3 Attending cultural festivals, like celebrations of Traditional Mardi Gras Indians in Louisiana, is an excellent way to gain firsthand exposure to diverse cultural practices. (credit: "Mardi Gras Indians at Algiers Riverfest New Orleans 2009" by Mark Gstohl/Flickr, CC BY 2.0)

Responsiveness to Cultural Diversity

Learning about different cultures is only one step toward providing culturally competent care. How one responds to cultural diversity is what directly affects the nurse-client relationship and outcomes. Being responsive to cultural diversity involves taking lessons learned about other cultures from conversations, experiences, and research and integrating the knowledge into practice. It also involves advocating for diversity and inclusion at a structural and institutional level.

Steps to Change

EveryNurse (2023) defines the cultural differences encountered by nurses that may pose barriers to quality nursing care. For example, language differences can impact communication and complicate the nurse-client relationship; cultural traditions may influence the client's acceptance of certain medications or interventions and may be misinterpreted by health-care providers; health literacy can create differences in understanding, accessing, and being able to use health-care information and can impact client education and discharge planning; cultural assumptions can lead to knowledge deficit and interfere with the nurse-client relationship.

Cultural sensitivity in nursing practice, and in health care in general, is essential (EveryNurse, 2023). Table 8.3 outlines strategies to meet these challenges.

Challenge	Strategy
Awareness	Share with your peers that you are working toward stronger cultural sensitivity; engage them in the process. Be open about this change, appreciate the effort, and state the goal of excellence in client care.
Assumptions	Build validation and inquiry into your interactions with clients and families. Keep your own nonverbal cues appropriate when clients clarify and answer.
Knowledge	Visit an area where a culture is dominant and read about the culture from reputable books and online sources. Reflect upon your own assumptions and strive to become informed.
Trust and rapport	If working with a translator, remain focused on the client for nonverbal cues and speak to the client. The translator will interpret the messages.
Language barriers	Explore translation technology, and use appropriate pictures or gestures to communicate if needed. Keep in mind that the process may be frustrating and allow sufficient time.
Client education	"Teach back" is an effective method to ensure messages have been received. Use translation assistance if necessary; seek to preserve the client's dignity. Your own awareness may be enhanced when you experience how you are received by others.
Active listening	Active listening is an effective technique in all nurse-client interactions. Use eye contact, touch, and proximity as appropriate. Repeat what you have heard them say and give them time to explain.

TABLE 8.3 Steps to Overcome Cultural Barriers to Optimal Nursing Care (EveryNurse, 2023)

Willingness to Change

Approach the process of learning about other cultures with cultural humility. Learning about other cultures requires self-examination and openness to new ideas, beliefs, and behaviors. It is normal to encounter beliefs and practices that are extremely different from one's own. They may be in direct conflict with the nurse's own cultural background, and may even make them uncomfortable, sad, angry, or confused. It is not expected that nurses will completely change all their thoughts and feelings, but a *willingness* to change is key to accepting others and putting cultural competence into action.

REAL RN STORIES

Recognition of Cultural Biases

Nurse: Jenny, RN
Years in Practice: 2 years
Clinical Setting: Med-Surg Unit

Geographic Location: Southern California

I was a twenty-eight-year-old registered nurse from Florida who recently resettled in an area of Southern California. I am White and prior to this had lived in Florida all of my life. I had been practicing for two years and had just started a new job on a med-surg floor at a local hospital. The hospital was located in a community that was known for its large Vietnamese population. Most of the nurses, providers, and clients at the hospital were either Vietnamese immigrants or of Vietnamese descent.

One day I took report on a new client. The client was a fifty-three-year-old Vietnamese female with a diagnosis of terminal brain cancer. The client had no expected chance of survival, but she remained a full code and the family was refusing hospice. I wondered why the client and family would refuse hospice care.

As I went to assess the client, I found her lying in bed and moaning while clutching her head in her hands. She was nonverbal and nonresponsive to my stimuli. I noticed she had pain medication, so I administered as ordered.

Upon reassessing her, I noticed the medication didn't seem to make much difference. The client was still clutching her head in her hands and moaning. The doctor refused to increase the dose at my suggestion, and seemed to brush me off when I recommended talking to the family again about hospice or comfort measures. I found myself growing increasingly frustrated on behalf of my client, and I felt she might be suffering unnecessarily at the end of her life.

At lunch, I called the client's daughter, Viv, and requested she come to the hospital to visit her mother. Upon the daughter's arrival, I administered the client some IV pain medication, but the client was not responding or showing signs of relief. Viv stated, "The pain medication does not seem to be making much of a difference the last couple of days." I asked her if she had considered hospice for her mother and explained that I had found hospice very helpful when my own grandmother was at the end of her life. Viv told me that she had discussed hospice with the physicians but decided against it. "Hospice is not an option for us. In our culture, we believe in fighting with everything we have down to the last minute," she stated. She explained that she and her family viewed the use of medication at end of life in hospice care as hastening death.

After having this conversation with Viv, I had a new understanding for why the family was refusing hospice and comfort measures. I now understood how important it was to the client and the client's family that their own views on end-of-life care be respected. This conversation allowed me to reexamine my own cultural biases and be more culturally respectful of the clients I was now serving.

8.3 Cultural Practice in Nursing

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the guidelines for nursing care of different cultural practices
- Explain the importance of cultural competency and transcultural nursing
- Recognize factors that can affect diversity and inclusion in nursing

Cultural competence enables a nurse to provide the best quality client-centered care possible. Establishing a culturally sensitive environment is the first step in providing culturally responsive care to clients. An accurate and thorough cultural assessment allows for the gathering of client-specific cultural information. The pursuit of culturally competent care also requires recognizing the various factors that can affect diversity and inclusion in nursing.

Guidelines for Nursing Care

Providing culturally responsive care integrates an individual's cultural beliefs into their health care. Begin by conveying cultural sensitivity to clients and their family members with these suggestions:

- Set the stage by introducing oneself by name and role when meeting the client and their family for the first time. Address the client formally by using their title and last name. Ask the client how they want to be addressed and record this in the client's chart. Respectfully acknowledge any family members and visitors at the client's bedside.
- Begin by standing or sitting at least arm's length from the client.
- Observe the client and family members in regard to eye contact, space orientation, touch, and other nonverbal

communication behaviors, and follow their lead.
- Make note of the language the client prefers to use, and record this in the client's chart. If English is not the client's primary language, determine if a medical interpreter is required before proceeding with interview questions.
- Use inclusive language that is culturally sensitive and appropriate. For example, do not refer to someone as "wheelchair bound;" instead, say "a person who uses a wheelchair."
- Be open and honest about the extent of knowledge of their culture. It is acceptable to politely ask questions about their beliefs and seek clarification to avoid misunderstandings.
- Adopt a nonjudgmental approach and show respect for the client's cultural beliefs, values, and practices. It is possible not to agree with a client's cultural expressions, but it is imperative that the client's rights be upheld. As long as the expressions are not unsafe for the client or others, the nurse should attempt to integrate them into their care.
- Assure the client that their cultural considerations are a priority of their care.

Cultural Assessment

After establishing a culturally sensitive environment, nurses should incorporate a cultural assessment when caring for all clients. There are many assessment guides used for client interviews that are adaptable to a variety of health-care settings and are designed to facilitate understanding and communication.

One such model is the 4C's of Culture, a mnemonic developed by Slavin et al. (2019) to prompt health-care providers with culturally sensitive inquiries more likely to present the client's point of view. This model asks questions about what the client *C*onsiders to be a problem, the *C*ause of the problem, how they are *C*oping with the problem, and how *C*oncerned they are about the problem. Use these questions to begin the cultural assessment:

- What do you think is wrong? What is worrying you? (In other words, discover what the client *Considers* to be the problem and what they call it.) Example: A client with a diagnosis of a sinus infection believes their body is "unbalanced."
- What do you think *Caused* this problem? How did this happen? Example: The client believes this illness is a punishment for a misdeed.
- What are you doing to *Cope* with this problem? How are you taking care of yourself? Example: The client avoids eating certain foods to treat the illness while also using home remedies, such as herbal tea.
- How serious is this problem for you? How *Concerned* are you? Example: A client views the illness as being "God's will" and states, "It's in God's hands."

PSYCHOSOCIAL CONSIDERATIONS

How to Perform a Brief Cultural Assessment

Scenario: The nurse enters the client's room to perform a cultural assessment. The client is a female from China in the area visiting family whose preferred language is Mandarin. The nurse sets up the video translator to begin the conversation and allows the translator to introduce themselves to the client.

Nurse: Hi, I'm Travis, and I'm going to be your nurse today. Can you please tell me your name and date of birth?

Client: Mei Wang, January 2, 1947.

Nurse: What would you like for me to call you?

Client: Mrs. Wang is fine.

Nurse: Mrs. Wang, I'm here to do a cultural assessment, which involves asking you a few questions. It should take less than 15 minutes. Is that okay?

Client: Yes, that is fine.

Nurse: What do you think is wrong? What is worrying you?

Client: The doctors are telling me that I have an infection in my lungs. I haven't been feeling well, and I believe it is

because my body is not in balance.

Nurse: What do you think caused this problem? How did this happen?

Client: My husband died four months ago, and I left China to live with my son and his family here in the United States. I miss my husband, and everything here is so different compared with what I'm used to.

Nurse: Have you been trying things at home to make yourself feel better? How have you been coping?

Client: I've been making some special food. A lot of soup, and other foods with ginger, onion, and garlic to help with the phlegm.

Nurse: How serious is this problem for you? How concerned are you?

Client: I've never been in the hospital before, so I'm worried, but I think the doctors are good here and will get me home. I want to make sure that my family can bring me food from home, though. I don't like the hospital food; my food from home is much better for me.

Nurse: I'll check with your doctor to see if your family can bring your food from home; I'll tell them how much better you like it, okay? My assessment is done for now; do you have any other questions for me?

Client: Not right now, thank you for talking to me.

Another, more comprehensive cultural assessment tool, inspired by R. E. Spector's Heritage Assessment Interview, is called the Sample Cultural Assessment Interview and includes these additional questions (Spector, 2017):

- Where were you born? Where were your parents born?
- What pronouns do you use (he, she, they)?
- In what language are you most comfortable speaking and reading?
- Did you grow up in a city or a town or a rural setting?

Cultural Knowledge

Another important step toward becoming a culturally competent nurse is acquiring cultural knowledge, which involves seeking information about a culture's health beliefs, history, customs, and values to understand clients' worldviews. To acquire cultural knowledge, the nurse actively seeks information about other cultures, including common practices, beliefs, values, and customs, particularly for those cultures that are prevalent within the communities they serve. Cultural knowledge includes understanding the historical backgrounds of culturally diverse groups in society, as well as physiological variations and the incidence of certain health conditions in culturally diverse groups. Cultural knowledge is best obtained through cultural encounters with clients from diverse backgrounds to learn about individual variations that occur within cultural groups and to prevent stereotyping.

Standards of Practice

The Transcultural Nursing Society has developed Standards of Practice for Culturally Competent Nursing Care (Douglas et al., 2011). These twelve standards are intended to serve as a universally applicable guide for nurses in all aspects of culturally competent nursing care. Table 8.4 lists the twelve standards and an example of each:

Standard	Example
1. Social justice: Nurses must promote and advocate for social justice for all.	Nurses advocate for equitable access to mental health services, ensuring that all individuals, regardless of socioeconomic status, can receive necessary care.
2. Critical reflection: Nurses must engage in ongoing, personal, critical reflection of how their cultural beliefs and practices affect their nursing care.	A nurse regularly examines how their cultural beliefs and implicit biases impact interactions with clients and adjusts their approach to respect diverse perspectives.

TABLE 8.4 Standards of Practice for Culturally Competent Nursing Care (Douglas, 2011)

Standard	Example
3. Knowledge of cultures: Nurses must understand diverse cultures and factors that affect health and well-being.	A nurse understands the dietary restrictions of a Hindu client and ensures their meal choices align with their cultural beliefs.
4. Culturally competent practice: Nurses must use cross-cultural knowledge and skills in implementing culturally competent nursing care.	A nurse uses language interpreters to communicate effectively with non-English-speaking clients, recognizing the importance of linguistic competence in care.
5. Cultural competence in health-care systems and organizations: Health-care institutions must provide the structure and resources necessary to meet the needs of their culturally diverse clients.	A health-care institution in a diverse urban area offers culturally tailored health education materials and services for its diverse client population.
6. Client advocacy and empowerment: Nurses must empower their clients to navigate the health-care system and advocate for inclusion of the client's cultural beliefs in their health care.	A nurse helps a Muslim client navigate the health-care system, ensuring their religious practices are respected during treatment.
7. Multicultural workforce: Nurses must actively work toward having a multicultural workforce in health-care settings.	A nurse actively recruits health-care professionals from diverse backgrounds to create a more culturally inclusive health-care team.
8. Education and training in culturally competent care: Nurses must be educationally prepared to promote and provide culturally congruent health care through formal education, clinical training, and continuing education for practicing nurses.	A nursing school incorporates cultural competency training into its curriculum to prepare students to provide culturally congruent care.
9. Cross-cultural communication: Nurses must use culturally competent communication skills when providing client care.	A nurse uses visual aids and gestures to communicate effectively with a client who speaks a different language, recognizing the importance of nonverbal communication.
10. Cross-cultural leadership: Nurses must strive to influence others to achieve culturally competent care for diverse groups.	A nurse leads a cultural competence training session for colleagues, sharing best practices in providing care to diverse client populations.
11. Policy development: Nurses must work to establish policies and standards for culturally competent care.	Nurses collaborate with hospital administrators to develop and implement a comprehensive policy that mandates cultural competency training for all health-care staff, ensuring that all client interactions are culturally sensitive and respectful.
12. Evidence-based practice and research: Nurses use current research to ensure policies and standards are effective for culturally diverse clients, or when evidence is lacking, they do their own investigation and testing.	A nurse establishes a committee for an evidence-based review of cultural best practices for improving client care of a diverse population.

TABLE 8.4 **Standards of Practice for Culturally Competent Nursing Care** (Douglas, 2011)

Complementary and Alternative Therapies

Nonmainstream approaches to health that are used alongside conventional Western medical care are called **complementary therapies**. When nonmainstream approaches are used in place of conventional Western medical care, they are called **alternative therapies** U.S. Department of Health and Human Services, n.d.-a). Conventional (Western) therapies are much more common than alternative therapies in the United States. Examples of complementary therapies include the use of guided imagery and meditation for insomnia, or acupuncture for muscle pain. It is important for the nurse to perform a thorough medication reconciliation to understand use of complementary or alternative therapies. Clients may not consider alternative supplements to be "medicines" or "drugs."

Nutritional/Supplemental Therapies

The most popular complementary therapy among Americans is dietary supplements, such as fish oil. This category also includes special diets, herbs, vitamins, minerals, and probiotics. Because these products can interact with drugs, it is important to get a comprehensive list from the client of all supplements they are taking. For example, St. John's Wort, a common supplement, is known to interact with numerous different common medications, including SSRIs, certain contraceptives, and digoxin (Mayo Foundation, 2021).

Physical and Psychological Therapies

Physical and psychological therapies include a wide range of modalities, such as acupuncture, massage therapy, meditation, reiki, and qigong. Cupping, coining, yoga, art, music, and dance also fall into this category. Acupuncture and cupping are two of the more popular alternative physical therapy modalities. Acupuncture is used to treat pain and multiple other conditions; it is performed by inserting needles at special points in the body. Acupuncture is intended to restore balance and is thought to work by releasing endorphins, the body's natural painkillers. Cupping is another traditional therapy where cups are placed on the skin to increase blood flow with the aim of helping with stress or muscle aches and pains (Figure 8.4).

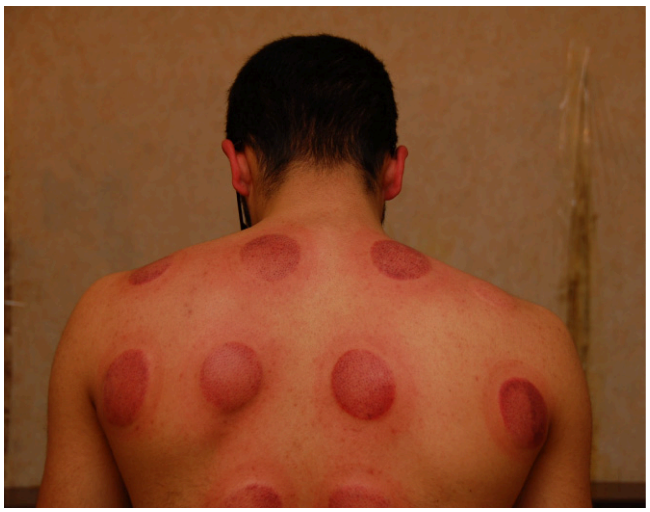


FIGURE 8.4 Blood marks such as these are a normal finding on someone after a cupping session. (credit: "Cupping" by Renato Ganoza/ Flickr, CC BY 2.0)

Other Complementary Therapies

There are other complementary therapies that do not fit in either category. These include traditional healers, Ayurvedic medicine, Traditional Chinese Medicine, naturopathy, and homeopathy. Naturopathic medicine is derived from eighteenth- and nineteenth-century European natural healing systems and involves a combination of therapies, including herbal medicine, diet, acupuncture, and psychotherapy (U.S. Department of Health and Human Services, 2017). Another complementary therapy is **homeopathy**, the belief that the body can heal itself with natural substances. It uses natural products in extremely diluted doses to treat illness. Examples include Chestal Honey cough syrup used for coughs, or chamomilla often used for colic, teething, and childhood irritability. Homeopathic products can still include ingredients that can cause significant drug interactions, so they must be noted on the client's chart (U.S. Department of Health and Human Services, n.d.-c).

Cultural Competency and Transcultural Nursing

All people have the freedom to express their cultural beliefs. Nurses realize that people speak, behave, and act in many different ways due to the influential role that culture plays in their lives and their view of the world. Cultural competency is the skill of applying evidence-based nursing in agreement with the cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes.

Culturally competent care requires nurses to combine their knowledge and skills with awareness, curiosity, and sensitivity about their clients' cultural beliefs. It takes motivation, time, and practice to develop cultural competence, and it will evolve throughout a nursing career. Nurses who accept and uphold the cultural values and beliefs of their clients are more likely to develop supportive and trusting relationships with their clients. In turn, this opens the way for optimal disease and injury prevention and leads toward positive health outcomes for all clients.

LINK TO LEARNING

This video shows a unique and inspiring discussion about becoming a culturally competent nurse (https://openstax.org/r/77culcomnurse) from nurse and professor Jana Lauderdale.

The roots of providing culturally competent care are based on a concept developed by nurse and anthropologist, Dr. Madeleine Leininger, called **transcultural nursing**, which incorporates cultural beliefs and practices of individuals to help them maintain and regain health or to face death in a meaningful way. It forms the foundation of all culturally competent care. Dr. Leininger's theory of culture care diversity and universality is also known as the culture care theory (CCT). It provides the framework for transcultural nursing and the development and practice of culturally competent nursing care (McFarland & Wehbe-Alamah, 2019). Dr. Leininger states that health-care providers cannot offer effective care without considering the client's cultural background. The theory emphasizes the importance of understanding the cultural values, beliefs, and practices of clients in order to provide appropriate care. According to Leininger, as cited in McFarland & Wehbe-Alamah (2019), culture is a fundamental component of human life and influences an individual's perception of health, illness, and health care. Therefore, health-care providers must approach each client with cultural sensitivity and strive to deliver care that is respectful and tailored to the client's cultural needs.

The culture care theory is an important framework for promoting culturally competent care and achieving health equity for all individuals. Using the culture care theory as a framework, nurses can guide research of discovery and translational research projects for evidenced-based nursing practice. Educational programs can develop nursing courses and curricula to prepare culturally competent nurses. Hospitals and medical facilities can use the framework to guide future culturally competent administrative and leadership policies and procedures.

Factors Affecting Diversity, Equity, and Inclusion in Nursing

The American Nurses Association recognizes specific factors that negatively affect diversity, equity, and inclusion in nursing. Explicit bias in the form of discrimination due to gender identity, race, ethnicity, sexual orientation, or socioeconomic status negatively impacts the health status of various populations. Implicit bias affects the relationship between health-care providers and clients, and between health-care team members, as well as outcomes (Jolley & Peck, 2022). Awareness of one's biases is always the first step in combating them.

Cultural Self-Awareness

A person's understanding of their own culture and its impact on themselves is their **cultural self-awareness**. Understanding oneself is a crucial step in forming a broader understanding and acceptance of other cultures (Lu & Wan, 2018). It is important to note that cultural awareness is not a one-time activity, but an ongoing process that requires continuous learning and adaptation. Cultural self-awareness can help nurses understand what shapes their own values and beliefs and recognize their place in a larger multicultural society.

The belief that one's culture (or race, ethnicity, or country) is better than and preferable to another's is called **ethnocentrism**. An example would be a nurse telling a client that conventional Western medical treatments are better than traditional healing remedies. Appropriate cultural self-awareness can help the nurse avoid ethnocentrism. Designing interventions that are relevant to and respectful of the client's culture is one way to avoid

ethnocentrism. Other ways to avoid ethnocentrism include avoiding making generalizations or stereotypes about other cultures. Deal with cultural differences with an open mind and a willingness to learn and understand. Always try to approach each client interaction with a sense of cultural humility and practice active listening.

Six Cultural Phenomena

There are other cultural considerations that can affect efforts to increase diversity and inclusion in nursing, which Giger and Davidhizar identify in their transcultural assessment model (2002). The transcultural assessment model developed as a way for nurses to assess and provide care for culturally diverse clients. This model states that each individual is unique and should be assessed according to six cultural phenomena:

- Communication: This includes the language, tone, and nonverbal cues used by the individual and the health-care provider. Communication styles can vary across cultures and can influence the effectiveness of health-care interactions.
- Personal space: All communication occurs in the context of space. There are four distinct zones of interpersonal space: intimate, personal, social and consultative, and public (Figure 8.5) (Hall, 1966). This includes the physical and emotional distance between the individual and the health-care provider. Cultural norms around personal space and touch can vary across cultures.
- Social organization: This includes the individual's cultural values and beliefs related to family, community, and social roles. Cultural expectations around family involvement in health-care decisions, for example, can vary across cultures. Another example is local, state, or government agencies that all share the same values, beliefs, and interests.
- Time orientation: Time is an important aspect of interpersonal communication. This includes the individual's cultural beliefs and practices related to time, such as punctuality and the perception of time as linear or cyclical. For example, the past, present, and future have different meanings and value to different cultures.
- Environmental control: This includes the individual's cultural beliefs and practices related to controlling their environment, such as beliefs around the causes of illness and how it is directly impacted by one's environment.
- Biologic variations: This includes the individual's cultural beliefs and practices related to biology, such as beliefs around the causes of illness and the use of alternative therapies. Cultural beliefs around pain management and the use of medication can also vary across cultures.

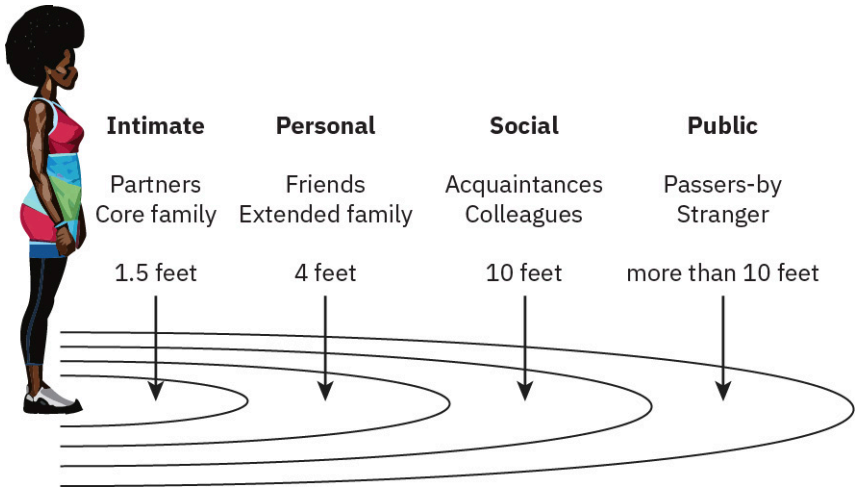


FIGURE 8.5 There are four zones of interpersonal space, and cultural norms around how much space is acceptable varies across cultures. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

CULTURAL CONTEXT

Clients, Personal Space, and Touch

The amount of space that a person surrounds themselves with to feel comfortable is influenced by culture. For example, for some people, it would feel awkward to stand four inches away from another person while holding a

social conversation, but for others, a small personal space is appropriate when conversing with another. There are times when a nurse must enter a client's personal space, which can cause emotional distress for some clients. The nurse should always ask for permission before entering a client's personal space and explain why and what is about to happen.

Clients may also be concerned about their modesty or being exposed. A client may deal with the violation of their space by removing themselves from the situation, pulling away, or closing their eyes. The nurse should recognize these cues for what they are, an expression of cultural preference, and allow the client to assume a position or distance that is comfortable for them.

Similar to cultural influences on personal space, touch is also culturally determined. This has implications for nurses because it may be inappropriate for a male nurse to provide care for a female client and vice versa. In some cultures, it is also considered rude to touch a person's head without permission.

8.4 Diversity, Equity, and Inclusion

LEARNING OBJECTIVES

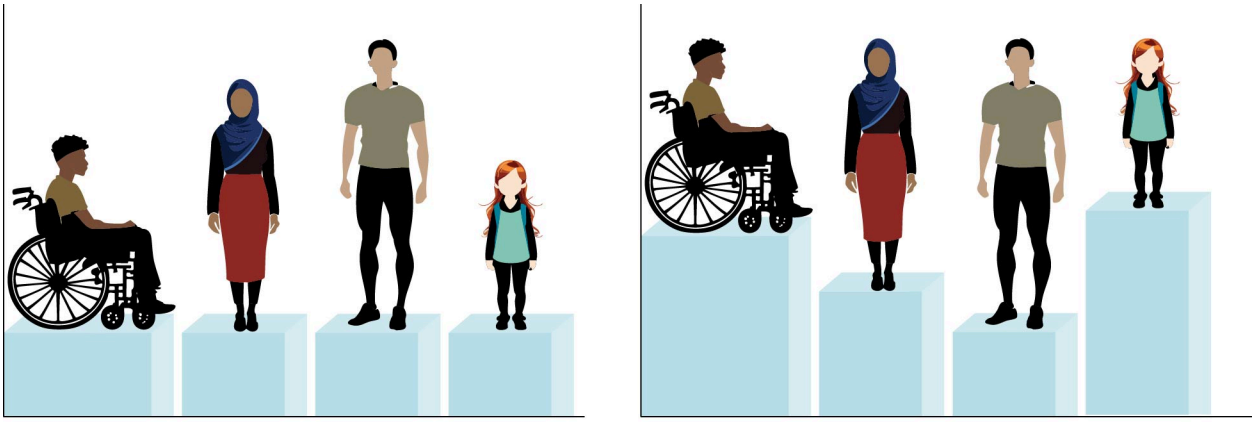
By the end of this section, you will be able to:

- Define important considerations related to providing equal, diverse, and inclusive nursing care
- Identify factors that can prevent diversity, equity, and inclusion
- Explain how barriers to communication affect diversity, equity, and inclusion

Diversity, equity, and inclusion (DEI) create an environment that encourages different ideas, cultures, backgrounds, and experiences. This type of environment allows nurses to provide more comprehensive and effective care to their clients. Diversity, equity, and inclusion foster a culture of mutual respect, understanding, and support, which can lead to improved client outcomes. DEI is at the organizational level and higher, while cultural competency works on an individual level. Additionally, diversity and inclusion can help to reduce health disparities, which can improve health-care access and quality for communities that are traditionally underserved. Ultimately, diversity and inclusion are critical components of successful nursing practice that can help to ensure that all clients receive the best possible care.

Health Equity through Diversity and Inclusion

In nursing, **health equality** means that nurses treat all clients as individuals, show respect for their personal choices and differences, and recognize their dignity and human rights. It assumes equal treatment and support. In contrast, **health equity** speaks to social justice and is when everyone has a fair opportunity to obtain optimal health (Centers for Disease Control and Prevention [CDC], 2022a). Both equity and equality are important considerations when providing inclusive nursing care Figure 8.6.



Health equality Health equity

FIGURE 8.6 Health equality implies that everyone gets the same treatment, and health equity gives everyone a fair opportunity to obtain optimal health. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The ethical principle and moral obligation to act on the basis of equality and equity, or **justice**, is a standard linked to

fairness for all in society. The ANA states that this obligation guarantees not only basic rights (respect, human dignity, autonomy, security, and safety), but also fairness in all operations of societal structures (2021). This includes care being delivered with fairness, rightness, correctness, unbiasedness, and inclusiveness while being based on well-founded reason and evidence.

The Centers for Disease Control and Prevention discuss diversity and inclusion as important factors in health equity considerations. Diversity refers to the existence of societies, communities, or subcultures that differ substantially from one another. Inclusion is the practice of creating an environment in which individuals of all backgrounds feel respected, valued, and supported (CDC, 2022b). There are numerous factors that can prevent diversity, inclusion, and justice. These can, in turn, create health disparities that limit access to care and worsen health outcomes for certain groups.

Race/Ethnic Heritage

Race and ethnicity are both socially constructed ideas. There are no true scientifically or genetically distinct races or ethnicities (Mersha & Beck, 2020). Nonetheless, race and ethnicity have an undeniable effect on health-care access and outcomes. The belief that races are distinct from one another, and that there is a hierarchy to race, implying that races are unequal is the concept of **racism**. As health-care providers, nurses have an obligation to recognize the impact of racism on their clients and the communities they serve. In the United States, race and ethnic background have long played a role in health disparities among different populations.

Most racial and ethnic minorities experience higher rates of chronic disease and premature death compared with White populations; some underrepresented groups, such as Asian and Hispanic immigrants, experience lower rates (Weinstein et al., 2017). American Indian, Alaska Native, and Black populations experience the highest infant mortality rates, while Asian and Pacific Islanders experience the lowest (Figure 8.7). Black individuals are more likely than White individuals to die prematurely from heart disease, and Black males are twice as likely as White males to die prematurely from stroke.

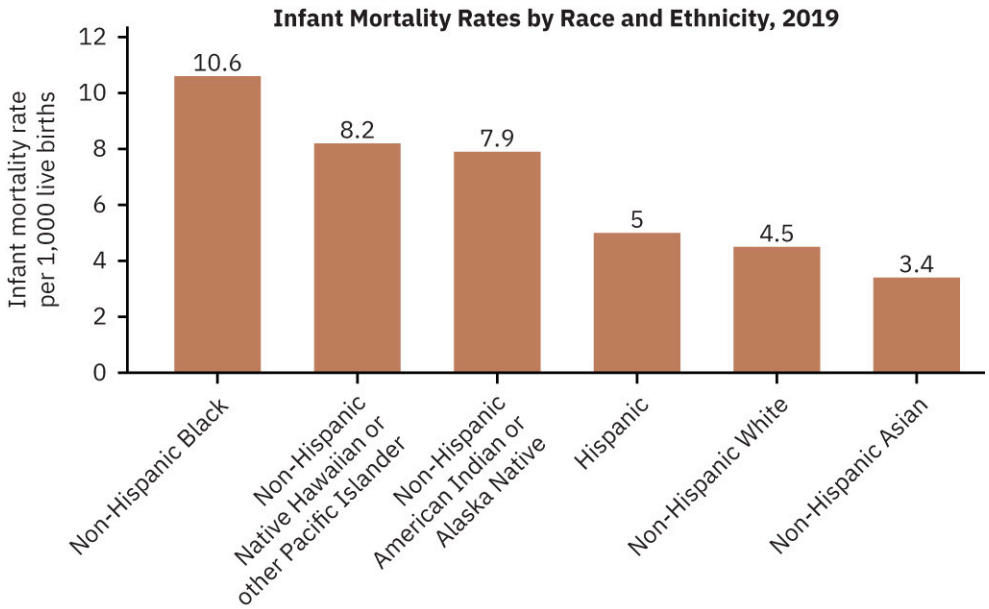


FIGURE 8.7 This chart from the Centers for Disease Control and Prevention shows infant mortality rates by race and ethnicity for the United States and illustrates discrepancies between groups. (credit: "Infant Mortality Rates by Race and Ethnicity, 2019" by Centers for Disease Control and Prevention, Public Domain)

Implicit bias related to race and ethnicity has been repeatedly shown in research to negatively affect client care and outcomes. Nurses should also be sensitive to the fact that individuals from certain ethnicities may be distrusting of health-care professionals due to cultural history and other factors.

Spirituality and Religion

Throughout human history, spirituality, religion, and health have often gone hand in hand. In many healing traditions, healers also serve as religious leaders (Figure 8.8). A person's religious beliefs may affect their diet, what medications they will take, their views on physical and mental illness, and their approaches to death and dying.

Many people consult and rely on their religious and spiritual beliefs when making medical decisions. For instance, Jehovah's Witnesses do not accept whole blood, plasma, and platelets because they believe that this might interfere with eternal salvation. A person's religious beliefs can affect their views on mental health care as well. For example, members of the Church of Scientology believe that modern psychology and psychiatric medicine are inhumane, cruel, and unscientific (McCall, 2006). They believe that modern mental health care robs an individual of their freedom and can even damage the brain, and that following certain practices within the Church are the only ways to improve one's mental well-being.

FIGURE 8.8 Religion and health are closely intertwined for many people. (credit: "Guatemalan Clergymen Lead Sunday Mass Aboard USNS *Comfort*" by Mass Communication Specialist 2nd Class Ethan J. Soto/Flickr, Public Domain)

Nurses must be prepared to take clients' religious and spiritual preferences into account as an important part of the treatment plan (Swihart et al., 2022). A thorough cultural assessment should include information on a client's religious or spiritual beliefs that might affect their health behaviors and their care. Nurses must be aware of implicit biases and personal beliefs and be culturally aware to provide equitable and competent care. One tool that can assist in a thorough spiritual assessment is FICA. FICA is an acronym that stands for faith or beliefs, the importance of beliefs, the community supporting the individual and beliefs, and the way in which we can address care issues related to spirituality.

LINK TO LEARNING

The FICA Spiritual Assessment tool developed by Christina Puchalski, MD, in 1991, provides a framework (https://openstax.org/r/77FICA) that may be helpful for obtaining a spiritual history from a client.

Age

Older adults struggle with some limitations in their care related to their age. Studies have shown that health-care providers are more likely to assume that older clients' conditions, such as cognitive decline, are due to their age and to deny them certain treatments as compared with younger clients (Hughes et al., 2020). Older clients also tend to be undertreated for pain and depression (Hughes et al., 2020).

Gender Identity and Sexual Orientation

An individual's deeply held sense of their gender, which may or may not align with the sex assigned to them at birth is called **gender identity**. The term used to describe a person whose gender identity matches their sex assigned at birth is **cisgender**. To the extent that a person's gender identity does not conform with the sex assigned to them at birth, they may identify as Transgender or as gender nonbinary. Someone whose gender identity or expression differs from traditional cultural gender roles for one's sex assigned at birth is called **Transgender**. Transgender people, like cisgender people, may be sexually oriented toward males, females, both sexes, or neither sex. Gender

expression refers to a person's outward demonstration of gender in relation to societal norms, such as in style of dress, hairstyle, or other mannerisms. Sharing pronouns as part of a basic introduction to a client can assist a Transgender client to feel secure sharing their pronouns in a health-care setting. Asking a client for their pronoun (he, she, they, ze, etc.) is considered part of a nursing assessment.

There is a strong body of research showing a history of gender bias in health care (Hughes et al., 2020). Providers are more likely to believe that the health complaints of women result from emotional instead of physical causes compared with men. There is also a demonstrated history of underdiagnosis and undertreatment of cardiovascular disease in women when compared with men. Moreover, studies reveal that "Transgender people already experience health inequities at a disparate rate compared to their cisgender peers, including increased rates of mental health disorders, substance use disorders, sexual and physical violence, and sexually transmitted infections" (Walter-McCabe & Chen, 2022, para 2).

A person's physical and emotional interest or desire for others is their **sexual orientation**. It exists on a continuum and is manifested in one's self-identity and behaviors. The acronym LGBTQIA stands for lesbian, gay, bisexual, Transgender, Queer or Questioning, Intersex, or Asexual in reference to sexual orientation. Historically, individuals within the LGBTQIA+ community have experienced discrimination and prejudice from health-care providers and avoided or delayed health care due to these negative experiences. Despite increased recognition of this group of people in recent years, members of the LGBTQIA+ community continue to experience significant health disparities (Walter-McCabe & Chen, 2022).

Disability

Disabilities can be present from birth or acquired later in life. They can be physical, cognitive, or mental health related. Adults with disabilities are more likely than adults with no disabilities to report poor health, including higher rates of obesity, diabetes, smoking, lack of physical activity, and cardiovascular disease. Adults with disabilities are also more likely to live in poverty, and even those with health insurance are less likely than adults without disabilities to seek care. Adults with disabilities also cite common stereotypes, bias, and beliefs among providers as barriers to care (VanPuymbrouck et al., 2020). Examples include lack of appropriate equipment to transfer clients with disabilities in doctor's offices, or a health-care provider's assumption that the client is unhealthy or fragile simply because they are disabled.

Education Level

Differences in educational levels can affect how people access health-care services and understand health information in order to make informed decisions. The higher a person's level of education, the higher their life expectancy and the more likely they are to access preventative and screening services (Viinikainen et al., 2022).

Raghupathi and Raghupathi (2020) analyzed data from twenty-six countries over ten years and identified connections between education and health. Their research proposed investments in education as investments in population health. Raghupathi and Raghupathi found that parental education at the tertiary level (beyond high school) was especially significant for infant and child health and overall life expectancy (2020). Heightened awareness of individual health could result from focused promotional campaigns. These efforts could increase school completion rates and employment skills and serve to reduce health disparities by promoting health maintenance and illness prevention (Raghupathi & Raghupathi, 2020).

Physical Characteristics

Certain physical characteristics have the potential to create barriers to care. For example, clients who are deaf or blind may need accommodations to ensure that communication is clear and accurate. To supplement spoken and printed communication, American Sign Language interpreters can be sought for deaf clients. Educational materials and consent forms printed in Braille can assist blind populations. Health equity and inclusion provides care for everyone assuming basic equal support and resources, no matter what their physical characteristics are.

Socioeconomic Status

In the United States, socioeconomic status is a major determinant of health status. People who belong to low socioeconomic groups—such as people who are homeless or people living in poverty—are more likely to report higher rates of disease, such as heart disease, diabetes, stroke, and obesity (National Academies of Sciences, 2017). This is because they have fewer opportunities to seek early prevention. They also are lacking the resources

to follow through with standard treatment plans. For instance, someone who is homeless is unable to perform clean dressing changes daily without adequate access to water. Socioeconomically disadvantaged individuals also have higher rates of infant mortality, substance misuse, and shorter life expectancies. Additionally, they may report avoiding care because they feel discrimination from health-care workers (Hughes et al., 2020).

In 2021, the majority of Americans relied on privately purchased insurance for their health care. Most of this insurance is made available through employers. Individuals are also able to purchase health insurance through the federal Marketplace. The Marketplace mandates that all of their available plans cover both inpatient and outpatient mental health and substance use disorder treatment (HealthCare.gov, n.d.). About 35 percent of the population holds a public form of insurance in the form of Medicaid or Medicare. Medicare is for those who have been determined to need special care, such as older people or those who have disabilities. Medicare covers both inpatient and outpatient mental health services, although clients may still be responsible for deductibles, copays, or coinsurance. Medicaid is for those who need aid in receiving care, such as people who meet certain lower income guidelines. It is the top payer of mental health services in the United States (Medicaid.gov, n.d.).

Veteran Status

Military veterans often have complex needs due to physical and psychological trauma sustained during military service and socioeconomic issues that arise after discharge (Figure 8.9). Many veterans are eligible for health-care benefits through the Veterans Administration if they meet certain criteria, such as age or level of disability (Veterans Affairs, n.d.). The Veterans Administration also offers free health care to veterans who meet certain low-income guidelines. The Veterans Administration covers community-based care in non-VA facilities for individuals who meet certain criteria, including those who live in a place where no VA facilities are available. That said, many veterans still struggle with a lack of access to health-care benefits, sometimes based on residing in rural locations that do not have veteran-specific health-care facilities.

FIGURE 8.9 Veterans are an especially vulnerable population and often have complex needs. (credit: U.S. Air Force photo by Tech. Sgt. Bennie J. Davis III, Public Domain)

Factors Preventing Sensitivity to Diversity

Several factors related to a person's experiences, attitudes, and knowledge hinder sensitivity to diversity. One significant factor is a lack of exposure to diverse individuals and cultures. Limited exposure can lead to a lack of understanding and appreciation for diversity. Stereotyping and prejudice can also contribute to insensitivity; preconceived notions or stereotypes about certain groups can lead to discrimination and bias. Personal biases can

influence perceptions and attitudes toward different groups, leading to insensitivity. Additionally, a lack of education or awareness about different cultures and backgrounds can lead to misunderstandings. Overcoming these barriers requires ongoing education, open-mindedness, and a willingness to learn about and appreciate different cultures and backgrounds. It also requires actively challenging one's biases and seeking out opportunities for exposure to diversity.

Stereotyping

The assumption that a person has the attributes, traits, beliefs, and values of a cultural group simply because they are a member of that group is called stereotyping. Engaging in stereotyping prevents the ability to identify people's needs on an individual level. One common stereotype is the assumption that all older clients are forgetful or have memory problems. This stereotype can lead to medical professionals overlooking or dismissing legitimate concerns or symptoms of older clients, attributing them solely to age-related memory decline, which can, in turn, lead to misdiagnosis or delayed treatment. Culturally equitable care extends beyond general knowledge of a cultural group to knowledge of the individual themselves.

Cultural Imposition

The imposition of one's own values, beliefs, and practices upon another person or group is called **cultural imposition**. It runs counter to cultural humility and can manifest in various ways. Examples include disregarding a client's cultural practices, beliefs, and values when making medical decisions, or imposing Western medical practices on non-Western cultures without consideration for their unique cultural beliefs and practices. For instance, health-care providers may fail to consider a client's traditional healing practices or the role of family members in health-care decisions, which can lead to a breakdown in communication and a lack of trust between clients and health-care providers.

Cultural Blindness

The belief that all cultural groups are the same and share identical experiences is called **cultural blindness** (Bhattacharya et al., 2019). Different cultural groups can have vastly different experiences just within the health-care system. Cultural blindness might lead a nurse to conclude that all treatment services are adequate for all clients, contributing to the continuation of policies that prevent diversity and inclusion. For example, a hospital may carry copies of all of its consent forms in English and Spanish, but there is a large local Vietnamese population as well, and the nurse can never find a Vietnamese consent form for these clients. This is a result of system-wide cultural blindness. Once the nurse identifies the issue, they can escalate it and have the issue addressed by having adequate Vietnamese-language consent forms available for the client population.

Culture Conflict

Tension or opposition between different cultures can result in **culture conflict**. Often, the dominant culture weakens the cultural practices of the underrepresented group as a result (APA, n.d.). Culture conflict can arise in many ways, such as when a client's cultural beliefs around illness and healing differ from those of the health-care provider, or when a client's cultural practices conflict with medical protocols. For example, a client who refuses to receive a blood transfusion due to religious beliefs may have conflict with the nurse who sees this treatment as medically necessary.

Culture conflict can also arise when health-care providers make assumptions or judgments about clients based on their cultural background, leading to biases and discrimination. This can result in disparities in health-care access and outcomes for clients from diverse backgrounds. Nurses should approach such conflicts with cultural humility to ensure they are resolved without damage to the nurse-client relationship.

Barriers to Communication Affecting Diversity and Inclusion

It is necessary to overcome communication barriers in order to maximize the clients' opportunities for best care. According to the Agency for Healthcare Research and Quality (2020), for instance, about three out of one hundred people in the United States have a hearing disability, and two out of one hundred have a visual disability to the extent that they are blind or have trouble seeing even with corrective vision wear. Various strategies can help improve the communication process for these clients.

For clients with hearing barriers, offer print materials, text telephones (TTYs), or videos with captioning. Sign language interpreters use American Sign Language or Signed English; there are also oral and cued-speech

interpreters who use articulation and gestures. When having conversations, make sure the television or other sources of background noise are silenced and the surrounding environment is free of distracting noise.

For clients with sight barriers, make sure that the lighting is at their comfort level. Whenever possible, provide assistance in the form of audio recordings, large-print materials, and screen magnifiers. Text-to-speech or Braille output screen reading software is also available.

According to recent data, 8 percent of the U.S. population has limited English proficiency (Haldar et al., 2023). Linguistically competent care aims to help these people understand their treatment. The Agency for Healthcare Research and Quality defines linguistic competence as "providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators" (Agency for Healthcare Research and Quality, 2019, para 2).

All educational materials, instructions, and consent forms should be offered in the client's preferred language. When caring for a client whose primary language is not English and they have a limited ability to speak, read, write, or understand the English language, seek the services of a trained medical interpreter. Health-care facilities are mandated by the Joint Commission to provide qualified medical interpreters. Use of a trained medical interpreter is linked to fewer communication errors, shorter hospital stays, reduced thirty-day readmission rates, and improved client satisfaction (Fidler, 2023).

Refrain from asking a family member to act as an interpreter. The client may withhold sensitive information from them, or family members may possibly edit or change the information provided. Unfamiliarity with medical terminology can also cause misunderstanding and errors.

Medical interpreters may be on-site or available by videoconferencing or telephone. When possible, obtain a medical interpreter of the same gender as the client to prevent potential embarrassment if a sensitive matter is being discussed. Some additional guidelines for working with a medical interpreter are to:

- Allow extra time for the interview or conversation with the client.
- Whenever possible, meet with the interpreter beforehand to provide background.
- Document the name of the medical interpreter in the progress note.
- Always face and address the client directly, using a normal tone of voice. Do not direct questions or conversation to the interpreter.
- Speak in the first person (using "I").
- Avoid using idioms, such as "Are you feeling under the weather today?" Avoid abbreviations, slang, jokes, and jargon.
- Speak in short paragraphs or sentences. Ask only one question at a time. Allow sufficient time for the interpreter to finish interpreting before beginning another statement or topic.
- Ask the client to repeat any instructions and explanations given to verify that they understood.

Summary

8.1 Understanding Cultural Differences

An individual's cultural background influences their beliefs, feelings, and attitudes toward health care. Their culture informs how they view health and illness, how they view healthcare providers, and how receptive they are to treatment plans. Culture also determines who receives care and the quality of their care. Certain cultures experience higher rates of disease due to genetics or health disparities caused by environmental factors. Various cultures have their own traditional healing practices and beliefs, and many people still use these practices either alongside or in place of Western medicine. Nurses care for clients from different cultures with their own beliefs and practices. It is important to be respectful of these individual differences and be aware of any implicit bias in order to provide the best possible care.

8.2 Ethical Practice in Culture and Diversity

Accommodating different cultural practices begins with the practice of cultural humility. By seeking cultural assistance from appropriate sources and practicing cultural negotiation, the nurse can demonstrate respect for other cultures. Engaging in cultural diversity practices can range from one-on-one conversations with clients, to researching written history, to actively participating in different cultural activities and experiences. Being responsive to cultural diversity involves understanding cultural differences and being willing to overcome personal biases to accommodate the cultural preferences of a client in order to provide the most culturally competent care.

8.3 Cultural Practice in Nursing

When providing care for clients from different cultural practices, it is necessary to perform a thorough cultural assessment to gain information on client-specific details. The Transcultural Nursing Society developed the Standards of Practice for Culturally Competent Nursing Care, which serves as universally applicable guidelines for nurses in all aspects of culturally competent nursing care. Cultural competency is important because it has the power to improve the quality of care and lead to better health outcomes for culturally diverse clients. Various factors can affect diversity and inclusion in nursing, including the six cultural phenomena of communication, space, social organization, time, environmental control, and biological variations. The best way to counteract this is to identify biases and change practices going forward.

8.4 Diversity, Equity, and Inclusion

Important considerations related to providing equal, diverse, and inclusive nursing care include nursing knowledge of health equity and health disparities. The nurse should be aware of possible disparities in care of client populations and strive to foster a culture of mutual respect, understanding, and support, which can lead to improved client outcomes. Factors that can prevent diversity and inclusion include stereotyping, cultural imposition, cultural blindness, and culture conflict. Barriers to communication related to language, literacy, and accessibility for all clients can negatively affect diversity and inclusion.

Key Terms

alternative therapies nonmainstream approaches that are used in place of conventional Western medical care
Ayurveda traditional Hindu form of medicine from India that is based on the idea that disease is caused by an imbalance in the body
cisgender person whose gender identity matches their sex assigned at birth
collectivism when a culture emphasizes the importance of the community over the individual
complementary therapies nonmainstream approaches to health that are used alongside conventional Western medical care
cultural blindness belief that all cultural groups are the same and share identical experiences
cultural competency skill of applying evidence-based nursing care in agreement with the cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes
cultural diversity existence of societies, communities, or subcultures that differ substantially from one another
cultural humility respecting and learning about the cultures of others while exploring one's own cultural biases
cultural imposition imposition of one's own values, beliefs, and practices upon another person or group
cultural negotiation process where the client and nurse seek a mutually acceptable way to deal with competing

interests of nursing care, prescribed medical care, and the client's cultural needs

cultural self-awareness person's understanding of their own culture and its impact on themselves

culturally responsive care when an individual's cultural beliefs are integrated into their health care

culture set of beliefs, attitudes, and practices shared by a group of people or community that is accepted, followed, and passed down to other members of the group

culture conflict tension or opposition between different cultures

curanderismo holistic practice traditional to Hispanic cultures that is rooted in beliefs that health is achieved through the right balance of mind, body, and spirit

ethnocentrism belief that one's culture (or race, ethnicity, country) is better and preferable to another's

gender identity individual's deeply held sense of their gender, which may or may not align with the sex assigned to them at birth

health disparities health outcomes impacted by social determinants of health that represent preventable differences experienced by underrepresented individuals

health equality when nurses treat all clients as individuals, show respect for their personal choices and differences, and recognize their dignity and human rights

health equity when everyone has a fair opportunity to obtain optimal health

homeopathy using natural products in extremely diluted doses to treat illness

inclusion practice of creating an environment in which individuals of all backgrounds feel respected, valued, and supported

individualism culture that focuses on the importance of the individual over community

interpersonal component of cultural humility that involves a respect for the client's culture and openness to their beliefs and experiences

intrapersonal component of cultural humility that consists of a personal awareness of one's own limited knowledge of the client's culture

justice principle and moral obligation to act on the basis of equality and equity

racism belief that races are distinct from one another, and that there is a hierarchy to race, implying that races are unequal

sexual orientation person's physical and emotional interest or desire for others

Traditional Chinese Medicine (TCM) ancient practice based on the ideas of qi and yin and yang

traditional healing various medicines and healing practices around the world that differ from the modern, Western health-care system

transcultural nursing incorporates cultural beliefs and practices of individuals to help them maintain and regain health or to face death in a meaningful way

Transgender person whose gender identity or expression differs from traditional cultural gender roles for one's sex assigned at birth

Assessments

Review Questions

1. What is the term for integrating an individual's cultural beliefs into their health care?
   a. cultural integrity
   b. culturally responsive care
   c. holistic care
   d. integrative care

2. A client is admitted to the medical surgical floor for uncontrolled hypertension. He is a seventy-five-year-old Hispanic male who speaks fluent English. He tells the nurse that he has been seeing a curandero, or traditional healer, for his health issues for the last several years. What is the best initial response from the nurse?
   a. Ask the client for a list of all herbs, plants, and special diets that he is currently taking.
   b. Educate the client on why adherence to a Western medical treatment plan is better for his health.
   c. Inform the client that the treatment he has been receiving from the curandero is not evidence-based.
   d. Tell the client he is welcome to continue whatever traditional treatments he likes while he is in the

hospital.

3. You are a nurse and have just finished taking a course on identifying implicit bias. You decide to journal after one of your shifts to reflect on any possible instances of implicit bias in your workday. What is an example of an interaction that represents implicit bias?
   a. You are frustrated when you learn during report that one of your clients is an eighty-two-year-old male with dementia who is forgetful, difficult to redirect, and often agitated.
   b. You learn that one of your clients went to another high school in your hometown. You rush through your medication pass so you can spend some extra time talking to this client.
   c. One of your clients is a fifty-nine-year-old female from Syria. During report, the client's previous nurse explains to you that the client's husband is at the bedside and that when the client is questioned, he usually answers the questions for her. The nurse states, "I think it's really sexist, but they are from the Middle East."
   d. You enter the room of your client who is a twenty-three-year-old Black female with a history of alcohol abuse. She is on alcohol withdrawal protocol and has orders for frequent vital signs. She shares with you her drinking history and how difficult it is for her to stop. You empathize with her and tell her you're supportive of her efforts to get sober.

4. What are nonmedical factors that influence health outcomes, including conditions in which people are born, grow, work, live, and age, and the wider sets of forces and systems shaping the conditions of daily life called?
   a. environmental influences
   b. life circumstances
   c. situational occurrences
   d. social determinants of health

5. A process where the client and nurse seek a mutually acceptable way to deal with competing interests of nursing care, prescribed medical care, and the client's cultural needs is known as cultural negotiation. What an example of cultural negotiation?
   a. a nurse insisting the client shave his facial hair
   b. a nurse demanding daily medication be taken at 0900, when the client wakes daily at 0500
   c. a nurse seeking arrangements to keep the client's hijab in place for a surgical procedure
   d. a nurse (not the client) requesting a special religious healer visit the client after admission

6. While learning about Chinese culture and attending local presentations on culturally competent care, you discover a local event happening in your area. You decide to ask a group of coworkers to join you in attending a local Chinese New Year parade. What practice does this scenario represent?
   a. active learning
   b. interpersonal awareness
   c. intrapersonal awareness
   d. willingness to change

7. What is an example of being culturally responsive?
   a. attending an Indian dance night at a local community center
   b. educating the client on your own cultural practices
   c. implementing a system to improve cardiovascular health screening procedures for Black women at your hospital
   d. insisting that a client answer your questions instead of her husband

8. What scenario is an effective example of cultural humility?
   a. a nurse allowing a non-English speaking client's son to translate for them
   b. a nurse listening to a client who is pregnant explain why they want a traditional midwife from their own culture present in the room while they are delivering their baby
   c. a nurse administering a new medication to a client with limited English, even though the translator is

late, so that it can be given on schedule
d. a nurse giving the client discharge paperwork printed in their preferred language because they don't have time to verbally discuss discharge instructions with the client

9. What is the purpose of the theory of culture care diversity and universality?
a. to provide a framework for transcultural nursing and the development and practice of culturally competent nursing care
b. to explain the many cultural differences that exist among communities
c. to shape the beliefs of nurses regarding certain health- and wellness-related customs communities of underrepresented people
d. to provide clients with a way to address health disparities and systemic inequality in the health-care system

10. Taking a test to examine one's implicit biases is an example of which of the twelve standards of practice for culturally competent nursing care?
a. critical reflection
b. culturally competent practice
c. knowledge of cultures
d. social justice

11. According to Giger and Davidhizar's six cultural phenomena, in what context does all communication exist?
a. biology
b. environment
c. space
d. time

12. What is one important purpose of cultural competency?
a. to improve the quality of care leading to better health outcomes for culturally diverse clients
b. to ensure that the predominant cultural voices in a community are the ones who shape health-care practices
c. to prevent unscientific beliefs from influencing important medical decisions
d. to provide education to cultural communities on how they can best adapt their practices to suit the modern health-care system

13. What is the state in which everyone has a fair and just opportunity to obtain their highest level of health?
a. health equality
b. health equity
c. fairness
d. justice

14. Report from another nurse says that the new client is an eighty-two-year-old Chinese female. The new nurse believes that they will have a good day with this client because older, Asian women are usually very polite, easy to get along with, and compliant with requests. What is the new nurse engaging in?
a. cultural application
b. cultural blindness
c. ethnocentrism
d. stereotyping

15. A Spanish-speaking client has to fill out a consent form and requests that their family member interpret for them. What is the most appropriate response?
a. Ask the family member to leave the room and use an official translator.
b. Find an official translator to assist with the conversation along with the client and family member.
c. Proceed with allowing the family member to interpret.

d. Tell the client that you are only allowed to use official translators or interpreters.

Check Your Understanding Questions

1. Describe ways in which a nurse can provide culturally sensitive nursing interventions for a client in pain.
2. Describe how a nurse can overcome implicit bias.
3. List some specific ways in which to engage in cultural diversity practices.
4. What are some ways to demonstrate responsiveness to diversity and inclusion?
5. Describe the steps to beginning a culturally sensitive nursing assessment.
6. List some different types of alternative and complementary therapies.
7. Describe the guidelines for working with a medical interpreter.

Reflection Questions

1. Why is it important for nurses to be aware of the health practices associated with different cultures?
2. Why is cultural humility such an important part of cultural competence?
3. Why do you think the Transcultural Nursing Society included "multicultural workforce" as one of their twelve standards of practice for culturally competent care?
4. The concept of cultural blindness is the belief that all cultural groups are the same and share identical experiences. How would experiencing cultural blindness be a barrier to diversity and inclusion?

What Should the Nurse Do?

Maria, a thirty-year-old female, comes to the primary care clinic reporting persistent fatigue, headaches, and difficulty sleeping. Maria reveals that she recently lost her job, which has added financial strain to her life. She expresses a preference for alternative healing practices and mentions consulting a traditional healer in her community for spiritual guidance. Maria has a history of hypertension and has been managing her blood pressure with medication. She is generally healthy but notes increased stress levels recently. Maria prefers natural remedies and has sought guidance from traditional healers in the past for spiritual and emotional well-being. Vital signs show an elevated blood pressure of 140/90 mmHg, a heart rate of 82 bpm, a respiratory rate of 18 breaths per minute, and a temperature of 98.6°F (37°C).

1. What cultural cues or verbal/nonverbal expressions from Maria might reveal her beliefs about health and illness? How can recognizing these cues help tailor the nursing approach to her cultural context?
2. How can the nurse proactively address unconscious bias when interacting with Maria, considering her cultural background? What strategies can be employed to ensure culturally competent and unbiased care?

Dolores, a forty-five-year-old female, presents at the community health clinic for a routine checkup. She recently immigrated from Mexico and speaks limited English. Dolores reports feeling fatigued and experiencing occasional headaches. Her medical history includes hypertension and type 2 diabetes, both well-managed with medications. During the assessment, her blood pressure is elevated (150/90 mmHg), and she exhibits signs of distress when trying to communicate her symptoms in English.

3. What immediate actions can be taken to address Dolores's elevated blood pressure and ensure her comfort in the health-care setting?
4. What culturally sensitive strategies can be employed to improve communication with Dolores and gather a more accurate medical history?

Tan, a sixty-year-old Vietnamese male, presents at the hospital emergency department with complaints of severe abdominal pain and difficulty breathing. He communicates primarily in Vietnamese, and his daughter, who is bilingual, serves as his interpreter. Tan has a history of chronic obstructive pulmonary disease (COPD) and recently underwent abdominal surgery for a gastrointestinal issue. Vital signs reveal an elevated respiratory rate and decreased oxygen saturation.

5. What cultural cues did you observe in Tan's communication style, and how might these cues impact the

nursing care provided?

6. How can you involve Tan's daughter in a way that respects cultural practices and enhances communication to ensure the provision of comprehensive care?
7. How will you assess the effectiveness of the interventions implemented to address Tan's symptoms and involve his daughter in the care process?
8. Francine, a new graduate nurse, was offered a full-time position on the dialysis floor of an acute care hospital. The new hire process includes a six-week training program that allows the new hire to observe and work closely with a seasoned employee. On Francine's first shift, she realizes that she has been assigned to shadow Muhammad. Muhammad has been an employee for over ten years and was awarded Nurse of the Year two years ago. Francine notices that with each client interaction, he educates the client on both conventional Western medical treatments and traditional healing remedies. Francine is very confused; she thought that Western medicine was superior to that of traditional healing practices. She decides to confront Muhammad.
   If you were Muhammad, how would you explain to Francine that her thought process is impacting diversity and inclusion?

Loretta, a seventy-year-old female, arrives at the outpatient clinic with complaints of persistent joint pain and difficulty moving. Loretta has a medical history of rheumatoid arthritis and hypertension, well-controlled with medications. During the assessment, she appears hesitant to share details about her symptoms and seems uncomfortable. Vital signs are all within the normal range: blood pressure of 120/80mm Hg, heart rate of 80 beats per minute, respiratory rate of 16 breaths per minutes, and a temperature of 98.8°F (37°C).

9. How might cultural factors influence Loretta's communication style and her willingness to disclose information about her joint pain?
10. What steps can be taken to foster an inclusive and culturally sensitive environment during the assessment and treatment of Loretta's joint pain?
11. How can you modify your communication approach to address potential barriers and ensure Loretta feels comfortable sharing information about her symptoms?

Competency-Based Assessments

1. Use various sources to research diverse cultural communities in your region. Note important cultural factors, such as language, race/ethnicity, and religion. Discuss how these cultural factors might impact the abilities of these diverse communities to access health care.
2. Identify a diverse cultural event in your community in which you can actively participate, such as a meal, dance, or festival. Attend the event and write a journal entry about your experience. What did you learn about diversity at this event? Did it help you to identify any implicit biases? What lessons will you take with you as you begin your nursing practice?
3. Have you ever experienced or witnessed an interaction where there was a lack of cultural competency? What factors caused the lack of cultural competency? Discuss how you can use your experiences to ensure better diversity and inclusion in nursing.
4. Develop a ten-minute presentation on an alternative or complementary therapy.

References

Agency for Healthcare Research and Quality. (2019, July). *What is cultural and linguistic competence?* https://www.ahrq.gov/ncepcr/tools/cultural-competence/definition.html

Agency for Healthcare Research and Quality. (2020, September). *The share approach-overcoming communication barriers with your clients: A reference guide for health care providers*. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-3.html

American Nurses Association. (2018, February 15). *Code of ethics*. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses

Association.

American Psychological Association. (n.d.). *APA dictionary of psychology*. https://dictionary.apa.org/cultural-blindness

Bhattacharya, S., Kumar, R., Sharma, N., & Thiyagarajan, A. (2019). Cultural competence in family practice and primary care setting. *Journal of Family Medicine and Primary Care, 8*(1), 1. https://doi.org/10.4103/jfmpc.jfmpc_393_18

Boston Medical Center. (n.d.). *Genetic screening: Ancestry based*. https://www.bmc.org/genetic-services/ancestry-based

Centers for Disease Control and Prevention. (2022a, December 8). *Advancing health equity in chronic disease prevention and management*. https://www.cdc.gov/chronicdisease/healthequity/index.htm

Centers for Disease Control and Prevention. (2022b, December 8). *NCCDPHP health equity glossary*. https://www.cdc.gov/chronicdisease/healthequity/health-equity-communications/nccdphp-health-equity-glossary.html

Centers for Disease Control and Prevention. (2024, February 23). *Cultural competence in health and human services*. https://npin.cdc.gov/pages/cultural-competence-health-and-human-services

Cruz, M. L., Christie, S., Allen, E., Meza, E., Nápoles, A. M., & Mehta, K. M. (2022). Traditional healers as health care providers for the Latine community in the United States, a systematic review. *Health Equity*, *6*(1), 412–426. https://doi.org/10.1089/heq.2021.0099

Department of Justice. (2020, April). *Drug fact sheet: Peyote & Mescaline*. DEA.gov. Retrieved February 28, 2023, from https://www.dea.gov/sites/default/files/2020-06/Peyote%20and%20Mescaline-2020_0.pdf

Douglas, M. K., Rosenkoetter, M., Pacquiao, D. F., Callister, L. C., Hattar-Pollara, M. Lauderdale, J., Milstead, J., Nardi, D., Purnell, L. (2011, October). Standards of practice for culturally competent nursing care: 2011 update. *Journal of Transcultural Nursing, 22*(4), 317–333. https://doi.org/10.1177/1043659611412965

EveryNurse. (2023). *Seven steps to become a more culturally sensitive nurse*. https://everynurse.org/7-steps-culturally-sensitive-nurse/

Fatehi, K., Priestley, J. L., & Taasoobshirazi, G. (2020). The expanded view of individualism and collectivism: One, two, or four dimensions? *International Journal of Cross Cultural Management*, *20*(1), 7–24. https://doi.org/10.1177/1470595820913077

Fidler, M. (2023, November 23). How high-quality medical interpreters can reduce costs and improve patient outcomes. *The Journal of mHealth*. https://thejournalofmhealth.com/how-high-quality-medical-interpreters-can-reduce-costs-and-improve-patient-outcomes/

Firenzuoli, F., & Gori, L. (2007). European traditional medicine – international congress – introductory statement. *Evidence-Based Complementary and Alternative Medicine*, *4*(s1), 3–4. https://doi.org/10.1093/ecam/nem134

Giger, J. N., & Davidhizar, R. (2002). The Giger and Davidhizar transcultural assessment model. *Journal of Transcultural Nursing*, *13*(3), 185–188. https://doi.org/10.1177/10459602013003004

Givler, A., & Bhatt, H. (2022, May 23). *The importance of cultural competence in pain and palliative care*. StatPearls. https://www.statpearls.com/ArticleLibrary/viewarticle/41271

Haldar S., Pillai, D., Artiga, S. (2023, July 7). *Overview of health coverage and care for individuals with limited English proficiency (LEP).* https://www.kff.org/racial-equity-and-health-policy/issue-brief/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency/

Hall, E. T. (1966). *The Hidden Dimension*. Anchor Books.

Harvard Divinity School. (2021, October 4). *The Native American Church and the sacrament of peyote*. YouTube. https://www.youtube.com/watch?v=r4q60Klygs8

HealthCare.gov. (n.d.). *Mental health and substance abuse health coverage options*. https://www.healthcare.gov/

coverage/mental-health-substance-abuse-coverage/

Hughes, V., Delva, S., Nkimbeng, M., Spaulding, E., Turkson-Ocran, R.-A., Cudjoe, J., Ford, A., Rushton, C., D'Aoust, R., & Han, H.-R. (2020). Not missing the opportunity: Strategies to promote cultural humility among future nursing faculty. *Journal of Professional Nursing*, *36*(1), 28–33. https://doi.org/10.1016/j.profnurs.2019.06.005

Jensen, E. (2022, June 10). *2020 U.S. population more racially and ethnically diverse than measured in 2010*. Census.gov. https://www.census.gov/library/stories/2021/08/2020-united-states-population-more-racially-ethnically-diverse-than-2010.html

Johns Hopkins Medicine. (2019a, December 2). *Ayurveda*. https://www.hopkinsmedicine.org/health/wellness-and-prevention/ayurveda

Johns Hopkins Medicine. (2019b, December 2). *Chinese medicine*. https://www.hopkinsmedicine.org/health/wellness-and-prevention/chinese-medicine

Johnson & Johnson Nursing. (2018, December 3). *Becoming a culturally competent nurse*. YouTube. https://www.youtube.com/watch?v=r62Zp99U67Y

Jolley, C., & Peck, J. (2022). Diversity, equity, & inclusion policies of national nursing organizations. *OJIN: The Online Journal of Issues in Nursing*, *27*(2). https://doi.org/10.3912/ojin.vol27no02man02

Jones, N. (2022, June 10). *2020 census illuminates racial and ethnic composition of the country*. https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html

Keisler-Starkey, K., & Bunch, L. N. (2022, November 15). *Health insurance coverage in the United States: 2021*. https://www.census.gov/library/publications/2022/demo/p60-278.html

Leonti, M., & Verpoorte, R. (2017). Traditional Mediterranean and European herbal medicines. *Journal of Ethnopharmacology*, *199*, 161–167. https://doi.org/10.1016/j.jep.2017.01.052

Lu, C., & Wan, C. (2018). Cultural self-awareness as awareness of culture's influence on the self: Implications for cultural identification and well-being. *Personality and Social Psychology Bulletin*, *44*(6), 823–837. https://doi.org/10.1177/0146167217752117

Mayo Foundation for Medical Education and Research. (2021, February 13). *St. John's Wort*. Mayo Clinic. https://www.mayoclinic.org/drugs-supplements-st-johns-wort/art-20362212

McCall, W. V. (2006). Psychiatry and psychology in the writings of L. Ron Hubbard. *Journal of Religion and Health*, *46*(3), 437–447. https://doi.org/10.1007/s10943-006-9079-9

McFarland, M. R., & Wehbe-Alamah, H. B. (2019). Leininger's theory of culture care diversity and universality: An overview with a historical retrospective and a view toward the future. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *30*(6), 540–557. https://doi.org/10.1177/1043659619867134

Medicaid. (n.d.). *Behavioral health services*. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html

Mersha, T. B., & Beck, A. F. (2020, November 24). *The social, economic, political, and genetic value of race and ethnicity in 2020 - human genomics*. BioMed Central. https://humgenomics.biomedcentral.com/articles/10.1186/s40246-020-00284.

Mokgobi, M. G. (2014, September). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation, and Dance, 20*(Suppl 2), 24–34. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4651463/

Moore, E. (2023). Native knowledge. *American Nurse Journal*, *18*(11), 32–34. https://doi.org/10.51256/anj112332

National Academies of Sciences. (2017). The Root Causes of Health Inequality. Essay. In *Communities in Action: Pathways to Health Equity*. The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844/

National Institutes of Health. (n.d.). *Native Voices-Native Peoples' Concepts of Health and Illness*. U.S. National

Library of Medicine. https://www.nlm.nih.gov/nativevoices/exhibition/healing-ways/medicine-ways/key-role-of-ceremony.html

Perreira, K. M., Wassink, J., & Harris, K. M. (2019). Beyond race/ethnicity: skin color, gender, and the health of young adults in the United States. *Population Research and Policy Review*, *38*(2), 271–299. https://doi.org/10.1007/s11113-018-9503-3

Project Implicit. (n.d.). Take a test. https://implicit.harvard.edu/implicit/takeatest.html

QSEN Institute. (n.d.) QSEN competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Raghupathi, V., & Raghupathi, W. (2020). The influence of education on health: An empirical assessment of OECD countries for the period 1995–2015. *Arch Public Health, 78*, 20. https://doi.org/10.1186/s13690-020-00402-5

Sabin, J. A. (2022). Tackling implicit bias in health care. *New England Journal of Medicine*, *387*(2), 105–107. https://doi.org/10.1056/nejmp2201180

Slavin, S., Kuo, A., & Galanti, G-A. (2019). *The 4C's. Understanding cultural diversity in healthcare*. https://ggalanti.org/the-4cs-of-culture/

Spector, R. E. (2017). *Cultural diversity in health and illness* (9th ed.). Pearson Education.

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse clients. *FOCUS*, *18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Substance Abuse and Mental Health Services Administration. (2014). *Quick guide for clinicians: Improving cultural competence*. https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2022, November 14). *Cultural religious competence in clinical practice*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK493216/

U. S. Census Bureau. (2021, October 27). *2020 census demographic data map viewer*. https://www.census.gov/library/visualizations/2021/geo/demographicmapviewer.html

U.S. Department of Health and Human Services. (2017, September). *Naturopathy*. National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/health/naturopathy/

U.S. Department of Health and Human Services. (n.d.-a). *Complementary, alternative, or integrative health: What's in a name?* National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name

U.S. Department of Health and Human Services. (n.d.-b). *Cultural responsiveness*. Cultural Responsiveness - Child Welfare Information Gateway. https://www.childwelfare.gov/topics/systemwide/cultural/

U.S. Department of Health and Human Services. (n.d.-c). *Homeopathy*. National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/health/homeopathy/

VanPuymbrouck, L., Friedman, C., & Feldner, H. (2020). Explicit and implicit disability attitudes of healthcare providers. *Rehabilitation Psychology*, *65*(2), 101–112. https://doi.org/10.1037/rep0000317

Veterans Affairs. (n.d.). *Eligibility for VA health care*. https://www.va.gov/health-care/eligibility/.

Viinikainen J., Bryson, A., Böckerman, P., Kari, J. T., Lehtimäki, T., Raitakari, O., Viikari, J., & Pehkonen, J. (2022). Does better education mitigate risky health behavior? A mendelian randomization study. *Economics & Human Biology*. *46*, 101–134. https://doi.org/10.1016/j.ehb.2022.101134.

Walter-McCabe, H., & Chen, A. (2022). Editors' introduction: Transgender health equity and the law. *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics*, *50*(3), 401–408. https://doi.org/10.1017/jme.2022.83

Weinstein, J. N., Geller, A., Negussie, Y., & Baciu, A. (Eds.). (2017). The State of Health Disparities in the United States. In *Communities in Action: Pathways to Health Equity*. essay, The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844/

World Health Organization. (n.d.). *WHO Global Traditional Medicine Centre*. https://www.who.int/initiatives/who-global-centre-for-traditional-medicine

Zuma, T., Wight, D., Rochat, T., & Moshabela, M. (2016). The role of traditional health practitioners in Rural KwaZulu-Natal, South Africa: Generic or mode specific?. *BMC Complementary and Alternative Medicine*, *16*(1), 304. https://doi.org/10.1186/s12906-016-1293-8

CHAPTER 9
Social and Emotional Concerns

FIGURE 9.1 Group therapy can occur in a variety of settings, such as this session in the woods by a river. (credit: "Men Sitting Talking by River Outdoors" by "JourneyPure Rehab:/flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION Death and dying are integral aspects of the human experience, and for health-care professionals, understanding and effectively responding to the end-of-life journey is paramount. Nurses are pivotal in providing compassionate care, support, and comfort to clients and their families during this sensitive time. Grieving individuals may experience social isolation, difficulty maintaining relationships, and hurdles to resuming daily activities. Different cultures and societies have unique beliefs, customs, and rituals surrounding death. In some instances, death-related topics may be stigmatized, leading to a lack of open discussion and support for those experiencing loss. Health-care providers must be sensitive to these diverse perspectives and accommodate individual and family preferences during the end-of-life journey.

Likewise, grief, anger, and aggression are universal human experiences, deeply ingrained within individuals' biological and psychological makeup. As survival mechanisms, they evolved to protect us from threats and ensure our existence. When misdirected or poorly managed, however, these emotions can lead to destructive outcomes, causing harm to oneself and others.

9.1 Death and Dying

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe social and legal concerns associated with death and dying
- Discuss emotional, spiritual, and practical concerns associated with death and dying
- Discuss cultural considerations related to death and dying

Understanding the intricacies of human emotions and experiences is as crucial as any medical procedure or treatment plan. As caregivers, nurses navigate a variety of human emotions, encountering profound challenges that test not just their medical expertise but also their empathy and understanding. A profound and inevitable aspect of the human experience is the concept of death and dying. Nurses play a pivotal role in supporting clients and families through this deeply personal and challenging phase. According to Kübler-Ross's theory, the stages of grief—denial, anger, bargaining, depression, and acceptance—guide individuals through the emotional journey surrounding death (Valliani & Mughal, 2022). Understanding these stages allows nurses to provide holistic care and support to clients and their loved ones during this delicate transition.

Social and Legal Concerns Associated with Death and Dying

Death and dying profoundly impact individuals, families, and communities because death is not solely a biological event but also a social and cultural phenomenon. Losing a loved one triggers intense grief reactions, which can have social implications. Death often carries societal stigmas and taboos, leading to varying degrees of discomfort or avoidance in discussing this inevitable facet of life (Dimitrov et al., 2022). Certain circumstances involving death—physician-assisted dying, abortion, and suicide—bring with them particular social and legal concerns of which nurses should be aware.

Generally, nurses play a pivotal role in ensuring compassionate care and support throughout any death and dying process:

- Client advocacy and support: Nurses serve as advocates for clients navigating end-of-life decisions, offering empathetic guidance and support while respecting individual autonomy. They facilitate informed discussions, ensuring clients comprehend their options and rights and client wishes related to dying such as whether they wish to be resuscitated or not.
- Ethical guidance and counseling: Nurses provide counseling to clients, families, and colleagues, fostering understanding of the moral, legal, and emotional implications surrounding death.
- Collaborative care coordination: Nurses serve as a liaison between clients, families, physicians, and support services, ensuring coordinated care aligned with the client's wishes and needs.
- Compassionate end-of-life care: Nurses offer compassionate care to clients, focusing on pain management, emotional support, and dignified end-of-life experiences. A focus on palliative care ensures comfort and quality of life until the final moments (Demedts et al., 2023).

Physician-Assisted Dying

Intentionally ending a life to prevent further pain and suffering is considered **assisted dying**. Most people are familiar with the concept of euthanasia, which is when someone other than the individual aids the person's dying through the administration of medication at the request of the individual (ANA, 2019). Euthanasia is illegal in the United States. It should not be confused with medical aid in dying. Physician-assisted, or medical aid in dying, is intentional assistance provided by a physician to enable an individual to end their own life by furnishing drugs for self-administration, always at the voluntary and competent request of the individual involved (Fontalis et al., 2018).

Physician-assisted dying is an emotionally charged and complex issue, and nurses face critical moral, legal, and ethical considerations. The laws on assisted dying vary globally, with only a few countries recognizing its legality (Emanuel et al., 2016). In the United States, it is legal in eleven states: California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington. An example of how legislation is applied is the Oregon Death with Dignity Act, permitting dying Oregonians to voluntarily kill themselves by taking physician-prescribed lethal medications. This law has sparked debates on ethical, legal, and moral grounds, serving as a catalyst for discussions about end-of-life care, client autonomy, and health-care provider roles in assisted dying. It has influenced similar legislation in other states and countries, contributing to ongoing discussions and

initiatives regarding end-of-life choices and physician-assisted dying (Oregon Health Authority, 2021). Under this act, nurses serve as primary educators, providing comprehensive information about end-of-life care options, ensuring clients possess informed decision-making capabilities. Nurses clarify procedural intricacies, explaining eligibility criteria and requirements, guiding clients through the process, and addressing inquiries to facilitate well-informed choices. In assessing client eligibility, they aid in documenting and communicating clients' preferences, while also advocating for client autonomy, ensuring that their wishes are effectively communicated within the health-care team. Furthermore, nurses extend emotional support to both clients and families, offering compassion during decision-making and throughout the end-of-life journey (Oregon Nurses Association, 2015). Nurses must have knowledge of the existing legal framework in their location and adhere strictly to it to avoid legal repercussions (Bellon et al., 2022). According to the ANA position statement (2019), nurses are ethically prohibited from actively being involved in medical aid in dying, other than providing support to their clients.

Nurses need to be aware of and sensitive to the ethics of assisted death as well. Assisted death raises fundamental ethical issues, such as respect for autonomy, the sanctity of life, and harm prevention. Nurses should carefully reflect upon and navigate these ideas, considering the individual client's wishes and the nurse's values (Bellon et al., 2022). No matter the laws or ethical considerations, effective communication is critical. Nurses should be able to engage in open, sensitive, and respectful discussions about physician-assisted dying with clients and their families. They should also communicate effectively with other health-care professionals to ensure coordinated care.

Abortion

As health-care professionals, it is crucial to explore and understand the complexities surrounding abortion to provide compassionate and nonjudgmental care to individuals facing this decision. According to the American Nurses Association (ANA), nurses have a professional and ethical obligation to respect the autonomy and dignity of clients and honor their right to make informed decisions about their reproductive health. The ANA emphasizes the importance of providing unbiased information, support, and access to safe and legal reproductive health-care services, including abortion (American Nurses Association, 2015).

Health-care professionals should approach the topic of abortion with sensitivity and respect, acknowledging the diverse perspectives and beliefs held by individuals, communities, and health-care professionals. Developing a comprehensive understanding of abortion empowers nursing professionals to deliver client-centered care, ensuring access to comprehensive reproductive health care, and supporting individuals in making informed decisions about their reproductive health (Schooley & Kratovil, 2023). When supporting individuals navigating this experience, it is crucial for the nurse to acknowledge the multifaceted nature of emotions involved, including grief. For instance, women's emotional responses postabortion can vary widely. Some may experience relief, while others might undergo grief, sadness, or a sense of loss (Reardon, 2018). Additionally, research suggests that health-care professionals' empathy and understanding play a vital role in supporting individuals dealing with abortion-related emotions (McLean et al., 2023). Techniques like active listening and creating a safe, nonjudgmental environment can aid in providing compassionate care (Tennant & Toney-Butler, 2022).

Suicide

Suicide is a major public health concern, and health-care professionals, including nurses, play a critical role in its prevention. Nurses must understand the importance of effective communication, active listening, and therapeutic relationships in suicide prevention. The collaborative efforts of health-care professionals, clients, and their support networks are essential in creating a safety net of support and identifying appropriate interventions (World Health Organization, 2014).

The ethical considerations surrounding suicide require health-care providers to balance autonomy, beneficence, and nonmaleficence. Respecting a person's autonomy means acknowledging their right to make decisions about their own life, while beneficence and nonmaleficence call for actions to prevent harm and promote well-being (Varkey, 2021). Furthermore, nurses must recognize the impact of their attitudes, biases, and stigma on the care they provide to individuals at risk of suicide. Developing a nonjudgmental and empathetic approach is crucial in establishing trust and promoting open discussions about suicidal ideation or behaviors (Saini et al., 2020).

Research underscores the importance of understanding the social determinants of suicide, emphasizing factors such as socioeconomic status, social support, and access to mental health services. Nurses, through their client interactions, can assess and address these determinants by advocating for improved access to mental health

resources and facilitating social support networks (Robertson et al., 2022).

Nurses are also involved in the aftermath of suicide, providing support to bereaved families and communities, offering counseling services, and helping individuals navigate the complex emotions associated with loss (Andriessen et al., 2019). Suicide is discussed in more detail in Chapter 16 Mood Disorders and Suicide.

Emotional, Spiritual, and Practical Concerns Associated with Death and Dying

Emotional concerns associated with death and dying encompass various psychological and interpersonal challenges for both clients and health-care professionals. Understanding and addressing these emotional concerns is important for providing holistic and compassionate care during the end-of-life journey. Likewise, research by Kostka et al. (2021) highlights the range of emotions nurses may encounter, including sadness, grief, empathy, and sometimes even relief or a sense of accomplishment in providing comfort during a client's end-of-life journey. Nurses often form strong bonds with clients and their families, which can intensify these emotions.

Furthermore, the Kübler-Ross model of the five stages of grief—denial, anger, bargaining, depression, and acceptance (Valliani & Mughal, 2022)—remains a foundational framework to understand not only the emotions experienced by dying clients and their families, but also those encountered by health-care providers, including nurses, as they navigate these challenging situations. Effective coping strategies for nurses are key, such as reflective practices, seeking peer support, and utilizing counseling services (Abdul-Mumin et al., 2023).

Nurses should cultivate empathy, active listening, and nonjudgmental attitudes to create a safe and supportive environment for clients and their families (Kim et al., 2020b). Open and honest communication fosters emotional connection, promotes understanding, and facilitates discussions about end-of-life wishes and concerns.

PSYCHOSOCIAL CONSIDERATIONS

Self-Care for the Nurse

Self-care practices in nursing encompass a spectrum beyond physical well-being, delving into the psychosocial aspects crucial for holistic health maintenance. As caregivers, nurses navigate emotionally demanding situations, underscoring the necessity for robust self-care strategies. Understanding the interplay between psychological and social components is pivotal in fostering self-care resilience within the nursing profession (Wang et al., 2022b). The areas where they intersect include the following:

- Emotional intelligence: Nurses harness emotional intelligence to navigate stressors, foster empathy, and maintain professional boundaries. By recognizing and regulating emotions, nurses cultivate resilience amid high-pressure environments (Aghajani Inche Kikanloo et al., 2019).
- Coping mechanisms: Utilizing effective coping mechanisms, such as mindfulness practices or reflective journaling, empowers nurses to process emotions and mitigate burnout (Malik & Annabi, 2022).
- Social support networks: Building support networks within the nursing community aids in sharing experiences, seeking guidance, and nurturing a sense of belonging (Pereira et al., 2021).
- Work-life balance: Striking a balance between professional commitments and personal life serves as a protective factor against burnout and enhances overall well-being (Putri et al., 2023).

Caring for the Nurses' Needs

Incorporating psychosocial elements into self-care paradigms is essential for nurses. Addressing psychological well-being and nurturing supportive social structures not only fortifies individual resilience, but also cultivates a healthier work environment conducive to optimal client care.

Effective communication skills are essential in addressing emotional concerns related to death and dying.

Furthermore, self-reflection is important for nurses to recognize and manage their emotional reactions to death and dying. Engaging in reflective practices, such as journaling or debriefing with mentors or peers, can help nurses process emotions, gain insights, and promote personal growth. After all, providing care to clients at the end of life can evoke strong emotions and potential burnout. Engaging in self-care practices can help nurses process their feelings and maintain their mental and emotional well-being (Hussain, 2021).

Caring for Clients' Emotional Needs

Mental and emotional needs are significant in caring for individuals and families facing death and dying. Recognizing and addressing these needs is crucial for nurses to provide holistic, client-centered care during this challenging period. One of the primary mental and emotional needs is psychological support. Clients and their families may experience a wide range of emotions, as referenced earlier, such as fear, anxiety, sadness, anger, and confusion. Nurses should cultivate effective communication and active listening skills to provide a safe and empathetic environment for individuals to express their emotions (Anderson et al., 2019). Offering emotional support, validation, and counseling services can help individuals navigate their feelings and cope with the challenges associated with end-of-life care.

Clients and families often have questions and concerns about the dying process, treatment options, and what to expect. Nurses can contribute to meeting these needs by providing clear and accurate information, discussing prognoses, and involving clients and families in care planning (Heyland et al., 2013). Equipping individuals with knowledge can help reduce anxiety and promote a sense of control and understanding.

Also helpful for addressing client emotional concerns is maintaining a peaceful and soothing environment. This includes controlling noise levels, providing appropriate lighting, and creating a calm atmosphere to facilitate relaxation (Zulueta Egea et al., 2022). Supporting the client's preferred spiritual or cultural practices can improve their physical comfort. By recognizing and addressing the mental and emotional needs related to death and dying, nurses can provide compassionate, holistic care for clients and their families.

Spiritual Needs

Spiritual support is also important. Many individuals find comfort and solace in their spiritual or religious beliefs. Nurses should be sensitive to diverse spiritual and cultural practices and, when appropriate, facilitate access to spiritual or religious leaders for guidance (Zare et al., 2019). Creating an environment that respects and supports the spiritual needs of clients and their families can contribute to their overall well-being, coping, and sense of peace.

One of the key spiritual needs is the need for meaning and purpose. Clients may question the meaning of their lives, their values, and the significance of their experiences. Nurses can engage in open and compassionate conversations to explore these existential concerns, helping individuals use their spirituality to find purpose and meaning in their lives, even in the face of mortality (Zare et al., 2019).

Supporting religious and cultural practices is another important spiritual need. Many individuals find comfort and draw strength from their religious or cultural beliefs and rituals and involvement with a spiritual leader, such as a priest, pastor, rabbi, or imam. Nurses should be knowledgeable about diverse spiritual practices and willing to facilitate access to spiritual leaders, prayer, or religious texts as requested by clients and their families (Puchalski et al., 2014).

Maintaining hope is also a significant spiritual need. Hope can take various forms, such as physical healing, a peaceful death, or hope for reunification with loved ones. Nurses should foster an environment that nurtures and supports hope, allowing individuals to express their desires and aspirations (Puchalski et al., 2014). Encouraging clients and families to identify and focus on what brings them hope can contribute to their spiritual well-being.

Nurses should be aware of their own spiritual beliefs and biases and separate them from their care. Maintaining a nonjudgmental and inclusive attitude toward diverse spiritual perspectives is essential in meeting the spiritual needs of clients. Respecting and supporting individual beliefs, regardless of personal agreement, is crucial in providing client-centered care (de Brito Sena et al., 2021).

Practical Nursing Responsibilities in Death and Dying

Nurses also have a practical role to play in managing death and dying. One of the most critical responsibilities is effective communication. Nurses must be able to relay information concisely and compassionately to the dying client, their families, and the rest of the health-care team (Dionne-Odom et al., 2019). They should also be skilled at facilitating discussions about end-of-life decisions, including advanced care planning and do-not-resuscitate orders.

Pain and symptom management is another task. Nurses must help administer appropriate pain relief, monitor for adverse effects, and adjust treatments based on a client's changing needs and preferences (Sinha et al., 2023). Nurses serve as advocates, educators, and compassionate caregivers in addressing the fear of pain and concerns about excessive pain medication in end-of-life care. Their role extends beyond administering medications,

encompassing holistic care, empathy, and effective communication to ensure clients' comfort and dignity during this critical phase (Twycross, 2019). Lastly, nurses often oversee postmortem care, which includes preparing the body for viewing, arranging for transport, completing the necessary documentation, and providing emotional support to grieving family members (Wang et al., 2021).

Death and Dying Cultural Considerations

When a nurse demonstrates understanding of and respect toward a client's cultural background and beliefs, their end-of-life care can be more effective and compassionate (Six et al., 2023). Some cultures may have specific practices and rituals associated with dying and death. These can range from wanting family members present at the time of death to specific customs around handling the body post death (Givler et al., 2023). Understanding these practices can assist nurses in providing culturally competent care and promoting client and family comfort and dignity in death. Additionally, conversations around advance care planning and the process of dying can vary widely between cultures. For example, in some Asian cultures, discussing death is considered taboo (Givler et al., 2023). Conversely, many Western cultures advocate for open discussions about death and end-of-life care planning.

Nurses should be aware of these differences and approach the topic sensitively, engaging family members, cultural liaisons, or translators when necessary. Education, communication, and empathy are fundamental for nurses to respect clients' cultural views on death, enhance their well-being, and fulfill their wishes (Busolo & Woodgate, 2015). The following cultural group examples are generalizations and may not apply to every individual.

Black Americans

For Black Americans, cultural considerations can significantly shape the experience of death, dying, and bereavement. Historically, Black culture values strong family connections and spiritual beliefs, often influencing end-of-life care perceptions (Givler et al., 2023). For many Black Americans, spirituality plays a critical role in coping with death and dying. They can rely heavily on faith, prayer, and the church community for support during illness or death (Collins et al., 2018). Nurses must understand the significance of these spiritual beliefs and respect their role in end-of-life decisions and coping mechanisms.

Additionally, Black Americans traditionally have a strong sense of community, which extends to the family's involvement in health-care decisions. This collective decision-making process includes the immediate family, extended kin, and close friends. Therefore, health-care professionals must incorporate these family dynamics into care planning (Givler et al., 2023).

Furthermore, research suggests that Black Americans often prefer more aggressive treatment measures at the end-of-life compared with other groups (Orlovic et al., 2018). The preference for aggressive measures may be related to the historic mistrust of health-care providers and the legacy of disparate care experienced by Black Americans. This mistrust is deeply rooted in historical injustices and systemic biases, such as the Tuskegee Syphilis Study, that have significantly impacted health-care access and outcomes (Hostetter & Klein, 2021). In the Tuskegee Syphilis Study, researchers studied the effects of syphilis on Black men without collecting informed consent or offering treatment (CDC, 2022). Nurses should consider this while discussing end-of-life care options, ensuring they understand and respect the client's wishes. To provide culturally competent care to Black clients at the end of life, nurses need to recognize the role of spirituality, value the collaborative decision-making process, and respect the preference for aggressive treatment.

American Indians/Alaska Natives

Understanding and respecting the cultural beliefs and practices of American Indians and Alaska Natives (AI/AN) surrounding death and dying is essential for health-care providers. Cultural beliefs and traditions in these communities are often influenced by a deep respect for the natural world and spiritual connections with ancestors and the afterlife (Colclough & Brown, 2014).

Many AI/AN communities perceive death as a part of the natural life cycle rather than an ending. This view can influence decisions regarding end-of-life care, where a focus may be on maintaining balance and harmony with the natural and spiritual world rather than prolonging life at all costs (Colclough & Brown, 2014).

Spiritual practices and rituals are essential components of the death and dying process in many AI/AN cultures. Ceremonies often involve the entire community, including prayer, singing, and using sacred items, such as eagle feathers or tobacco. Health-care providers should respect and accommodate these practices whenever possible

(Isaacson & Lynch, 2018).

Family and community connections are highly valued in AI/AN cultures. In end-of-life care decisions, the client's family and community often play significant roles (Dennis & Washington, 2016). Nurses need to understand this communal approach to health-care decision-making and include family and community members in discussions when appropriate.

It is important to remember that there is significant diversity among the AI/AN community. Each tribe or community has unique cultural beliefs, traditions, and practices surrounding death and dying. Therefore, nurses should not assume that all AI/AN clients share the same beliefs or preferences but should instead seek to understand the specific cultural context of each client.

Asian Americans

Asian Americans encompass diverse ethnic groups with unique cultures, languages, and beliefs. Therefore, attitudes toward death, dying, and end-of-life care can vary greatly among Asian American communities. Certain cultural values and practices are often shared, however, and they do influence how individuals and families approach end-of-life decisions (Lee, 2009). Respect for one's parents, elders, and ancestors and family cohesion are fundamental concepts in many Asian cultures. These values often translate into collective decision-making processes for health-care decisions, including end-of-life care. Therefore, involving family members in discussions around the terminal prognosis and treatment decisions is crucial to culturally appropriate care (Lee, 2009).

Many Asian cultures emphasize respect for elders, which might influence decisions about disclosing terminal prognoses. Directly telling a client about a terminal prognosis can sometimes be seen as disrespectful or causing unnecessary distress, and thus, family members often prefer to receive the information first (La et al., 2021) and then determine if and how to relay that information to the person.

Spirituality and religion, such as Buddhism, Christianity, Confucianism, Hinduism, Islam, and Taoism, play a significant role in shaping views on death and dying among Asian American communities. For instance, beliefs in karma, reincarnation, or the afterlife can affect preferences for end-of-life care, mourning rituals, and funeral arrangements (Lee et al., 2018).

Health-care providers should also be aware of potential language barriers and the need for accurate interpretation services when discussing end-of-life care with Asian American clients and their families (Lee, 2009). Overall, nurses providing care for Asian American clients near the end of life should appreciate the significance of family decision-making, consider cultural attitudes toward disclosing terminal prognoses, respect spiritual and religious beliefs, and acknowledge the importance of language-accessible services. Following is a discussion of three groups of Asian Americans that have specific practices regarding death and dying.

Filipino Americans

Filipino Americans possess unique beliefs and practices surrounding death and dying stemming from their rich blend of indigenous, Spanish, and American influences. Appreciating these cultural nuances is critical in providing culturally competent end-of-life care. Family plays a central role in the lives of Filipino Americans, and this extends to health-care decisions. Many place a high value on kapwa (shared identity), emphasizing interconnectedness among family members. Consequently, decisions regarding end-of-life care often involve the entire family (Constante, 2022).

Spirituality, influenced predominantly by Catholicism due to Spanish colonization, profoundly impacts Filipino Americans' perspectives on death and dying. Many may find solace in prayer and religious rituals and prefer receiving sacraments, such as the Anointing of the Sick, during end-of-life care (Lagman et al., 2014). Moreover, Filipino Americans may value *pag-aaruga*, or caring, expressed through a high level of physical care and presence by family members at the bedside of a dying loved one. This cultural practice reflects their commitment and love for their family (David & Okazaki, 2006).

In Filipino culture, direct communication about death can be considered disrespectful or distressing. Health-care providers may need to approach these conversations carefully, considering the client's and family's comfort with discussing death openly (Givler et al., 2023).

Language barriers can also be a concern, especially for older Filipino Americans. Providers should ensure the

availability of appropriate interpretation services to facilitate clear and respectful communication (Lagman et al., 2014).

Japanese Americans

Japanese Americans have unique beliefs and traditions surrounding death and dying rooted in their Japanese heritage and experiences in the United States. Understanding these cultural nuances can improve end-of-life care for Japanese American clients (Matsumura et al., 2002). Collective decision-making is common in many Japanese American families. Maintaining familial unity and avoiding conflict are often emphasized in line with the cultural concept of *wa*, or harmony. End-of-life care discussions may involve the client and their family members, but as Japanese Americans become more Americanized, they may want more autonomy in their own decisions (Matsui, 2009).

Spirituality, particularly in the form of Buddhism, Shintoism, and Christianity, shapes perspectives on death and dying in the Japanese American community. Certain rituals, like chanting or prayer, may be important for some families. In addition, many Japanese Americans believe in continuing a spiritual relationship with their deceased loved ones, which is honored through practices like maintaining a family altar (Suzuki, 2012).

Communication around death can be indirect in Japanese culture, guided by the concept of *honne* (true feelings) and *tatemae* (public facade). This might influence disclosure and receipt of information about prognosis and end-of-life (Matsumura et al., 2002). Health-care providers also must be mindful of potential language barriers.

Vietnamese Americans

Vietnamese Americans also have unique cultural practices and beliefs surrounding death and dying, rooted in their Vietnamese heritage, and influenced by their experiences in the United States. Culturally sensitive health-care providers, including nurses, can enhance the quality of end-of-life care for Vietnamese American clients by understanding these cultural nuances (Tran et al., 2019).

The Vietnamese culture places a high value on the family unit. As a result, decisions about end-of-life care often involve collective decision-making, with family members playing key roles in discussing options and making final decisions (Tran et al., 2019). Spiritual beliefs are fundamental to understanding death and dying among Vietnamese Americans. These beliefs often incorporate a mix of Buddhism, Confucianism, Taoism, and ancestor veneration, all of which can influence preferences for end-of-life care, including pain management, life-prolonging interventions, and funeral rites (Tran et al., 2019).

Buddhism's influence on end-of-life care emphasizes alleviating suffering and allowing the client to achieve a peaceful transition (Tran et al., 2019). Clients may prefer noninvasive treatments or palliative care to manage pain while maintaining mental clarity for spiritual contemplation. Funeral rites often involve rituals honoring the deceased, such as chanting or meditation, promoting a tranquil passage to the afterlife and comforting the bereaved (Kalra et al., 2018). Confucianism's emphasis on family and societal harmony influences end-of-life preferences. Respect for elders and maintaining familial harmony guide decisions on care. Funeral rites emphasize honoring ancestors, with rituals focusing on proper ceremonies to ensure a peaceful afterlife transition (Badanta et al., 2022). Taoism's approach to end-of-life care centers on harmony with nature and acceptance of the natural cycle of life and death. Funeral rites might include simplicity, embracing the natural order, and rituals to facilitate the departed soul's journey into the Tao, fostering peace and harmony (International End-of-Life Doula Association, 2017).

Communication about terminal illness and death is often indirect in Vietnamese culture because discussing death may be perceived as disrespectful or as bringing bad luck. Health-care providers should consider this cultural sensitivity when discussing prognosis and treatment options (Givler et al., 2023). Potential language barriers also exist, especially among older Vietnamese Americans with limited English proficiency.

Jewish Americans

Jewish Americans have unique cultural considerations about death and dying, rooted deeply in their religious traditions and beliefs. Within the Jewish culture, there are diverse beliefs and rituals (JCFS Chicago, n.d.), but in general, the approach toward the end of life is one of acceptance and reverence, where the dying process is seen as a natural part of life. There is a belief in the sanctity of life until the very end, emphasizing the importance of quality of life. Medical treatments that prolong life are encouraged, but extraordinary measures to prolong life without meaningful recovery are generally discouraged, highlighting the value placed on the dignity and autonomy of the

individual (Rosenberg et al., 2020).

The process of death in Jewish culture involves several rituals. Upon death, it is customary for the eyes and mouth of the deceased to be closed, the body covered, and a candle lit near the body, symbolizing the soul's divine spark (Popovsky, 2007). The burial traditionally occurs as quickly as possible, usually within forty-eight hours of death. Practices, such as embalming and cremation, do not take place because of the belief in the sanctity and respect of the body. After the funeral, family and friends observe a seven-day mourning period, known as shiva, allowing for grief and remembrance (Rosenberg et al., 2020).

Mexican Americans

Death and dying hold significant cultural and religious importance for Mexican Americans. According to Mexican cultural tradition, death is perceived as a natural phase in life's continuum. It is not considered an end but a part of a cycle of life and rebirth, influenced by the belief system and the dominant religion of Catholicism (Altamirano, 2018).

One significant aspect of death in Mexican American culture is the commitment to familial responsibilities and the idea of *buen muerte* (good death), which emphasizes dying at home surrounded by family (Ko et al., 2013). This reflects the strong cultural importance of family bonds and the collective approach to life and death. Many Mexican Americans uphold the Catholic belief in an afterlife, making spiritual care important at the end of life. Spiritual rituals often take place and provide comfort and peace.

Mexican Americans traditionally celebrate *Dia de los Muertos* (Day of the Dead). This multiday holiday focuses on gatherings to pray for and remember friends and family members who have died (Altamirano, 2018). Health-care professionals must understand these unique cultural considerations to provide culturally competent, sensitive, and appropriate end-of-life care to Mexican American clients and their families.

REAL RN STORIES

Nurse: Sarah
Years in Practice: Seven
Clinical Setting: Senior care facility
Geographic Location: Ohio

Sarah, a seasoned nurse, was assigned to care for Mrs. Chen, an older Chinese female nearing the end of her life. Mrs. Chen's family filled the room with the aroma of incense and brought offerings of her favorite foods. Initially, Sarah was uncertain how to navigate these cultural practices within the hospital setting. However, guided by her past experiences and knowledge, she understood the significance of these rituals in Chinese culture.

Sarah approached Mrs. Chen's family with respect and curiosity, eager to learn about their traditions. Through a translator, she discovered that the family believed in maintaining a connection with the departed through offerings. Sarah coordinated with the hospital staff to accommodate these practices while ensuring client safety.

As Mrs. Chen's condition worsened, her family expressed the importance of maintaining a peaceful environment. They requested to perform a brief ceremony involving prayers and chants. Sarah collaborated with the hospital chaplain to create a serene space within the facility for this ritual.

Throughout Mrs. Chen's final days, Sarah and the health-care team not only tended to her physical needs but also respected and integrated the family's cultural beliefs. They arranged for a quiet corner where the family could light incense, allowing Mrs. Chen's family to continue their customs while maintaining hospital regulations.

When Mrs. Chen passed away, Sarah witnessed the family's gratitude for the compassionate care that honored their cultural practices. The family expressed how comforting it was to have their beliefs acknowledged and respected during this difficult time. Reflecting on this experience, Sarah understood the profound impact of cultural competence in end-of-life care. She realized that embracing and accommodating diverse spiritual beliefs not only provided comfort to the family, but also enriched the holistic care provided by the health-care team (Victorian Agency for Health Information, 2016).

9.2 Grief and Loss

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss social factors that influence grief and loss responses relating to the five stages of grief
- Discover the physical, social, and spiritual impacts of grief and loss
- Describe the impact of grief and loss on the nurse

Grief and loss are universal human experiences. As inevitable as they are challenging, these moments can shape individuals profoundly and permanently, influencing emotions, thoughts, behaviors, relationships, and even views of the world. The natural emotional response to loss, which is often most powerful when an individual loses someone or something deeply important to them, is called **grief**. This could include the death of a loved one, the ending of a significant relationship, or the loss of physical or mental health, among many other possibilities. Grief is complex, deeply personal, and can manifest differently for everyone, defying simple definitions or timelines. It can include a range of emotions, such as sadness, anger, confusion, guilt, and fear, and can also evoke a host of physical symptoms.

Related to grief, **loss** is not just to what has been taken away, but also to the secondary losses that might follow. These might include the loss of identity, routine, security, or future plans. Although intrinsically tied to grief, it has its unique complexities. A significant loss can change a person's life trajectory and necessitate navigating a new, unfamiliar reality.

Understanding grief and loss involves many perspectives, from the psychological processes to the social and cultural contexts shaping how an individual mourns. It means acknowledging the less recognized or understood types of grief, such as anticipatory, complicated, and disenfranchised. The following section on grief and loss aims to provide a compassionate, comprehensive exploration of grief and loss for both clients and nurses.

Social Factors and Processes That Influence Grief and Loss

Social factors play a role in how individuals experience and navigate grief and loss. Cultural norms and traditions, societal expectations, and social support can significantly shape the grieving process. For instance, societies often have prescribed "grieving rules" that dictate who, how, and when people should grieve (Dayes et al., 2023). These norms can influence the legitimacy of one's grief and can lead to **disenfranchised grief**, a type of grief that is not openly acknowledged or socially supported. For instance, consider the grief experienced by a person after the loss of a pet. While deeply impactful, this loss might not receive the same understanding or support as the loss of a human loved one. In nursing, disenfranchised grief can also manifest in situations like miscarriages, where the emotional impact on the mother and family might not be fully recognized by others, leading to feelings of isolation and prolonged grief (Thompson & Doka, 2017).

Social support is another critical factor. Social support systems, such as family, friends, and community groups, can provide emotional comfort, practical help, and a sense of belonging, all of which can facilitate the grieving process. Inadequate or unsupportive responses can compound feelings of loss, however, and make the bereaved feel more isolated (Peña-Vargas et al., 2020).

Societal expectations and stigma can also shape grief experiences. This can manifest as pressure to quickly return to normalcy and function effectively in society. Furthermore, societal stigma around death and grief can lead to silence and avoidance, exacerbating feelings of loneliness and distress (Cacciatore et al., 2021) and leading to **complicated grief**, characterized by prolonged and intense mourning (Shear et al., 2016). Complicated grief is a profound and prolonged response to loss that impacts a person's ability to move forward. For example, consider a client who has lost a loved one and finds themselves unable to return to their daily activities or experiences severe emotional distress for an extended period, well beyond what might be considered a "normal" grieving process. They might struggle with intense feelings of disbelief, anger, or even guilt. In nursing, recognizing complicated grief is important because it can lead to significant mental health challenges (Mughal et al., 2019).

Withdrawal and Isolation

Withdrawal is a common, not necessarily unhealthy, side effect of grief, marked by a sense of pulling away from others and the world, a deep internalization of the grieving process. Withdrawing individuals may seem disengaged

from their surroundings. This can be a crucial time for self-reflection and reevaluation, although others can misinterpret it as a lack of progress or healing (Vasquez, 2022).

Similarly, isolation is a common experience after losing a loved one, often occurring as part of the grieving process and frequently leading to withdrawal. The bereaved may experience isolation in various forms, including physical, emotional, and social isolation. Physical isolation may result from withdrawing from everyday activities and social interactions as part of the natural response to loss (Vasquez, 2022). The bereaved may spend time alone, reflecting on the loss and processing their grief.

Emotional isolation can lead to withdrawal. Even when surrounded by supportive friends and family, individuals who have experienced loss may feel misunderstood or disconnected due to their grief's deeply personal and unique nature. They may feel that others cannot fully comprehend their pain, leading to feelings of loneliness.

Social isolation can also occur when social networks change after a loss. The bereaved may feel alienated or detached from their usual social groups due to the shared history and memories with the deceased. Furthermore, societal expectations and stigma around grief can exacerbate feelings of isolation (Pitman et al., 2018).

It is important to note that everyone's grieving process is unique, and all may not experience withdrawal and isolation. While some may withdraw, others may seek social connection to cope with their loss. And while some degree of isolation may be a normal part of the grieving process, prolonged or extreme isolation can indicate a more serious issue, such as complicated grief or depression (Shear et al., 2016). Therefore, the individual may need professional help to assist in dealing with significant feelings of isolation after a loss. Thus, it is critical to provide individualized support during this time.

Kübler-Ross Model of Grief

The Kübler-Ross model, also known as the five stages of grief, is a psychological framework that describes the emotional process individuals go through when facing their mortality or experiencing significant loss. This model states that grief involves five stages: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969). These stages are not necessarily linear or experienced in a fixed order, and not everyone goes through all of them. They serve as a guide to understand the range of emotions people might encounter during a grieving process. Health-care professionals must remember that everyone's grief is unique and may not neatly fit into these stages (Figure 9.2).

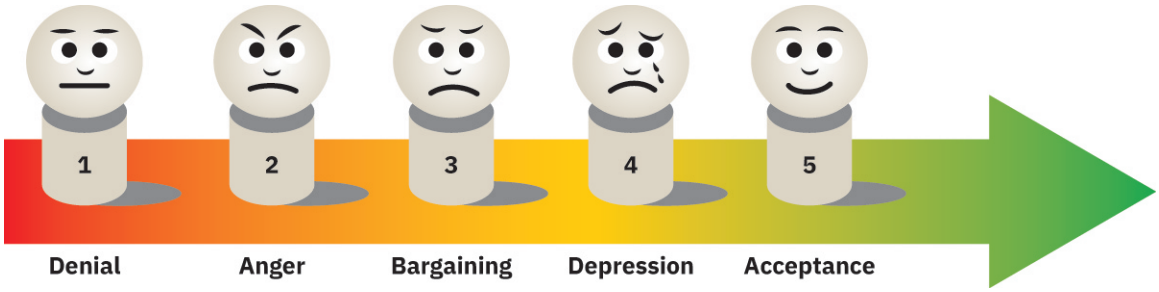


FIGURE 9.2 Kübler-Ross believed that most people go through five stages of grief, although not all in the same order. (modification of work from *Clinical Nursing Skills*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Denial

Denial is recognized as a significant stage in the grieving process, according to the Kübler-Ross model of grief (1969). The denial stage is often the initial response to a devastating loss, functioning as a defense mechanism that helps individuals cope with the initial shock (Stroebe et al., 2017). During this stage, individuals may refuse to acknowledge the reality of the loss or perceive it as a mistake or misunderstanding (Corr et al., 2018). For clients in this stage of grief, nurses can validate feelings without reinforcing denial. Gentle and compassionate communication can help the client gradually accept the reality of their situation (Tyrrell et al., 2023).

Anger

According to Kübler-Ross's (1969) model of grief, anger is the second stage that individuals might experience after a profound loss. This stage is characterized by frustration, irritation, and even rage (Kübler-Ross, 1969). The grieving person might direct this anger toward themselves, others, or even inanimate objects, attributing blame for the loss that has occurred (Stroebe et al., 2017). Anger can also be a manifestation of deep pain, a reaction to feeling

abandoned by the deceased, or a protest against the reality and finality of death (Corr et al., 2018). In this stage, nurses can create a safe environment for the client to express anger without judgment and use active listening and empathetic communication to facilitate expression of emotion. As with all stages of grief, the anger phase is not linear and may overlap with other stages or return later in the grieving process. Additionally, some people might not experience this stage, demonstrating grief's individual and complex nature (Tyrrell et al., 2023).

Bargaining

According to Kübler-Ross's (1969) model, bargaining is another potential stage in grieving. During this stage, individuals often make deals or promises to a higher power, the universe, or themselves, in an attempt to reverse or lessen the loss (Kübler-Ross, 1969). This stage typically involves "what if" and "if only" statements that reflect a desire to regain control over the situation (Stroebe et al., 2017). People may also fantasize about ways things could have been different, leading to a temporary escape from their pain (Corr et al., 2018). While this can provide temporary relief, extended time in this stage may prolong the grieving process if it prevents acceptance of the loss. In this stage, nurses may support clients in discussing their hopes, wishes, and concerns. They should also offer self and be open to conversations about spirituality or alternative treatments (Tyrrell et al., 2023).

Depression

Depression, as conceptualized in Kübler-Ross's (1969) grief model, is typically the fourth stage in the grief process. Unlike clinical depression, this grief stage is characterized by profound sadness, despair, and loneliness that arise from the recognition and reality of the loss (Kübler-Ross, 1969). Individuals may exhibit symptoms, such as loss of appetite, lack of energy, sleep difficulties, and a general withdrawal from life and social activities (Stroebe et al., 2017). This stage of grief is not pathological but rather an expected response to a significant loss. It signifies an individual's grappling with the loss's impact and attempts to adjust to a new reality without the deceased (Corr et al., 2018). In this stage, nurses may offer empathetic support and validation of feelings of sadness and loss. They can also encourage expression of emotions and provide a supportive presence (Tyrrell et al., 2023). As with all stages of grief, the depression phase is not necessarily linear, and individuals might experience it in different ways and at different times during their grieving process.

Acceptance

According to Kübler-Ross's (1969) model, the final stage of the grieving process is acceptance. Acceptance does not imply happiness or that the individual is "over" the loss. Rather, it signifies understanding and coming to terms with the reality of the loss (Kübler-Ross, 1969). During this stage, individuals often begin to look forward and engage more with life, albeit with the acknowledgment that it will be different than before (Stroebe et al., 2017). This stage is characterized by a sense of calm, a decreased anger or despair, and an increased ability to reflect on the loss without overwhelming pain (Corr et al., 2018). In this stage, nurses may celebrate small victories and support the client's acceptance without minimizing their experiences and continuing to provide compassionate care and assistance (Tyrrell et al., 2023). For those who do experience this stage, it may not represent the end of grief but rather an integration of the loss into their life.

Unrealistic Expectations

The grieving process is highly personal and unique to each individual. As such, setting expectations, particularly unrealistic ones, can often hinder the process rather than facilitate it. One common unrealistic expectation is the belief that grief should follow a predictable, linear path, such as the five stages proposed by Kübler-Ross (1969). Grief is a complex process, often involving cycling between different emotions and stages (Stroebe et al., 2017).

Another common misconception is the expectation that grief has a distinct endpoint or a deadline when an individual will or should completely "get over" the loss. In many cases, individuals do not fully "move on" from their loss but rather learn to live with it and integrate it into their ongoing lives at their own pace (O'Connor, 2019).

The expectation that all individuals should display their grief openly or, conversely, should grieve in private is also unrealistic. Grief is experienced and expressed differently by different individuals, and all expressions of grief are valid (Stroebe et al., 2017). The key to healthy grieving is allowing individuals to experience and express grief in a way that feels right. Nurses facilitate an environment conducive to individualized grief expression through empathetic listening, personalized care, education, collaboration with interdisciplinary teams, and fostering a supportive community. This approach empowers individuals to navigate grief in a manner that feels right for them, fostering healing and resilience (Oates & Maani-Fogelman, 2022).

Impacts of Grief and Loss

Grief and loss can profoundly affect individuals, changing various aspects of their lives, including physical, mental, and overall well-being. Physically, grief can lead to symptoms, such as fatigue, changes in appetite, sleep disturbances, and even increased susceptibility to illness due to the stress and exhaustion it can cause (O'Connor, 2019). Mentally, individuals can experience sadness, anger, guilt, and anxiety and may even face an increased risk of conditions like depression and post-traumatic stress disorder (Stroebe et al., 2017).

Loss can also change an individual's identity and understanding of the world. They may struggle with finding meaning in life after the loss, and their identity may change as they adjust to a new life and navigate the loss they have experienced (Bellet et al., 2020). Individuals endure various types of losses that can encompass physical, emotional, and spiritual realms, all of which can have an impact on their overall well-being. These losses can challenge a client's sense of identity and self-worth, necessitating comprehensive support and care. Grief can also have social implications, as individuals may feel isolated or misunderstood by others, which can strain relationships (Mortazavi et al., 2020). The impact of grief and loss on an individual is multifaceted and extends far beyond emotional distress.

Physical

Grief and loss have significant physical impacts on individuals. The stress and emotional turmoil associated with grief can lead to a range of physiological symptoms. Fatigue, sleep disturbances, and changes in appetite are common among grieving individuals (Stroebe et al., 2017). In some cases, intense grief can lead to physical pain, such as chest pain or headaches (O'Connor, 2019).

Research also suggests that grieving individuals may experience weakened immune function, making them more susceptible to infections and illnesses (O'Connor, 2019). Furthermore, a prolonged period of intense grief, often called complicated or prolonged grief, can increase the risk of cardiovascular problems, high blood pressure, and even mortality (O'Connor, 2019). The physical impact of grief illustrates the intricate interplay between emotional distress and physical health, underscoring the need for comprehensive care for those dealing with loss.

LINK TO LEARNING

Visit Registered Nursing.org (https://openstax.org/r/77regnursingorg) for more information on supporting clients and families with dying and grief.

Emotional

Grief and loss profoundly trigger various complex emotions. Feelings of sadness and despair are common, as is a sense of loneliness or isolation following a significant loss (Stroebe et al., 2017). The grieving individual may also experience guilt or regret, especially if there are unresolved issues or unexpressed feelings toward the deceased (Currier et al., 2015). Anger is another common emotional response; it may be directed at oneself, the deceased, other individuals, health-care providers, or even a higher power (Kübler-Ross, 1969). Additionally, anxiety can occur, including fears about mortality or the inability to cope with the loss alone (Mortazavi et al., 2020). In complicated grief, individuals may experience severe emotional distress, intrusive thoughts about the deceased, and difficulty accepting the death, which can significantly interfere with daily functioning (Duffy & Wild, 2017). Thus, the emotional effects of grief are multifaceted, illustrating the necessity of emotional support and care in times of loss.

CLINICAL JUDGMENT MEASUREMENT MODEL

Applying the CJMM to the Stages of Grief

Walter has recently been diagnosed with dementia and is a new resident in the memory unit attached to the assisted living facility (ALF). Walter receives palliative care through the local hospice and already has legal documents in place to assist with his ongoing care.

Walter refuses to eat and tells staff to "get out" when they try to assist him with activities of daily living (ADLs), including bathing and hygiene. Walter says he just wants to be left alone to die. Walter refuses to leave his room

and sits and stares at the floor. Nurses suspect that Walter is experiencing two stages of grief. Review this assessment of Walter's grief using the steps of the Clinical Judgment Measurement Model (CJMM).

CJMM Step	CJMM Data
Recognize Cues	History: Dementia and newly admitted to LTC; refuses to eat or leave room, tells staff to "get out," stares at floor, refuses assistance with ADLs. States he wants to be left alone to die.
Analyze Cues	Dementia, depressed, angry, refusing care.
Prioritize Hypotheses	Grief Stages: (1) Anger, (2) Depression (The five stages are: denial, anger, bargaining, depression, acceptance.)
Generate Solutions	Establish trust and rapport, use therapeutic communication, involve Walter in decision-making, find out what he likes/enjoys and incorporate into care.
Take Action	Spend time with client, listen/offer self, offer choices, order his favorite meal, locate his favorite book, encourage family visits, use distraction techniques to get him to think of other things, ask him to tell you a story, ask his chaplain to visit.
Evaluate Outcome	If Walter is responsive, continue plan and continue to monitor. If not responsive, keep trying, make referrals as needed, ask the provider for antidepressant medication.

TABLE 9.1 Walter's Assessment

Spiritual

The spiritual impacts of grief and loss are significant and can manifest in numerous ways. For some, a loss might prompt a deep questioning of their faith or belief systems, leading to a crisis of meaning. Individuals might grapple with questions about the nature of life and death, the existence of an afterlife, or the perceived fairness or justice of their loss. Sometimes, these questions can lead to spiritual distress or a loss of faith (Wong & Yu, 2021).

LINK TO LEARNING

Read this article for more information on spiritual well-being tools (https://openstax.org/r/77spiritualsupp) and how to support your own well-being.

Spirituality can also serve as a vital source of comfort and resilience in the face of loss. Many individuals find solace in their faith or spiritual beliefs, which can provide a sense of hope and meaning amidst their grief. Spiritual practices, such as prayer or meditation, can provide peace and connectedness (Biancalani et al., 2022). For some, the experience of loss can lead to spiritual growth or transformation. They may develop a deeper or more nuanced understanding of their beliefs or discover new spiritual perspectives that help them make sense of their loss (Eames & O'Connor, 2022).

LINK TO LEARNING

Access this site for more information on the spiritual assessment tool FICA (https://openstax.org/r/77FICEtool) and how to apply to nurse-client relationships.

Impact of Grief and Loss on the Nurse

The impact of grief and loss on nurses is significant, involving emotional, physical, and psychological components.

Due to the nature of their work, nurses often develop close relationships with clients and their families, making them susceptible to feelings of loss when a client dies (Üstükuş & Eskimez, 2021). Emotionally, nurses may experience sadness, guilt, or helplessness, especially if they felt close to the client or if the death was unexpected (Kostka et al., 2021). They may also experience symptoms of grief similar to those held by the client's family, such as disbelief, anger, and depression (McCallum et al., 2021).

Physically, the stress associated with grief and loss can lead to fatigue, sleep disturbances, and other health issues (Rahmani et al., 2023). Psychologically, the repeated experience of loss can contribute to **burnout**, a state of chronic physical and emotional exhaustion often associated with feelings of cynicism and detachment from work (Friganović & Selič, 2021). There is also an increased risk for **compassion fatigue**, characterized by a decreased capacity for empathy over time due to repeated exposure to traumatic events or losses (Gustafsson & Hemberg, 2022).

CULTURAL CONTEXT

Cultural Stigma: Potential for Nurses' Compassion Fatigue

Psychiatric and physical symptoms combine in culture-bound syndromes, which are mental health conditions specific to the client's primary social group. Perceived experience with spiritual phenomena, or altered engagement in culture-based activities or rituals, may present during mental health care. Lack of understanding or acceptance, even lack of inquiry, on the part of the health-care providers may result in inadequate or delayed treatment, incorrect diagnosis, or stigma.

Nurses should seek culturally-informative education and evidence-based resources to help identify and address symptoms and cues that are difficult to interpret. Nurses can refer clients and families to community mental health and inquire as to peer services. Nurses are called to act as advocates to mitigate risks posed by stigma for conditions that may be poorly understood.

(Ahad et al., 2023)

In extreme cases, prolonged exposure to grief and loss without adequate coping mechanisms or support can result in traumatic stress responses similar to PTSD (Gabra et al., 2022). Dealing with grief can be emotionally challenging, especially for nurses who often witness and support clients and families through difficult situations. This is why it is important for nurses to employ self-care strategies in their daily lives. Some of these strategies include engaging in regular exercise, maintaining a balanced diet, and ensuring adequate rest. In addition, talking to colleagues, mentors, or support groups can provide an outlet to express emotions and share experiences, offering valuable emotional support. Nurses should also be mindful to recognize personal limits and establish clear boundaries between work and personal life to help prevent emotional exhaustion (Rabow et al., 2021). Health-care institutions need to recognize these impacts and support nurses, providing opportunities for debriefing, counseling services, and education about healthy coping strategies (Rahmani et al., 2023).

LIFE-STAGE CONTEXT

Interventions for Assisting a Teenage Client with Grief After Loss

Psychoeducation

Understanding the stages and process of grief can be helpful for a teenager, particularly if this is their first significant loss. It can normalize their experience and reduce feelings of confusion or isolation. It can also prepare them for some of the different emotions they may experience, helping them understand that grief is not a linear process.

Individual Therapy (CBT, EMDR)

Cognitive behavioral therapy can help teenagers manage and understand their emotions and develop coping strategies. Eye Movement Desensitization and Reprocessing (EMDR) could be considered if the teenager is experiencing traumatic grief, helping to process the traumatic elements of the loss.

Group Therapy

Participating in group therapy with other teenagers experiencing grief can foster a sense of community and reduce feelings of isolation. They can share experiences and coping strategies and support each other in a safe and controlled environment.

Art Therapy or Expressive Arts Therapy

Teenagers may struggle to articulate their emotions verbally, especially if they are intense or confusing. Art therapy provides an alternative medium through which they can express their feelings. Creating art can also be a therapeutic process, serving as a distraction and providing a sense of accomplishment.

Physical Activity

Regular physical activity can improve mental health by reducing anxiety, depression, and negative mood and improving self-esteem and cognitive function. Exercise is a powerful tool to help teenagers manage grief-related stress and insomnia.

Mindfulness and Relaxation Techniques

Techniques, such as yoga, meditation, and deep breathing, can help teenagers manage the physical symptoms of grief, such as tension and difficulty sleeping. They can also promote a sense of calm and control, which can be particularly helpful in times of intense emotion or stress.

Family Therapy

The death of a close friend or relative affects the whole family. Family therapy can help each member understand the others' grief process and coping mechanisms. It can improve communication and help the family support each other effectively.

School-Based Support

Schools can provide resources and create an environment conducive to healing. This may involve coordinating with teachers and administrators to ensure the teenager can access grief counseling, time off as needed, and academic support.

All these interventions should be tailored to the teenager's unique needs, cultural background, and personal preferences. These strategies aim to support them during this difficult time and equip them with coping mechanisms to manage their grief.

9.3 Anger, Abuse, and Violence

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Understand and define anger and aggression
- Review the cycle of abuse and types of abuse and violence
- Learn prominent risk factors for anger, abuse, and violence
- Comprehend the social problems relating to anger, abuse, and violence
- Discuss ways to handle anger, abuse, and violence in clinical settings

Anger is a universal human emotion. As a survival mechanism, it evolved to protect people from threats and to ensure existence. When misdirected or poorly managed, however, anger can lead to destructive outcomes, causing harm to oneself and others. The nursing profession brings individuals face-to-face with some of these destructive outcomes: abuse and violence.

Abuse and violence come in many forms and can occur in various contexts, ranging from domestic settings to institutions, such as hospitals or nursing homes. This issue can affect individuals across the life span, from children to older adults. It encompasses physical, emotional, psychological, and sexual abuse, as well as neglect, and often has severe consequences for the health and well-being of the affected individuals. Nurses are often the first to recognize signs of anger, abuse, and violence, making their role pivotal in preventing, identifying, and intervening in these issues. Nurses are not just caregivers but are also advocates for clients, which demands understanding these societal problems and their manifestations in the health context.

Anger and Aggression Defined

Anger and aggression are two interrelated yet distinct constructs in psychology. The subjective, emotional state characterized by antagonism toward someone or something perceived as causing harm or offense is called **anger**. By contrast, **aggression** pertains to behaviors intended to harm or assert dominance over others. Both can be triggered by external or internal stimuli, such as perceived threats, frustration, or chronic stress, and can manifest in various ways, including verbal or physical confrontations, destructive behaviors, or even internalized distress.

Anger does not always lead to aggression; it can be expressed and managed in healthy ways through strategies like cognitive restructuring, relaxation techniques, and problem-solving (Richard et al., 2022). In turn, aggression does not always originate from anger alone. While anger is a common emotion associated with aggressive behavior, aggression can also stem from various other sources or triggers. It might arise from frustration, fear, self-defense, protection of oneself or others, or even from learned behavior or societal influences. For instance, aggression can manifest in response to a threat. It can be a learned behavior from environmental factors or past experiences. Some individuals might display aggressive behavior as a result of neurological conditions or certain mental health issues (Kruglanski et al., 2023). There are multiple issues that can cause anger, including medications, emotional dysregulation, poor impulse control, trauma, depression, poor outcomes, and challenging diagnoses and symptoms.

The Cycle and Types of Abuse Defined

Anger and aggressive behavior can be precursors to violence and abuse. The cycle of abuse is a model developed to explain behavior patterns in abusive relationships; it encompasses four stages: tension building, acute violence, reconciliation or honeymoon, and calm (Focht & Chu, 2020). In the tension-building phase, stress and conflict begin to escalate, often accompanied by verbal abuse or other forms of psychological torment. This phase may last for minutes or months, with the abused partner often feeling as though they are “walking on eggshells” (Focht & Chu, 2020).

The acute violence phase follows, characterized by outbursts of aggressive, abusive behavior, which can include physical, verbal, emotional, sexual, or financial abuse. Most harm occurs in this stage, but it is usually shorter than the tension-building phase (Focht & Chu, 2020).

After the violent episode, the cycle enters the reconciliation or honeymoon phase. The abuser may feel guilty or afraid of consequences, leading them to apologize, promise change, or exhibit unusually kind behavior. This period gives the victim hope that their abuser has truly changed, making it less likely they will leave the abusive relationship (Focht & Chu, 2020).

The calm phase is the period of relative tranquility before the tension starts building again. During this phase, the abuser might deny or minimize the abuse or act as if it never occurred. This behavior can confuse the victim and keep them in the relationship (Focht & Chu, 2020). It is important to note that while the cycle of abuse model has been widely used, it does not fit all abusive relationships. The pattern and frequency of the cycle can vary drastically between relationships (Dutton, 2007).

LINK TO LEARNING

Visit this website for more information on abuse and intimate partner violence (https://openstax.org/r/77prtnerviolence) from the Centers for Disease Control.

Physical Abuse

The intentional use of physical force that results in injury, pain, or impairment is called **physical abuse**. This form of abuse can encompass a broad range of behaviors, including hitting, slapping, punching, kicking, burning, choking, and the use of weapons. It is important to understand that the injuries resulting from physical abuse are not always apparent and can be concealed by the abuser or the victim due to fear, shame, or efforts to protect the abuser (Warren et al., 2023).

Health-care professionals must be aware of the signs of physical abuse, which can include unexplained or inconsistently explained injuries, frequent visits to the emergency department, delayed treatment seeking, and

symptoms of anxiety or depression (Hegarty et al., 2020). Nurses play a pivotal role in recognizing, documenting, and reporting instances of physical abuse. They are also instrumental in providing emotional support and resources to victims, such as information on safety planning, crisis intervention services, and legal options. Mandatory reporting for nurses is an ethical and legal obligation aimed at safeguarding vulnerable individuals from harm or potential harm. Nurses are ethically bound to advocate for clients' well-being and safety. Mandatory reporting requirements vary by jurisdiction but commonly include instances of suspected child abuse or neglect, elder abuse, domestic violence, and certain communicable diseases (Thomas & Reeves, 2020). Failure to comply with mandatory reporting obligations can result in legal repercussions and may compromise client safety and well-being (Geiderman & Marco, 2020).

Nurses must be mindful of potential cultural, linguistic, or societal barriers when addressing physical abuse. This includes respecting privacy, recognizing the influence of cultural norms on abuse disclosure, and acknowledging that all individuals, regardless of gender, age, or sexual orientation, can be victims of physical abuse (Arora et al., 2023).

Psychological Abuse

Subjecting or exposing another individual to behavior that can result in psychological harm, such as anxiety, chronic depression, decreased self-esteem, or even post-traumatic stress disorder, is called **psychological abuse** or **emotional abuse** (Dokkedahl et al., 2019). This form of abuse is often characterized by a pattern of behavior that can include belittling, constant criticism, manipulation, intimidation, humiliation, gaslighting, and coercive control. This form of abuse often aims to undermine an individual's sense of self-worth and independence, making them more dependent on the abuser (Dokkedahl et al., 2019).

While psychological abuse does not leave physical marks, its effects can be long-lasting, influencing an individual's emotional health and well-being. Victims may experience feelings of fear, confusion, and doubt about their perceptions of the events. They may also exhibit symptoms, such as withdrawal, low self-esteem, and depression (Heise et al., 2019). It can be challenging for health-care professionals to identify psychological abuse due to its nonphysical nature. Being aware of possible signs, such as changes in behavior, withdrawal from social activities, and an unusual degree of compliance or deference toward a partner, can be helpful (Radell et al., 2021). Addressing psychological abuse requires a sensitive and holistic approach, including providing emotional support, encouraging clients to speak about their experience, connecting them with appropriate community resources, and potentially involving social services or mental health professionals (Dokkedahl et al., 2019).

Risk Factors for Anger, Violence, and Abuse

Emotional factors play a significant role in triggering anger and aggression. Specifically, negative emotions, such as frustration, stress, anxiety, and fear, often serve as antecedents to anger. For example, frustration, when a person's goals are thwarted, can readily precipitate feelings of anger. Stress, too, increases irritability and impairs coping mechanisms, leading to heightened anger. Anxiety and fear, particularly if they are chronic or pervasive, can contribute to anger and violence as defensive responses to perceived threats. The inability to manage or appropriately express emotions, or **emotional dysregulation**, is another significant factor, as individuals who struggle with this often resort to aggression as an inappropriate coping mechanism (Richard et al., 2022). Social, economic, and environmental factors also increase the risk of anger, abuse, and violent behavior.

There are also several mitigating factors that can lessen the likelihood that an individual will engage in or be a victim to abusive or violent behavior. This section briefly reviews several of these items as well.

Stress

Stress plays a crucial role in increasing the risk that a client will display anger. Stressful situations can distort cognitive processes, leading to increased hostility. Specifically, clients under stress might misinterpret social cues, perceive threats where none exist, and respond disproportionately with anger or aggression. Chronic or high-stress levels can also impair emotional regulation, making it challenging for clients to manage their anger appropriately (Chipidza et al., 2016). Furthermore, stress can exacerbate preexisting mental health conditions, such as depression, anxiety, or personality disorders, increasing the risk of aggressive behaviors (Neelam et al., 2021). Interventions that help clients manage stress, such as mindfulness, relaxation training, and cognitive behavioral therapies, can effectively reduce stress-induced anger and aggression (Chipidza et al., 2016).

Experiencing Abuse

Research has continuously shown a strong correlation between being abused and individuals' subsequent development of anger and aggression (Auslander et al., 2016). Abusive experiences often cause complex emotional and psychological effects, including the manifestation of anger. Abuse can lead to a hostile worldview, creating a sense of perceived threat that may trigger defensive responses, including aggression (Dugal et al., 2016). Anger and aggression can be coping mechanisms used by victims to deal with the ongoing pain or trauma associated with their abusive experiences (Center for Substance Abuse Treatment, 2014). Exposure to abusive environments often leads to normalizing aggressive behavior as an adaptive response to perceived threats, thereby perpetuating a cycle of anger and aggression (Auslander et al., 2016).

Unfairness

Anger is a common emotional response to perceived injustice or unfairness and is often a precursor to aggression if the individual decides to act on this emotion (Archer & Mills, 2019). The appraisal theory of emotion reasons that not only does the experience of unfairness elicit these emotions but so does the individual's interpretation and appraisal of the situation (Moors, 2017). Individuals are more likely to exhibit aggressive behavior when they perceive they have been treated unfairly and may be more prone to display aggression to rectify the perceived injustice (Qin & Zhang, 2022). Nurses may see this type of aggression in clients or family members if they feel they are not receiving the care they deserve.

Strained Relationships

Strained relationships, characterized by conflict, discord, and a lack of positive communication, may predict anger and aggression in individuals. The strain or stressors arising from these relationships can elicit various negative emotional responses, with anger being a common outcome (Wang et al., 2022a). Interpersonal relationships can be strained by various factors, such as communication breakdown, where misinterpretation or lack of effective communication can escalate tension and frustration (Gratis, 2022). Additionally, unresolved conflicts and disagreements over fundamental issues, such as finances, values, or priorities, can create persistent strain (Gossman et al., 2023). Stressors external to the relationship, such as work-related pressures or family conflicts, can spill over and impact the dynamics within the relationship, contributing to heightened emotional responses, including anger (Lau et al., 2019). Furthermore, breaches of trust, such as infidelity or dishonesty, can severely strain relationships and evoke strong feelings of betrayal and anger (Rokach & Chan, 2023). These factors can contribute to the deterioration of relationships, fostering anger and animosity between individuals involved.

Anger often serves as a catalyst for aggressive behavior, violence, and abuse, particularly within interpersonal relationships where conflict is present (Chen et al., 2019). People may resort to psychological or physical aggression as a coping mechanism or a means to assert control in the face of ongoing strain in their relationships. Strained relationships can create conditions that foster feelings of anger, which, in turn, can lead to abuse (Soreff et al., 2023).

Disparities in Access to Care

Disparities in access to care compound the risk factor for violence and abuse. The availability of essential services, such as health care, psychosocial support, and legal assistance, often varies based on geographic location, socioeconomic status, race, and ethnicity, creating barriers to care for many people in need of psychosocial support and for victims of abuse. In rural areas, for instance, individuals often face limited access to services due to physical distance, lack of transportation, and a shortage of specialized service providers (Cyr et al., 2019). In low-income communities, a lack of resources can similarly inhibit access to needed care. These disparities underscore the systemic issues inherent in the provision of services for abuse and violence victims. They also underscore a lack of access for people for whom early intervention may prevent later violence. Racial and ethnic disparities in care also persist. Victims from marginalized racial and ethnic groups may face additional barriers [barriers such as] such as cultural insensitivity, language barriers, or fear of discrimination, that can deter them from seeking or receiving care.

Families and Communities

Families can both be a source of support and risk for individuals when it comes to anger, violence, and abuse. For example, family structure and dynamics, such as marital conflict, divorce, single-parent households, and large family size, have been associated with an increased risk of child abuse and neglect. Exposure to violence within the family normalizes violent behavior and may perpetuate intergenerational cycles of abuse (Almuneef et al., 2016).

Conversely, a strong and supportive family environment can help prevent violence and mitigate its effects when it does occur (Mercy et al., 2017).

Communities, similarly, play a crucial role in either exacerbating or alleviating anger and violence. Factors, such as high levels of neighborhood violence, social disorder, and poverty, can increase anger and the risk of aggression. In contrast, supportive communities with strong social networks and institutions can foster resilience and protect against violence. Societal norms and attitudes within communities can discourage violent behavior (World Health Organization, 2022).

Factors Mitigating Anger and Violence

Prevention programs are key to mitigating violence generally, focusing on early intervention to deter violent behavior. These initiatives often center around enhancing at-risk individuals' social skills and emotional intelligence, implementing anti-bullying initiatives, or teaching conflict resolution methods (Rivara & Le Menestrel, 2016). Furthermore, mental health support is a crucial component in reducing violent behavior, given that many individuals exhibiting such behaviors have mental health challenges. Mental health services, such as counseling and medication, can relieve these conditions and decrease instances of violence. Community outreach programs that actively engage community members can play a significant role in reducing violence. Such programs may include establishing secure spaces for at-risk youth, providing mentorship programs, or creating opportunities for positive social interaction (Sugimoto-Matsuda & Braun, 2013). Additionally, potent tools for violence prevention include school-based programs educating on the impacts of violence and professional training for individuals like teachers and police officers to identify and de-escalate potentially violent situations. Policy changes and legislation also contribute to violence reduction, with reforms like stricter gun control laws, shifts in the criminal justice system toward a focus on rehabilitation over punishment, or policies addressing systemic issues, such as poverty and inequality, which are frequently tied to violence (National Academies of Sciences, Engineering, and Medicine et al., 2018).

Therapeutic approaches, such as CBT and positive behavior support (PBS), can help individuals change destructive or disturbing thought patterns that negatively influence their behavior and emotions (Wilmots et al., 2020). In addition, conflict resolution skills training can foster connections within communities and encourage peaceful conflict resolution, significantly reducing instances of violence (Kamatsiko, 2021) (Figure 9.3).

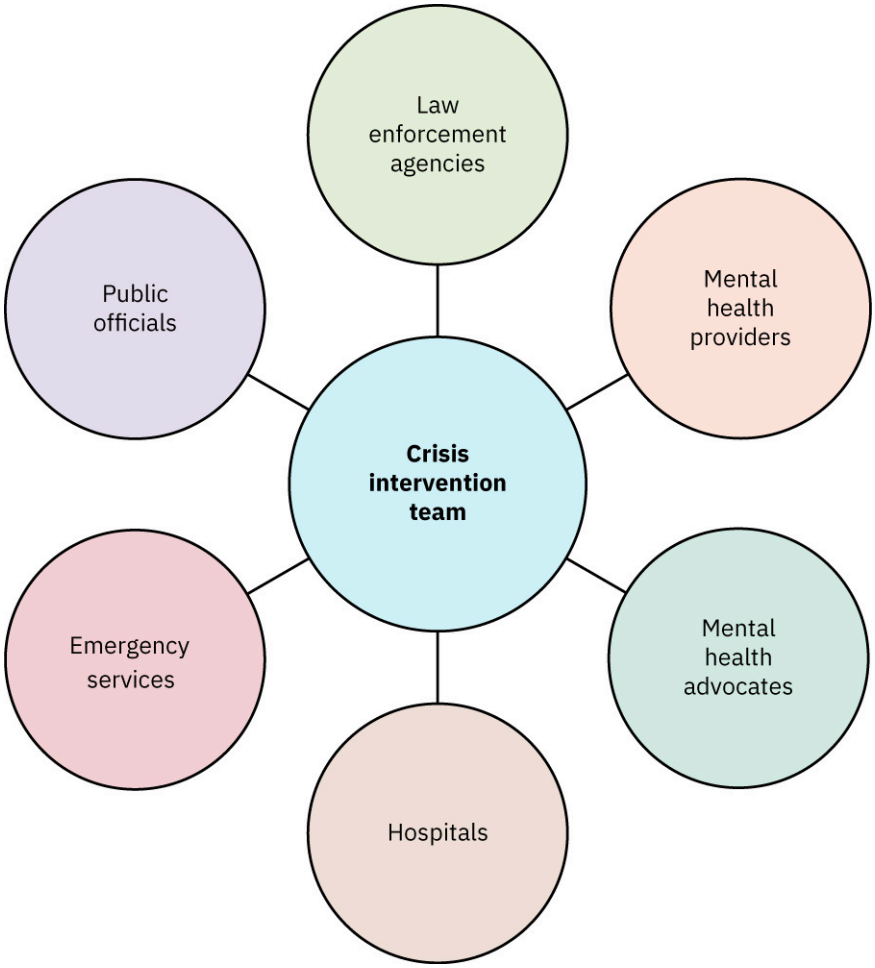


FIGURE 9.3 Crisis intervention requires an interdisciplinary team. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Social Problems Related to Anger, Abuse, and Violence

Anger has long been associated with a range of social problems. This emotion, when unregulated, can damage interpersonal relationships, disrupt the workplace environment, and pose significant barriers to effective communication. When unmanaged, anger can escalate into aggression, leading to antisocial behaviors and even violence (Reilly & Shopshire, 2019). Abuse and violence within society have direct and indirect impacts that ripple through communities, affecting individuals' physical, psychological, and emotional health and overall societal structures (Wessells & Kostelny, 2022). Exposure to violence can lead to trauma, contributing to various mental health conditions, such as depression, anxiety, and post-traumatic stress disorder (PTSD). These conditions can further exacerbate societal problems, as individuals dealing with these conditions may struggle with employment, relationships, and other areas of daily life (Dabaghi et al., 2023). Moreover, abuse and violence have significant economic implications. The Centers for Disease Control and Prevention (CDC) reported that the financial toll of violence, including the cost of medical care and loss of productivity, amounted to billions of dollars annually (CDC, 2019).

Job Loss

Job loss due to anger and aggression in the workplace can have profound implications on an individual's career trajectory and overall well-being. Frequent displays of anger and aggressive behavior can significantly contribute to strained interpersonal relationships, reduced team cohesion, and ultimately result in termination of employment. Such behaviors not only disrupt the work environment but also compromise productivity and morale among colleagues (Popa et al., 2023). The repercussions of job loss linked to anger management issues extend beyond the professional realm, impacting one's financial stability and mental health (Adler et al., 2022).

Rates of abusive behavior tend to increase during periods of economic decline, where job loss is more common.

Added stress from unemployment could lead to a rise in violent behaviors because job loss might lead to a reduced sense of self-worth and increased feelings of stress and anger (Schleimer et al., 2022).

Loss of Family or Significant Others

Anger and aggression can negatively affect personal relationships, leading to damaged and irreparable relationships. Persistent anger and aggressive behavior significantly contribute to domestic discord, often resulting in strained familial relationships and, in extreme cases, separation or divorce. This behavior pattern not only inflicts emotional distress, but also poses a threat to the safety and well-being of family members (Killgore et al., 2021). Children exposed to parental aggression face adverse psychological and developmental consequences, which can lead to lasting impacts on their mental health and future relationships. The loss of family ties due to unmanaged anger and aggression underscores the urgency of seeking appropriate interventions and support systems to foster healthy relationships and prevent further emotional turmoil (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Trauma

The psychological impact of aggression and abuse is profound, often manifesting as traumatic stress responses. Individuals who have experienced abuse or violence may develop trauma symptoms, ranging from intrusive memories of the traumatic event, avoidance of reminders of the event, changes in thoughts and mood, and changes in physical and emotional reactions to everyday life events (SAMHSA, 2019). Physically, victims might demonstrate heightened startle responses, increased vigilance, or hypervigilance in mundane situations. For instance, sudden loud noises may evoke intense fear or panic due to past trauma experiences, leading to an exaggerated startle reflex. Additionally, survivors might manifest altered emotional reactions, such as emotional numbing or dissociation when faced with stressors that remind them of their traumatic experiences. In these cases, individuals may disconnect from their emotions or surroundings as a coping mechanism to manage overwhelming feelings associated with past abuse or violence (SAMHSA, 2019).

It is essential to acknowledge the long-term consequences of these traumatic experiences. Literature establishes a correlation between adverse childhood experiences (such as abuse or violence) and health and well-being issues in adulthood, including mental health disorders and chronic physical health conditions (Chang et al., 2019). This indicates that the traumatic effects of abuse and violence can span a lifetime, leading to many health problems, anger, and aggression.

Furthermore, victims of abuse and violence may develop post-traumatic stress disorder (PTSD). Symptoms of PTSD include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event. The prevalence of PTSD underscores the severe psychological damage that abuse and violence can cause (National Institute of Mental Health, 2023).

Trauma-informed care is a framework that acknowledges the prevalence of trauma in individuals' lives and seeks to create an environment sensitive to their experiences. It is grounded in understanding the profound impact of trauma on one's mental, emotional, and physical health (Menschner & Maul, 2016). Trauma-informed care emphasizes safety, trustworthiness, collaboration, empowerment, and cultural humility. Its principles guide health-care providers in delivering compassionate, individualized care while respecting the autonomy and dignity of those who have experienced trauma (Ranjbar et al., 2020). See 6.5 Trauma-Informed Care for more information.

LINK TO LEARNING

Visit this website for more information on trauma and the effects of adverse childhood experiences (ACEs) (https://openstax.org/r/77adverschildhd) from the Centers for Disease Control.

Substance Misuse

Substance misuse and violence are interconnected and often co-occurring. Substance misuse is not necessarily a result of violence—although sexual abuse victims, for example, do have higher rates of substance misuse (SAMHSA, 2022)—but is often a cause of it. It can impair judgment, reduce inhibition, and increase impulsivity, escalating the likelihood of violent behavior. Various substances, including alcohol, illicit drugs, and prescription drugs, can contribute to interpersonal violence, such as domestic violence, and self-directed violence, such as self-harm or

suicide (Zhong et al., 2020).

Research indicates that individuals with substance use disorders are more likely to engage in violent behavior, including physical assault and the use of weapons. They are also at a heightened risk of becoming victims of violence themselves. This increased risk may be due to various factors, such as engagement in high-risk activities, association with violent peers, or being targeted due to perceived vulnerability (Zhong et al., 2020). Conversely, experiencing violence, particularly during formative years, can increase an individual's susceptibility to substance misuse. Exposure to violence, trauma, and stress can lead to maladaptive coping strategies, such as substance use, to manage overwhelming emotional pain or distress (Edalati & Krank, 2016).

From a health-care perspective, it is vital to recognize the intricate links between substance misuse and violence. Integrative approaches, including trauma-informed care, substance misuse treatment, mental health services, and violence prevention programs, have been effective (Center for Substance Abuse Treatment, 2014).

Incarceration

Individuals who commit aggressive, abusive, or violent behavior may face incarceration. At the same time, imprisonment can expose individuals to various abuses, including physical violence, sexual assault, and psychological trauma (Mears & Cochran, 2015). In other words, incarceration can contribute to and result from various forms of abuse, highlighting the complex relationship between the criminal justice system and abuse (Saxena & Messina, 2021). The experience of incarceration can also indirectly contribute to patterns of abuse. Post release, individuals often face significant social, economic, and psychological challenges, leading to high-stress environments that may increase the likelihood of violent or abusive behavior once released (Saxena & Messina, 2021). Incarceration can deeply affect familial relationships, leading to emotional trauma, economic hardship, and potentially a continuation of the cycle of abuse in the families affected (Massoglia & Pridemore, 2015).

Prevention and intervention strategies are essential in breaking the cycle, such as trauma-informed care within correctional facilities, support for reintegration post incarceration, and efforts to address the root causes of abuse and criminal behavior (Lehrer, 2021). Nurses employ assessment tools and techniques to identify trauma exposure and its potential effects on an individual's health and well-being. Through comprehensive assessments, they gather information regarding trauma experiences, enabling them to develop personalized care plans that consider the unique needs of each person (Lehrer, 2021). They serve as frontline health-care providers who have direct and frequent interactions with incarcerated individuals. Their responsibilities encompass creating a safe and supportive environment conducive to healing while respecting the inherent dignity of the incarcerated individuals (Levenson & Willis, 2018).

Social and Emotional Concerns of Victims of Abuse and Violence

Abuse and violence can lead to a range of social and emotional concerns in victims, significantly affecting their psychological well-being and overall life quality. Immediate emotional responses to abuse and violence may include fear, anxiety, confusion, and anger. Over time, these can evolve into more chronic conditions, such as PTSD, depression, anxiety disorders, and complex trauma, characterized by difficulties with emotion regulation, relationship issues, and altered belief systems (Center for Substance Abuse Treatment, 2014).

Victims of violence and abuse often experience shame, guilt, and self-blame, which can exacerbate their emotional distress and hinder their help-seeking behavior (Ullman & Peter-Hagene, 2014). They may also suffer from diminished self-worth and develop a negative self-concept. They have an increased risk of resorting to substance misuse. In addition, experiencing violence can lead to chronic feelings of powerlessness and a persistent sense of threat, creating a state of hypervigilance and difficulty trusting others (Smith et al., 2019). These emotional concerns underscore the need for trauma-informed interventions that address the profound psychological impacts of violence and abuse.

Stigmatization and Discrimination

Stigmatization and discrimination compound the harm inflicted by abuse and violence. The social stigma attached to being a victim of abuse or violence often discourages victims from reporting these experiences, seeking help, or pursuing justice (Dahal et al., 2022). According to the World Health Organization (WHO), fear of stigma and discriminatory attitudes can deter individuals from seeking and receiving necessary medical, legal, and psychosocial support, potentially exacerbating trauma and health consequences (2021).

Furthermore, victims may face societal discrimination, often stemming from deeply ingrained societal norms that blame victims or trivialize the abuse or violence they experienced (UN Women, 2020). This discrimination can contribute to a culture of silence around abuse and violence, making it more difficult for victims to reach out for support and resources for recovery. It is common for victims to be ostracized or judged by their communities or certain cultures, which only amplifies the emotional toll of the abuse and violence they have suffered (Dahal et al., 2022) and places them at higher risk of secondary victimization or revictimization (Sabri et al., 2022).

Fear and Anxiety

Fear and anxiety are common psychological responses to abuse and violence and can lead to both acute and chronic mental health difficulties. Following a traumatic event, such as experiencing violence or abuse, individuals often report intense fear, which can stem from the immediate threat to their safety and well-being (Smith et al., 2019). This fear can continue long after the threat has passed, particularly if the individual experiences ongoing abuse or is constantly afraid of recurrence.

Anxiety is also frequently seen in survivors of abuse and violence. This anxiety may present as generalized anxiety disorder, characterized by excessive and persistent worry, or as PTSD (National Institute of Mental Health, 2023). Moreover, survivors may experience panic attacks and specific phobias related to the trauma, further compounding their distress (Cruz et al., 2022). Fear and anxiety can negatively impact an individual's daily functioning, relationships, and quality of life. They may cause sleep disturbances, problems concentrating, and physical health issues, such as heart disease and chronic pain (Scott et al., 2013).

Shame and Guilt

Shame and guilt play critical roles in the dynamics of abuse and violence, affecting both the victim and the perpetrator. Abuse victims often report shame and guilt, as they may blame themselves for the abuse or believe they could have prevented it. This self-blame can exacerbate feelings of worthlessness and hopelessness, potentially leading to chronic emotional distress and contributing to the development of mental health disorders, such as depression and anxiety (McElvaney et al., 2022). Sometimes, these feelings can deter victims from seeking help and delay their recovery (Ullman & Peter-Hagene, 2014).

Anger and Loss of Trust

Anger and loss of trust are significant emotional consequences frequently associated with experiences of abuse and violence. Victims often experience anger toward their perpetrators, which can be a normal and healthy response to injustice but also a potential source of chronic distress if not appropriately addressed. In some instances, this anger may be internalized and misdirected toward the self, leading to feelings of self-loathing and perpetuating a cycle of victimization (Avdibegovic et al., 2017).

In addition to anger, victims of abuse often experience a profound loss of trust, particularly when the perpetrator is a close family member, partner, or friend. This loss of trust can extend beyond the perpetrator, affecting the victim's relationships with others and their ability to form new, healthy relationships. Victims may develop a pervasive sense of insecurity, expecting others to harm or betray them, leading to social withdrawal and isolation (Radell et al., 2021). Furthermore, loss of trust can significantly hinder the healing process because it may reduce the likelihood of victims seeking or accepting help from others, including professionals (Ullman & Peter-Hagene, 2014).

Isolation and Loneliness

Abuse and violence can lead to feelings of isolation and loneliness in victims, worsening the traumatic impacts of the experiences. Perpetrators of abuse often employ tactics of control and manipulation, which may include isolating the victim from their social networks in an attempt to increase their dependence on the abuser. This isolation can leave victims feeling alone and unsupported, contributing to hopelessness and despair (Harsey et al., 2017). At times, the stigma and shame associated with being a victim of abuse can lead individuals to isolate themselves out of fear of judgment or misunderstanding by others (Ullman & Peter-Hagene, 2014). This self-imposed isolation can compound feelings of loneliness and exacerbate mental health issues, such as depression and anxiety (Birken et al., 2023).

Anger, Abuse, and Violence in Clinical Settings

When dealing with anger and aggression in clinical situations, understand that these emotions may stem from fear, frustration, or a loss of control related to clients' medical conditions (Llor-Esteban et al., 2017). Nurses most often

encounter types of verbal aggression in clinical settings. This type of aggression involves hostile communication or threats without physical harm. Clients might become verbally aggressive due to frustration with treatment, communication barriers, or feelings of powerlessness (BCcampus, 2014). It is important first to ensure safety for staff and clients, and then to consider all of the institutional, legal, and ethical implications. After all, in clinical settings, anger and aggression can manifest in various forms, each presenting distinct characteristics and consequences.

Causes of Anger and Violence in the Clinical Environment

Anger and aggression within the clinical environment are often categorized as client-related, health-care provider-related, or systemic (Vento et al., 2020). From the client's perspective, certain medical conditions, including chronic pain and mental health disorders, such as dementia, personality disorders, schizophrenia, delirium, and substance misuse, can precipitate aggressive behaviors (Pekurinen et al., 2017). Severe psychiatric symptoms, a history of violence, and substance misuse can contribute to the risk of violence in health settings as well. It is important to stress, however, that most individuals with mental health disorders are not violent, and mental illness alone does not predict violence (DeAngelis, 2021).

Additionally, the stress induced by hospitalization, diagnoses of serious illnesses, limited opportunities for meaningful activities, and the need for medical procedures can often lead to heightened fear and anxiety, which may manifest as anger or aggression (Center for Substance Abuse Treatment, 2014). A nurse may encounter impulsive aggression, which often occurs quickly in response to perceived provocation or threat. For instance, a client might exhibit this type of aggression if they feel misunderstood or subjected to intrusive procedures, leading to an outburst of anger or violence (BCcampus, 2014).

Provider-related factors can also motivate aggressive behaviors. These may include poor communication skills, lack of empathy, perceived neglect, and rushed consultations that may frustrate clients and their families. An unfriendly and unsupportive attitude from the health-care provider can trigger defensive mechanisms, such as anger and aggression (Pekurinen et al., 2017).

Systemic issues within the health-care system likewise can be catalysts for anger and aggression. These systemic problems often include long waiting times, inadequate resources, overworked staff, and poor hospital conditions (Lim et al., 2022). Such conditions may exacerbate client-related factors, creating a stressful environment leading to anger and violence.

Handling Anger and Violence in Clinical Settings

Addressing anger and aggression in mental health settings requires a comprehensive, person-centered approach, acknowledging the individual's unique psychological state and needs (Välimäki et al., 2022). Nurses must approach these situations with empathy, validation, and nonjudgmental attitudes, which can help defuse tension and foster a therapeutic relationship. Safety should be the primary concern, however. At the group level, teamwork and good interpersonal relationships among health-care providers can contribute to a less stressful environment, potentially reducing the occurrence of anger and aggression. Regular team meetings, supervision, and stress management workshops can support the health-care staff, further alleviating workplace stress (Pollock et al., 2020). At the organizational level, hospitals and health-care institutions should prioritize creating a safe, respectful, and supportive environment for clients and staff. This may involve reducing waiting times, improving resources, and ensuring appropriate staffing levels. Clear policies on managing aggression and violence and a zero-tolerance approach to such behaviors are crucial (Rosen et al., 2018). In situations where violence occurs, a thorough risk assessment ensures the safety of all involved and helps in developing appropriate management strategies for future incidents. The implementation of restrictive measures, such as seclusion and restraint, should be used as a last resort and only when less invasive strategies are ineffective and safety is at immediate risk. It is more appropriate to handle aggressive/escalating behaviors by employing client engagement through therapeutic communication, respecting the wishes and personal space of the client, and suggesting alternative physical activities such as walking.

Setting Boundaries

Setting boundaries with angry and aggressive clients is critical to effective clinical practice. It protects the safety of the health-care professional and the client, supports the therapeutic relationship, and fosters an environment conducive to effective client care. A crucial first step is maintaining a calm, nonthreatening demeanor and utilizing

active listening to understand the client's frustrations and fears. Validating the client's feelings without condoning aggressive behavior can help to de-escalate the situation. It is essential to set clear and explicit behavioral expectations, such as respect for personal space and nonviolence, and to be consistent with consequences for violations of these boundaries. Providing clients with choices where possible can also help them regain control and reduce anger and aggression (Adeniyi & Puzi, 2021).

Trauma-Informed Approach

In clinical situations, addressing abuse and violence with sensitivity, awareness, and a trauma-informed approach is crucial. This entails understanding the widespread impact of trauma, recognizing signs and symptoms of trauma in clients, and responding by integrating knowledge about trauma into treatment planning. It is important to ensure that the environment is safe, trustworthy, and nurturing for individuals who have experienced abuse. Health-care professionals should respect clients' decisions about when and how much to disclose about their experiences because forcing the issue can lead to further traumatization. Finally, health-care professionals should empower survivors of abuse and violence by facilitating self-efficacy and resilience, encouraging them to take an active role in their recovery process (Doyle et al., 2022). This client-centered approach recognizes the individual as the expert on their experience and is key in fostering healing and growth.

Client Engagement

Client engagement is a critical component of effectively mitigating violent incidents in health-care settings. Active engagement involves creating a respectful and therapeutic relationship with the client, which can help lessen feelings of distress and fear that often contribute to escalating behaviors (Pomey et al., 2015).

Client engagement entails involvement in the decision-making process. When clients are included in decision-making about their care, it can foster a sense of control, reduce feelings of powerlessness, and minimize the likelihood of agitation or aggression. Shared decision-making can involve explaining procedures, discussing treatment options, and seeking the client's input and preferences (Pomey et al., 2015).

Client engagement in developing a personalized de-escalation plan may enhance the effectiveness of these strategies. This plan would include the client's triggers, signs of escalation, and preferred de-escalation techniques. Client engagement is a critical part of de-escalation, with key components of open communication, shared decision-making, and personalized care planning (Crisis Prevention Institute, 2022).

De-escalation

The concept of **de-escalation** involves recognizing early signs of agitation or aggression, such as changes in a client's body language, tone of voice, or behavior to prevent an escalating situation from becoming harmful or violent by reducing the intensity and reestablishing communication with the individual involved (Spencer et al., 2018). De-escalation in health-care settings is vital in managing anger, aggression, and potential violence.

Techniques for de-escalation include using a calm, reassuring tone of voice, maintaining appropriate body language, actively listening, and demonstrating empathy. Health-care providers should communicate empathetically and nonjudgmentally, validating the individual's feelings and concerns. It is crucial to ensure the individual's safety and the safety of others. This might involve creating physical space, reducing environmental stimuli, or calling for additional assistance in more severe cases (Goodman et al., 2020).

More specifically, de-escalation involves employing active listening and empathy to understand the client's perspective. By actively listening without judgment and acknowledging their feelings, nurses can establish rapport and defuse escalating tension. Additionally, utilizing nonthreatening body language, such as maintaining a calm posture and speaking in a soft tone, helps convey a sense of reassurance and safety. Redirecting attention away from the source of agitation to a more calming topic or environment can further aid in de-escalation. These techniques, when combined with a comprehensive understanding of individualized client triggers, contribute significantly to the creation of a safer and more supportive care environment (Khan et al., 2021). Creating a therapeutic environment that promotes resilience and adherence to the rights and dignity of clients, even in the face of aggression, is paramount in mental health settings.

Training Staff

Staff training is essential to preventing and managing abuse and violence in health-care settings. Structured de-escalation training programs, such as the Crisis Prevention Institute's Nonviolent Crisis Intervention Program, have

effectively taught health-care providers these de-escalation techniques and are recommended for all health-care staff (Crisis Prevention Institute, 2020). Regular debriefing sessions after such incidents can help staff cope with their emotions and understand that such incidents reflect not their clinical competence but a part of the complex human behavior in stressful circumstances (Richardson et al., 2019).

In addition, staff should receive training in recognizing and managing traumatic responses often seen in clients who have experienced abuse. This requires education on trauma-informed care principles emphasizing understanding, empathy, and respect for the client's trauma history (Muskett, 2014). Training should also include clear instructions on organizational policies and procedures related to managing violence and abuse, such as reporting incidents and implementing safety measures like medication, seclusion, or restraints, should they be necessary (NICE, 2015). Training should also address staff well-being and self-care, including strategies for coping with the emotional impact of encountering violence and abuse in the workplace (Nowrouzi-Kia et al., 2019).

The Use of PRN Medication to Manage Violent Clients

The primary purpose of using pro re nata (PRN) medications is to ensure the safety and comfort of the client, other clients, and staff. The most commonly used PRN medications include antipsychotics, benzodiazepines, and antihistamines, which have sedative effects (van Schalkwyk et al., 2018). Antipsychotic medications, such as haloperidol or risperidone, can be administered when the client exhibits violent behavior or aggression linked to psychotic symptoms (Einberger et al., 2020). Benzodiazepines, such as lorazepam or diazepam, are frequently used in managing acute agitation due to their rapid onset of action (Amore et al., 2021). Atypical antipsychotics and antihistamines may also be administered for their calming effects, especially when traditional methods are insufficient or contraindicated (Garakani et al., 2020). It is critical to note, however, that while PRN medications can be useful, they should be used cautiously and in conjunction with a broader therapeutic strategy. Overreliance on PRN medications can lead to unnecessary sedation, mask underlying conditions, or result in physical dependence (Mardani et al., 2022).

CLINICAL SAFETY AND PROCEDURES (QSEN)

Safety: Procedures for Initiating PRN to Manage Behavioral Crises

Pro re nata (PRN): This Latin term refers to medication taken "as needed." It is frequently used in psychiatric settings to manage behavioral crises, including violent or aggressive behavior.

Common PRN medications: The most commonly used PRN medications for managing violent behavior include antipsychotics (e.g., haloperidol, risperidone), benzodiazepines (e.g., lorazepam, diazepam), and antihistamines. These medications often have calming or sedative effects.

Role of PRN medication: PRN medication is crucial in ensuring the safety and comfort of the client, other clients, and staff members. It can help de-escalate acute episodes of aggression or violence often associated with psychotic symptoms or agitation.

Cautious use: PRN medications should be used judiciously; overreliance can lead to unnecessary sedation, mask underlying conditions, or result in physical dependence. They are not a substitute for a comprehensive treatment plan but a part of it.

Broad therapeutic strategy: PRN medications should be incorporated into a broader therapeutic strategy that includes regular medication management, psychological therapies, and environmental modifications to reduce the frequency of behavioral crises. It is essential to have a health-care professional involved in any decisions regarding PRN medications.

The Use of Seclusion and Restraint to Intervene with Violent Clients

Seclusion and restraint are occasionally used interventions in health-care settings to manage violent or aggressive behavior and to ensure the safety of the client, other clients, and staff. These techniques should be used as last-resort measures, when all less restrictive interventions have been ineffective, and only used as long as necessary (Fletcher et al., 2019).

Confining a client in a room from which the client cannot freely exit, called **seclusion**, is used when the client poses

an immediate danger to themselves or others. It provides the client with a safe, quiet environment to de-escalate without causing harm (Oostermeijer et al., 2021). The technique where physical or mechanical means restrict a client's movement is called **restraint**. Physical restraint involves health-care staff physically holding a client to prevent harm, while mechanical restraint devices, such as straps or belts, restrict movement (Chieze et al., 2019). While these interventions can be necessary in some cases, they are not without risks and ethical concerns. They can be traumatic experiences for clients, potentially resulting in physical injury, emotional distress, and undermining therapeutic relationships (Chieze et al., 2019). As a result, their use should always be accompanied by a thorough risk assessment, clear documentation, and follow-up care.

Professional guidelines and policies often suggest that seclusion and restraint should only be used in emergency situations as a last resort and should be discontinued as soon as the client is no longer a danger to themselves or others. Furthermore, there should be a commitment to restraint-free care, and efforts should be made to develop and implement preventative strategies to manage aggressive behavior and reduce the use of these interventions (American Psychiatric Nurses Association, 2018).

PSYCHOSOCIAL CONSIDERATIONS

Controversy Surrounding the Use of Seclusion and Restraint in Clinical Environments

Seclusion and restraint are considered last-resort interventions to manage violent or aggressive behavior in health-care settings. They are only to be used (1) when all less restrictive methods have proven ineffective, and (2) for as short a duration as possible. These methods can be traumatic for clients. They might cause emotional distress and physical injury, negatively impacting therapeutic relationships. The potential for harm raises ethical concerns about client rights and autonomy. For these reasons, there is ongoing debate about the efficacy of these interventions (Hodel, 2023). Some studies suggest that these methods do not necessarily decrease the frequency of violent incidents and may even lead to increased agitation in some clients. In fact, the use of seclusion and restraint has been criticized as a potential violation of clients' human rights. Concerns about misuse or overuse, particularly in vulnerable populations, have led to calls for stricter regulation and oversight. The growing emphasis on restraint-free care focuses on preventive strategies, such as de-escalation techniques, crisis intervention training, and client-centered care plans. The goal is to reduce reliance on these measures and promote a more humane approach to managing aggressive behavior (Hodel, 2023).

Summary

9.1 Death and Dying

The section delves into the multifaceted aspects surrounding death and dying, exploring social, emotional, and cultural dimensions. It explains the social concerns intertwined with end-of-life experiences, shedding light on societal attitudes, stigmas, and the impact on individuals and families facing mortality, specifically in the areas of assisted dying, abortion, and suicide. Furthermore, it delves into the intricate emotional landscape, discussing grief, coping mechanisms, and the psychological intricacies involved in processing impending loss. It emphasizes nursing responsibilities at the end of life, as well as the importance of nursing self-care to avoid burnout. Central to the section are cultural considerations, emphasizing the diverse beliefs, rituals, and practices related to death and dying across various cultures and religions. It underscores the significance of cultural competence in health care, emphasizing how understanding and respecting diverse cultural perspectives are essential in providing compassionate and holistic end-of-life care.

9.2 Grief and Loss

Grief and loss are profound, deeply emotional experiences that occur in response to significant events, such as the death of a loved one, the ending of a relationship, the loss of a job, or a decline in health. This emotional journey is unique to every individual and does not follow a specific, predictable course.

The experience of grief and loss typically encompasses a range of emotional states. These can include feelings of shock or denial, sadness, anger, guilt, anxiety, and even relief. It is common for individuals to experience physical symptoms, such as fatigue, changes in appetite or sleep patterns, and physical discomfort. Kübler-Ross's model, the five stages of grief—denial, anger, bargaining, depression, and acceptance—conceptualizes grief. It is important to remember that not everyone will go through all these stages or in the given order.

While grief and loss are incredibly challenging to navigate socially, emotionally, and spiritually, they are a universal part of the human experience. Many people, including nurses, emerge from these experiences with a new perspective and a deeper understanding of their resilience (Murray, 2023).

9.3 Anger, Abuse, and Violence

Understanding the emotion of anger is integral in health care, affecting client care and professional interactions. Unmanaged anger can lead to aggression, violence, and abuse, which pose significant problems affecting client safety, staff well-being, and health-care outcomes (Khan et al., 2021). Abuse and violence refer to harmful behaviors directed toward an individual or group of individuals that cause physical, sexual, or psychological harm and suffering. These harmful behaviors can take various forms, including, but not limited to, physical assault, sexual assault, verbal abuse, harassment, and emotional manipulation. Some of the risk factors for anger and violence include stress, having experienced abuse, unfairness, strained relationships, and disparities in health-care access.

The effects of abuse and violence can be profound, leading to physical injuries, psychological issues, and, in some cases, chronic health problems or death. Anger, abuse, and violence can lead to job loss, loss of close ties, trauma, substance misuse, and incarceration, and impacts on victims of abuse are far-ranging. Handling abuse in clinical settings is a challenge for health-care providers and involves, among other things, learning de-escalation techniques and offering trauma-informed care to clients.

Key Terms

aggression behaviors intended to harm or assert dominance over others

anger subjective, emotional state characterized by antagonism toward someone or something perceived as causing harm or offense

assisted dying intentionally ending a life to prevent further pain and suffering

burnout state of chronic physical and emotional exhaustion often associated with feelings of cynicism and detachment from work

compassion fatigue decreased capacity for empathy over time due to repeated exposure to traumatic events or losses

complicated grief type of grief characterized by prolonged and intense mourning

de-escalation recognizing early signs of agitation or aggression, such as changes in a client's body language, tone of voice, or behavior to prevent an escalating situation from becoming harmful or violent by reducing the intensity and reestablishing communication with the individual involved
disenfranchised grief type of grief that is not openly acknowledged or socially supported
emotional abuse (also: **psychological abuse**) involves a person subjecting or exposing another individual to behavior that can result in psychological trauma
emotional dysregulation inability to manage or appropriately express emotions
grief natural emotional response to loss
loss actual or perceived deprivation of someone or something valued, leading to an experience of grief
physical abuse intentional use of physical force that results in injury, pain, or impairment
psychological abuse (also: **emotional abuse**) involves a person subjecting or exposing another individual to behavior that can result in psychological trauma
restraint technique where physical or mechanical means restrict a client's movement
seclusion confining a client in a room from which the client cannot freely exit

Assessments

Review Questions

1. A nurse is caring for a client who is requesting information about assisted death (euthanasia). Understanding the ethical considerations of assisted death, what does the nurse know?
   a. Assisted death is universally accepted and legally executed across the country.
   b. Nurses should advocate for their clients regardless of their own personal beliefs.
   c. Nurses must comply with their client's wishes no matter the legal or personal boundaries.
   d. Assisted death is a personal decision, and therefore, no consideration for the family or other team members should be a factor in the execution of the desired intervention.

2. Nurses often care for clients and families experiencing death and dying. What is an important part of self-care for a nurse to promote their own health? Select all that apply.

   a. Reflection
   b. Peer support
   c. Isolating
   d. Seeking counseling services when needed

3. When providing care for a client who is terminally ill, how can the nurse assess and support the client's spiritual distress? Select all that apply.

   a. Asking about the client's spiritual practices and preferences
   b. Connecting the client to spiritual support persons in the hospital or community
   c. Incorporating prayer or other religious practices into the care of the client when able
   d. Avoiding discussing spirituality to avoid confusion and conflict

4. What is complicated grief?
   a. a normal and expected response to loss
   b. grief that persists longer than six months
   c. intense and prolonged grief that significantly impairs daily functioning
   d. grief experienced due to the loss of a beloved pet

5. What social factor is likely to have a significant influence on grief and loss responses?
   a. socioeconomic status
   b. height
   c. eye color
   d. shoe size

6. What potential impact might prolonged exposure to clients' grief and loss have on a nurse?

a. decreased empathy and emotional detachment
b. increased stress due to excessive sympathy
c. enhanced coping skills and emotional resilience
d. unchanged emotional state and unaffected work performance

7. What is grief?
a. a state of emotional numbness and detachment
b. a natural response to loss, encompassing emotional, physical, and cognitive aspects
c. a prolonged feeling of anger and resentment
d. an immediate acceptance of the reality of loss without any emotional response

8. A client experienced the death of their grandmother six months ago. They present to the clinic today with feelings of hopelessness, sadness, not sleeping, and crying throughout the day. What does the nurse anticipate the cause of the client's symptoms to be?
a. Anxiety
b. Prolonged grief
c. Normal grieving process
d. Emotional numbness

9. What is a key difference between anger and aggression?
a. Anger is a subjective emotional state, while aggression is the behavior resulting from anger.
b. Anger and aggression are synonymous and can be used interchangeably.
c. Anger is a behavior aimed at harming others, while aggression is an internal feeling.
d. Anger is a reaction to a perceived threat, while aggression is a response to frustration.

10. What social issue is frequently connected to uncontrolled anger and abuse?
a. community engagement
b. healthy relationships
c. substance misuse
d. empathy development

11. What societal factor can exacerbate the impact of abuse and violence?
a. strong community support
b. economic stability
c. cultural acceptance of violence
d. access to mental health services

12. How might abuse and violence impact an individual emotionally?
a. improved self-esteem
b. reduced anxiety
c. increased fear and trauma
d. enhanced trust in others

13. What is a primary goal of crisis care in cases of abuse and violence?
a. encouraging long-term dependency on support systems
b. restoring safety and stability
c. promoting isolation from social networks
d. normalizing the abusive situation

14. How can health-care professionals address abuse and violence in the clinical setting?
a. ensuring confidentiality for the abuser
b. providing support and resources for victims
c. ignoring signs of abuse to respect privacy

d. minimizing documentation of abuse cases

15. What is an essential step for health-care providers dealing with abuse cases?
    a. reporting only severe cases of abuse
    b. documenting all suspected cases of abuse
    c. assuming every client is lying about abuse
    d. offering biased opinions on the situation

Check Your Understanding Questions

1. Perceptions and beliefs regarding death and dying vary with different cultures. For each ethnicity, describe some of the common perceptions of death and dying in the culture

Ethnicity	Cultural Perception of Death and Dying
American Indians/Alaska Native	
Asian American	
Black American	
Filipino American	
Japanese American	
Jewish American	
Mexican American	
Vietnamese American	

2. Describe social concerns regarding abuse and violence.
3. Discuss emotional concerns for victims of abuse and violence.
4. Explain crisis care and intervention.
5. Outline ways client abuse and violence can be dealt with in the clinical environment.
6. How do emotional factors contribute to the development of anger and aggression?
7. What societal issues are linked with uncontrolled anger and violence?

Reflection Questions

1. How do cultural perceptions of death and dying impact the way individuals and families cope with end-of-life situations?
2. Why is it essential for health-care providers to be culturally sensitive when addressing death and dying?
3. What should the nurse do to honor cultural beliefs and practices when caring for a dying client from a different cultural background?
4. How do you distinguish between anger and aggression in a clinical context?
5. How does one's understanding of anger influence client care in a health-care setting?
6. What factors commonly contribute to the manifestation of anger and violence in health-care settings?

7. How can nurses effectively manage and mitigate the impact of anger and violence in a clinical setting?

What Should the Nurse Do?

Gloria, a seventy-five-year-old widow, arrives at the oncology clinic accompanied by her daughter, Emily. She has been diagnosed with advanced-stage lung cancer. Gloria presents with symptoms of increasing pain, fatigue, and shortness of breath. Her medical history includes a previous diagnosis of chronic obstructive pulmonary disease (COPD), which has exacerbated in recent months. Vital signs show an elevated blood pressure of 150/90 mm Hg, a heart rate of 95 beats per minute, and a respiratory rate of 22 breaths per minute. During the assessment, Gloria expresses concerns about the impact of her illness on her family and worries about being a burden. Emily mentions their family's cultural background and the importance of certain end-of-life rituals. Recognizing the social, emotional, and cultural dimensions of Gloria's concerns, the health-care team aims to provide holistic and culturally sensitive care.

1. What nonverbal cues from Gloria and verbal cues from Emily might indicate that cultural considerations are crucial in addressing their concerns about end-of-life care?
2. Considering Gloria's COPD diagnosis and advanced-stage lung cancer, prioritize hypotheses regarding the emotional concerns that are likely to have the most significant impact on her well-being. How might these emotional concerns influence her overall care plan?

Frank, a sixty-year-old male, visits the outpatient clinic following the recent loss of his wife to cancer. He presents with symptoms of overwhelming sadness, difficulty sleeping, and social withdrawal. Frank's medical history includes hypertension, for which he takes medication regularly. Vital signs reveal an elevated blood pressure of 140/85 mm Hg, a heart rate of 92 beats per minute, and a respiratory rate of 18 breaths per minute. During the assessment, Frank expresses feelings of guilt about not being able to do more for his wife and struggles to engage in conversation about his grief. Recognizing the concepts of grief and loss, the nurse aims to understand the social factors influencing Frank's response and be mindful of the potential impact of grief on both the client and the health-care provider.

3. How can the nurse create a safe and empathetic environment that encourages open communication about grief?
4. If the nurse implements interventions to address Frank's grief, what specific indicators of progress or positive outcomes would you monitor to assess the effectiveness of the interventions for both Frank and the nurse?

Competency-Based Assessments

1. Provide two examples of social concerns that individuals and their families may experience when facing death and dying, and begin a discussion on how these concerns might affect an individual's end-of-life experience.
2. Take on the role of a nurse caring for a client who has different cultural practices than your own. You can choose the culture. How can you best navigate these cultural differences and ensure respectful and client-centered care?
3. Critical thinking is crucial in understanding grief concepts. You are a nursing student working with a client who exhibits complicated grief reactions. List the factors that might contribute to complicated grief, and brainstorm ways that you can adapt your interventions to address this complexity.
4. You have been asked to name some factors that may influence the effectiveness of group therapy for individuals with social anxiety. As part of your answer, discuss how cultural factors are relevant and can impact the dynamics of group therapy.
5. Explore ways to differentiate between normal grief reactions and signs of complicated grief. What interventions can you implement to address complicated grief effectively?
6. Consider the impact of grief and loss on emotional well-being as a caregiver. Brainstorm ways to proactively manage emotional responses to prevent burnout and maintain professional effectiveness in providing empathetic care.
7. Outline three ways in which anger can manifest in the clinical environment and potentially affect client outcomes. How can nurses proactively create a therapeutic environment that minimizes anger-related challenges and promotes positive client experiences?

8. In a scenario where a client expresses anger due to frustration with their treatment plan, critically analyze how the nurse can explore the underlying causes of this anger. How can the nurse employ communication strategies to address the client's frustration and enhance collaboration?
9. Reflect on a situation where a nurse observes a colleague struggling to manage their anger in response to a challenging client interaction. How can the observing nurse provide support to their colleague, and what resources or interventions can be implemented to promote a healthy work environment?

References

Abdul-Mumin, K. H., Maideen, A. A., Lupat, A., Mohd-Alipah, S. N., Mohammad-Alli, R. H., Abd-Manaf, H. H., Osman, A. R., Abd Fata, H. M. R., Busrah, N., Darling-Fisher, C., & Idris, D. R. (2023). "Embracing the inner strength and staying strong": Exploring self-care preparedness among nurses for enhancing their psychological well-being against the long-term effect of COVID-19 pandemic in Brunei Darussalam. *International Journal of Environmental Research and Public Health, 20*(17), 6629. https://doi.org/10.3390/ijerph20176629

Adams, G. S., & Inesi, M. E. (2016). Impediments to forgiveness: Victim and transgressor attributions of intent and guilt. *Journal of Personality and Social Psychology, 111*(6), 866–881. https://doi.org/10.1037/pspi0000070

Adeniyi, O. V., & Puzi, N. (2021). Management approach of patients with violent and aggressive behaviour in a district hospital setting in South Africa. *South African Family Practice: Official Journal of the South African Academy of Family Practice/Primary Care, 63*(1), e1–e7. https://doi.org/10.4102/safp.v63i1.5393

Adler, A. B., LeardMann, C. A., Yun, S., Jacobson, I. G., Forbes, D., & Millennium Cohort Study Team (2022). Problematic anger and economic difficulties: Findings from the Millennium Cohort Study. *Journal of Affective Disorders, 297*, 679–685. https://doi.org/10.1016/j.jad.2021.10.078

Aghajani Inched Kikanloo, A., Jalali, K., Asadi, Z., Shokrpour, N., Amiri, M., & Bazrafkan, L. (2019). Emotional intelligence skills: Is nurses' stress and professional competence related to their emotional intelligence training? A quasi-experimental study. *Journal of Advances in Medical Education & Professionalism, 7*(3), 138–143. https://doi.org/10.30476/JAMP.2019.74922

Ahad, A. A., Sanchez-Gonzalez, M., Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus*, 15(5):e39549. https://doi.org/10.7759/cureus.39549.

Almuneef, M. A., Alghamdi, L. A., & Saleheen, H. N. (2016). Family profile of victims of child abuse and neglect in the Kingdom of Saudi Arabia. *Saudi Medical Journal, 37*(8), 882–888. https://doi.org/10.15537/smj.2016.8.14654

Altamirano, I. (2018). Death and dying in Mexico: Embracing, laughing, and celebrating life's transitions [Interview]. In Death Ed. https://deatheducationlund.com/2018/03/20/death-and-dying-in-mexico-embracing-laughing-and-celebrating-through-it-all/

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. https://www.nursingworld.org/coe-view-only

American Nurses Association. (2019). *The nurse's role when a patient requests medical aid in dying*. https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf

American Psychiatric Nurses Association. (2018). *Seclusion & restraint*. https://www.apna.org/i4a/pages/index.cfm?pageid=3728

American Psychological Association. (2017). Clinical Practice Guideline for the Treatment of PTSD Guideline Development Panel for the Treatment of Posttraumatic Stress Disorder in Adults Adopted as APA Policy. https://www.apa.org/ptsd-guideline/ptsd.pdf

Amore, M., D'Andrea, M., & Fagiolini, A. (2021). Treatment of agitation with lorazepam in clinical practice: A systematic review. *Frontiers in Psychiatry, 12*. https://doi.org/10.3389/fpsyt.2021.628965

Anderson, R. J., Bloch, S., Armstrong, M., Stone, P. C., & Low, J. T. (2019). Communication between healthcare professionals and relatives of patients approaching the end-of-life: A systematic review of qualitative evidence. *Palliative Medicine, 33*(8), 926–941. https://doi.org/10.1177/0269216319852007

Andriessen, K., Krysinska, K., Kõlves, K., & Reavley, N. (2019). Suicide postvention service models and guidelines 2014–2019: A systematic review. *Frontiers in Psychology, 10*, 2677. https://doi.org/10.3389/fpsyg.2019.02677

Arcaya, M., & Schnake-Mahl, A. (2017, October). *Health in the segregated city*. Furmancenter.org. https://furmancenter.org/research/iri/essay/health-in-the-segregated-city

Archer, A., & Mills, G. (2019). Anger, affective injustice, and emotion regulation. *Philosophical Topics, 47*(2), 75–94. https://www.jstor.org/stable/26948107

Arora, S., Bhate-Deosthali, P., Rege, S., Amin, A., & Meyer, S. R. (2023). Healthcare providers' perceptions and experiences of training to respond to violence against women: Results from a qualitative study. *International Journal of Environmental Research and Public Health, 20*(4), 3606. https://doi.org/10.3390/ijerph20043606

Auslander, W., Sterzing, P., Threlfall, J., Gerke, D., & Edmond, T. (2016). Childhood abuse and aggression in adolescent girls involved in child welfare: The role of depression and posttraumatic stress. *Journal of Child & Adolescent Trauma, 9*, 1–10. https://doi.org/10.1007/s40653-016-0090-3

Avdibegovic, E., Brkic, M., & Sinanovic, O. (2017). Emotional profile of women victims of domestic violence. *Materia Socio-Medica, 29*(2), 109–113. https://doi.org/10.5455/msm.2017.29.109-113

Badanta, B., González-Cano-Caballero, M., Suárez-Reina, P., Lucchetti, G., & de Diego-Cordero, R. (2022). How does Confucianism influence health behaviors, health outcomes and medical decisions? A scoping review. *Journal of Religion and Health, 61*(4), 2679–2725. https://doi.org/10.1007/s10943-022-01506-8

BCcampus. (2014, September 26). *Defining aggression—Principles of social psychology—1st international edition*. Opentextbc.ca. https://opentextbc.ca/socialpsychology/chapter/defining-aggression/

Bellet, B. W., LeBlanc, N. J., Nizzi, M. C., Carter, M. L., van der Does, F. H. S., Peters, J., Robinaugh, D. J., & McNally, R. J. (2020). Identity confusion in complicated grief: A closer look. *Journal of Abnormal Psychology, 129*(4), 397–407. https://doi.org/10.1037/abn0000520

Bellon, F., Mateos, J. T., Pastells-Peiró, R., Espigares-Tribó, G., Gea-Sánchez, M., & Rubinat-Arnaldo, E. (2022). The role of nurses in euthanasia: A scoping review. *International Journal of Nursing Studies, 134*. https://doi.org/10.1016/j.ijnurstu.2022.104286

Biancalani, G., Azzola, C., Sassu, R., Marogna, C., & Testoni, I. (2022). Spirituality for coping with the trauma of a loved one's death during the COVID-19 pandemic: An Italian qualitative study. *Pastoral Psychology, 71*(2), 173–185. https://doi.org/10.1007/s11089-021-00989-8

Birken, M., Chipp, B., Shah, P., Olive, R. R., Nyikavaranda, P., Hardy, J., Chhapia, A., Barber, N., Lee, S., Pearce, E., Lloyd-Evans, B., Perkins, R., McDaid, D., Stefanidou, T., Shafran, R., Pitman, A., & Johnson, S. (2023). Exploring the experiences of loneliness in adults with mental health problems: A participatory qualitative interview study. *PloS One, 18*(3). https://doi.org/10.1371/journal.pone.0280946

Busolo, D., & Woodgate, R. (2015). Palliative care experiences of adult cancer patients from ethnocultural groups: A qualitative systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 13*(1), 99–111. https://doi.org/10.11124/jbisrir-2015-1809

Cacciatore, J., Thieleman, K., Fretts, R., & Jackson, L. B. (2021). What is good grief support? Exploring the actors and actions in social support after traumatic grief. *PloS One, 16*(5). https://doi.org/10.1371/journal.pone.0252324

Cavazzana, A., Röhrborn, A., Garthus-Niegel, S., Larsson, M., Hummel, T., & Croy, I. (2018). Sensory-specific impairment among older people. An investigation using both sensory thresholds and subjective measures across the five senses. *PloS One, 13*(8). https://doi.org/10.1371/journal.pone.0202969

Center for Substance Abuse Treatment (US). (2014). *Trauma-Informed Care in Behavioral Health Services*. Substance Abuse and Mental Health Services Administration (US). Treatment Improvement Protocol (TIP) Series,

No. 57. https://www.ncbi.nlm.nih.gov/books/NBK207191/

Centers for Disease Control and Prevention. (2019). *Cost of intimate partner violence*. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

Centers for Disease Control and Prevention. (2022, December 5). *The untreated syphilis study at Tuskegee timeline*. https://www.cdc.gov/tuskegee/timeline.htm

Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. (2019). Associations between adverse childhood experiences and health outcomes in adults aged 18–59 years. *PloS One, 14*(2). https://doi.org/10.1371/journal.pone.0211850

Chen, X., Zeng, Y., Jiang, L., Tian, L., Yi, J., He, H., Li, F., Long, Y., & Li, L. (2023). Assessing emergency department nurses' ability to communicate with angry patients and the factors that influence it. *Frontiers in Public Health, 11*. https://doi.org/10.3389/fpubh.2023.1098803

Chen, X., Zhang, G., Yin, X., Li, Y., Cao, G., Gutiérrez-García, C., & Guo, L. (2019). The relationship between self-efficacy and aggressive behavior in boxers: The mediating role of self-control. *Frontiers in Psychology, 10*, 212. https://doi.org/10.3389/fpsyg.2019.00212

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of seclusion and restraint in adult psychiatry: A systematic review. *Frontiers in Psychiatry, 10*, 491. https://doi.org/10.3389/fpsyt.2019.00491

Chipidza, F., Wallwork, R. S., Adams, T. N., & Stern, T. A. (2016). Evaluation and treatment of the angry patient. *The Primary Care Companion for CNS Disorders, 18*(3). https://doi.org/10.4088/PCC.16f01951

Colclough, Y. Y., & Brown, G. M. (2014). Complete manuscript title: American Indians' experiences of life-threatening illness and end of life. *Journal of Hospice and Palliative Nursing: JHPN: The Official Journal of the Hospice and Palliative Nurses Association, 16*(7), 404–413. https://doi.org/10.1097/NJH.0000000000000086

Collins, J. W., Zoucha, R., Lockhart, J. S., & Mixer, S. J. (2018). Cultural aspects of end-of-life care planning for African Americans: An integrative review of literature. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 29*(6), 578–590. https://doi.org/10.1177/1043659617753042

Constante, A. (2022, March 17). How 'hiya,' 'kapwa' and other cultural values play a role in Filipino American mental health. *Los Angeles Times*. https://www.latimes.com/lifestyle/story/2022-03-17/how-hiya-kapwa-and-other-cultural-values-play-a-role-in-filipino-american-mental-health.

Corr, C. A., Nabe, C. M., & Corr, D. M. (2018). Death and dying, life and living. Cengage Learning.

Crisis Prevention Institute. (2020). *Nonviolent crisis intervention training*. https://www.crisisprevention.com/Our-Programs/Nonviolent-Crisis-Intervention

Crisis Prevention Institute. (2022, June 28). *CPI's top 10 de-escalation tips*. https://www.crisisprevention.com/Blog/CPI-s-Top-10-De-Escalation-Tips-Revisited

Cruz, D., Lichten, M., Berg, K., & George, P. (2022). Developmental trauma: Conceptual framework, associated risks and comorbidities, and evaluation and treatment. *Frontiers in Psychiatry, 13*. https://doi.org/10.3389/fpsyt.2022.800687

Currier, J. M., Irish, J. E., Neimeyer, R. A., & Foster, J. D. (2015). Attachment, continuing bonds, and complicated grief following violent loss: Testing a moderated model. *Death Studies, 39*(1–5), 201–210. https://doi.org/10.1080/07481187.2014.975869

Cyr, M. E., Etchin, A. G., Guthrie, B. J., & Benneyan, J. C. (2019). Access to specialty healthcare in urban versus rural US populations: A systematic literature review. *BMC Health Services Research, 19*(1). https://doi.org/10.1186/s12913-019-4815-5

Dabaghi, N., Amini-Rarani, M., & Nosratabadi, M. (2023). Investigating the relationship between socioeconomic status and domestic violence against women in Isfahan, Iran in 2021: A cross-sectional study. *Health Science Reports, 6*(5). https://doi.org/10.1002/hsr2.1277

Dahal, P., Joshi, S. K., & Swahnberg, K. (2022). A qualitative study on gender inequality and gender-based violence

in Nepal. *BMC Public Health, 22*(1). https://doi.org/10.1186/s12889-022-14389-x

David, E. J., & Okazaki, S. (2006). Colonial mentality: A review and recommendation for Filipino American psychology. *Cultural Diversity & Ethnic Minority Psychology, 12*(1), 1–16. https://doi.org/10.1037/1099-9809.12.1.1

Dayes, J., Keenan, J., Sadza, M., & Croucher, K. (2023). Etiquette in the context of death and dying: Communication and conversation. *OMEGA - Journal of Death and Dying*. https://doi.org/10.1177/00302228231196623

de Brito Sena, M. A., Damiano, R. F., Lucchetti, G., & Peres, M. F. (2021). Defining spirituality in healthcare: A systematic review and conceptual framework. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.756080

DeAngelis, T. (2021, April 1). *Mental illness and violence: Debunking myths, addressing realities*. Apa.org. https://www.apa.org/monitor/2021/04/ce-mental-illness

Demedts, D., Fobelets, M., Tricas-Sauras, S., & Bilsen, J. (2023). Nursing students' view on their future role and skills regarding euthanasia due to unbearable mental suffering: A mixed-method study. *Nurse Education in Practice, 71*. https://doi.org/10.1016/j.nepr.2023.103718

Dennis, M. K., & Washington, K. T. (2016). *"Just let me go": End-of-life planning among Ojibwe elders*. The Gerontologist. https://doi.org/10.1093/geront/gnw151

Dimitrov, R., Jelen, A., & L'Etang, J. (2022). Taboos in health communication: Stigma, silence and voice. *Public Relations Inquiry, 11*(1), 3–35. https://doi.org/10.1177/2046147X211067002

Dionne-Odom, J. N., Ornstein, K. A., & Kent, E. E. (2019). What do family caregivers know about palliative care? Results from a national survey. *Palliative & Supportive Care, 17*(6), 643–649. https://doi.org/10.1017/S1478951519000154

Dokkedahl, S., Kok, R., Murphy, S., Kristensen, T., Bech-Hansen, D., & Elklit, A. (2019). The psychological subtype of intimate partner violence and its effect on mental health: Protocol for a systematic review and meta-analysis. *Syst Rev 8, 198*. https://doi.org/10.1186/s13643-019-1118-1

Doyle, K. W., Knetig, J. A., & Iverson, K. M. (2022). Practical implications of research on intimate partner violence experiences for the mental health clinician. *Current Treatment Options in Psychiatry, 9*(3), 280–300. https://doi.org/10.1007/s40501-022-00270-6

Duffy, M., & Wild, J. (2017). A cognitive approach to persistent complex bereavement disorder (PCBD). *The Cognitive Behaviour Therapist, 10*, E16. https://doi.org/10.1017/S1754470X17000034

Dugal, C., Bigras, N., Godbout, N., & Bélanger, C. (2016). *Childhood interpersonal trauma and its repercussions in adulthood: An analysis of psychological and interpersonal sequelae*. InTech. https://doi.org/10.5772/64476

Dutton, D. G. (2007). *The abusive personality: Violence and control in intimate relationships* (2nd ed). The Guilford Press.

Eames, C., & O'Connor, D. (2022). The role of repetitive thinking and spirituality in the development of posttraumatic growth and symptoms of posttraumatic stress disorder. *PloS One, 17*(8). https://doi.org/10.1371/journal.pone.0272036

Edalati, H., & Krank, M. D. (2016). Childhood maltreatment and development of substance use disorders. *Trauma, Violence, & Abuse, 17*(5), 454–467. https://doi.org/10.1177/1524838015584370

Einberger, C., Puckett, A., Ricci, L., & Melloni, R., Jr. (2020). Contemporary pharmacotherapeutics and the management of aggressive behavior in an adolescent animal model of maladaptive aggression. *Clinical Psychopharmacology and Neuroscience: The Official Scientific Journal of the Korean College of Neuropsychopharmacology, 18*(2), 188–202. https://doi.org/10.9758/cpn.2020.18.2.188

Emanuel, E. J., Onwuteaka-Philipsen, B. D., Urwin, J. W., & Cohen, J. (2016). Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA, 316*(1), 79–90. https://doi.org/10.1001/jama.2016.8499

Fletcher, J., Hamilton, B., Kinner, S., Sutherland, G., King, K., Tellez, J. J., Harvey, C., & Brophy, L. (2019). Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice. *International Journal of Mental Health Nursing, 28*(2), 538–550. https://doi.org/10.1111/inm.12559

Focht, J., & Chu, A. (2020, October 27). *The cycle of domestic violence*. National Center for Health Research. https://www.center4research.org/the-cycle-of-domestic-violence/

Fontalis, A., Prousali, E., & Kulkarni, K. (2018). Euthanasia and assisted dying: What is the current position and what are the key arguments informing the debate? *Journal of the Royal Society of Medicine, 111*(11), 407–413. https://doi.org/10.1177/0141076818803452

Friganović, A., & Selič, P. (2021). Where to look for a remedy? Burnout syndrome and its associations with coping and job satisfaction in critical care nurses—A cross-sectional study. *International Journal of Environmental Research and Public Health, 18*(8), 4390. https://doi.org/10.3390/ijerph18084390

Gabra, M., Mohammed, K., Hegazy, M., & Hendi, A. (2022). Post-traumatic stress disorder symptoms among nursing staff who provided direct care to COVID-19 patients: A cross-sectional study. *Middle East Curr Psychiatry, 29*, 67. https://doi.org/10.1186/s43045-022-00233-w

Garakani, A., Murrough, J. W., Freire, R. C., Thom, R. P., Larkin, K., Buono, F. D., & Iosifescu, D. V. (2020). Pharmacotherapy of anxiety disorders: Current and emerging treatment options. *Frontiers in Psychiatry, 11*. https://doi.org/10.3389/fpsyt.2020.595584

Geiderman, J. M., & Marco, C. A. (2020). Mandatory and permissive reporting laws: Obligations, challenges, moral dilemmas, and opportunities. *Journal of the American College of Emergency Physicians Open, 1*(1), 38–45. https://doi.org/10.1002/emp2.12011

Ghelani, A. (2021). Knowledge and skills for social workers on mobile crisis intervention teams. *Clinical Social Work Journal*. https://doi.org/10.1007/s10615-021-00823-x

Givler, A., Bhatt, H., & Maani-Fogelman, P. (2023). *The importance of cultural competence in pain and palliative care*. Stat Pearls. https://www.ncbi.nlm.nih.gov/books/NBK493154/

Goodman, H., Papastavrou Brooks, C., Price, O., & Barley, E. A. (2020). Barriers and facilitators to the effective de-escalation of conflict behaviours in forensic high-secure settings: A qualitative study. *International Journal of Mental Health Systems, 14*, 59. https://doi.org/10.1186/s13033-020-00392-5

Gossman, W., Ellis, V. L., & Toney-Butler, T. J. (2023, July 3). *Conflict management*. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK470432/

Gratis, B. (2022, February 4). *Overcoming interpersonal barriers to communication*. Nulab. https://nulab.com/learn/collaboration/overcoming-interpersonal-barriers-communication/

Gustafsson, T., & Hemberg, J. (2022). Compassion fatigue as bruises in the soul: A qualitative study on nurses. *Nursing Ethics, 29*(1), 157–170. https://doi.org/10.1177/09697330211003215

Harsey, S. J., Zurbriggen, E. L., & Freyd, J. J. (2017). Perpetrator responses to victim confrontation: DARVO and victim self-blame. *Journal of Aggression, Maltreatment & Trauma, 26*(6), 644–663. https://doi.org/10.1080/10926771.2017.1320777

Hartogh, G. D. (2017). Suffering and dying well: On the proper aim of palliative care. *Medicine, Health Care, and Philosophy, 20*(3), 413–424. https://doi.org/10.1007/s11019-017-9764-3

Heckemann, B., Zeller, A., Hahn, S., Dassen, T., Schols, J. M., & Halfens, R. J. (2015). The effect of aggression management training programmes for nursing staff and students working in an acute hospital setting. A narrative review of current literature. *Nurse Education Today, 35*(1), 212–219. https://doi.org/10.1016/j.nedt.2014.08.003

Hegarty, K., McKibbin, G., Hameed, M., Koziol-McLain, J., Feder, G., Tarzia, L., & Hooker, L. (2020). Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PloS One, 15*(6). https://doi.org/10.1371/journal.pone.0234067

Heise, L., Pallitto, C., García-Moreno, C., & Clark, C. J. (2019). Measuring psychological abuse by intimate partners:

Constructing a cross-cultural indicator for the sustainable development goals. *SSM - Population Health, 9*. https://doi.org/10.1016/j.ssmph.2019.100377

Heyland, D. K., Jiang, X., Day, A. G., Cohen, S. R., & Canadian Researchers at the End of Life Network (CARENET). (2013). The development and validation of a shorter version of the Canadian Health Care Evaluation Project Questionnaire (CANHELP Lite): A novel tool to measure patient and family satisfaction with end-of-life care. *Journal of Pain and Symptom Management, 46*(2), 289–297. https://doi.org/10.1016/j.jpainsymman.2012.07.012

Hodel, J. (2023). Myths behind restraint and seclusion: A literature review. https://endseclusion.org/2023/06/27/myths-behind-restraint-and-seclusion-a-literature-review/

Holmes, S. C., Maxwell, C. D., Cattaneo, L. B., Bellucci, B. A., & Sullivan, T. P. (2022). Criminal protection orders among women victims of intimate partner violence: Women's experiences of court decisions, processes, and their willingness to engage with the system in the future. *Journal of Interpersonal Violence, 37*(17–18). https://doi.org/10.1177/08862605211021965

Hostetter, M., & Klein, S. (2021, January 14). *Understanding and ameliorating medical mistrust among Black Americans*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans

Hussain, F. (2021, April). *Psychological challenges for nurses working in palliative care and recommendations for self-care*. British Journal of Nursing. https://www.britishjournalofnursing.com/content/professional/psychological-challenges-for-nurses-working-in-palliative-care-and-recommendations-for-self-care/

International End-of-Life Doula Association. (2017, June 23). *The Chinese approach to death and dying*. Inelda. https://inelda.org/the-chinese-approach-to-death-and-dying/

Isaacson, M. J., & Lynch, A. R. (2018). Culturally relevant palliative and end-of-life care for U.S. indigenous populations: An integrative review. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 29*(2), 180–191. https://doi.org/10.1177/1043659617720980

JCFS Chicago. (n.d.). *Traditional Jewish ritual and mourning practices*. https://www.jcfs.org/our-services/jewish-community-programs/illness-loss-grief/guide-for-the-grieving/traditional-mourning

Kalra, S., Priya, G., Grewal, E., Aye, T. T., Waraich, B. K., SweLatt, T., Khun, T., Phanvarine, M., Sutta, S., Kaush, U., Manilka, Ruder, S., & Kalra, B. (2018). Lessons for the health-care practitioner from Buddhism. *Indian Journal of Endocrinology and Metabolism, 22*(6), 812–817. https://doi.org/10.4103/ijem.IJEM_286_17

Kamatsiko, V. (2021). Vertical social cohesion: Linking concept to practice. Peace and Conflict Studies. https://doi.org/10.46743/1082-7307/2021.1782

Khan, M. N., Khan, I., Ul-Haq, Z., Khan, M., Baddia, F., Ahmad, F., & Khan, S. (2021). Managing violence against healthcare personnel in the emergency settings of Pakistan: A mixed methods study. *BMJ Open, 11*(6). https://doi.org/10.1136/bmjopen-2020-044213

Killgore, W. D. S., Cloonan, S. A., Taylor, E. C., Anlap, I., & Dailey, N. S. (2021). Increasing aggression during the COVID-19 lockdowns. *Journal of Affective Disorders Reports, 5*. https://doi.org/10.1016/j.jadr.2021.100163

Kim, A. S., Jang, M. H., Park, K. H., & Min, J. Y. (2020a). Effects of self-efficacy, depression, and anger on health-promoting behaviors of Korean elderly women with hypertension. *International Journal of Environmental Research and Public Health, 17*(17), 6296. https://doi.org/10.3390/ijerph17176296

Kim, J. S., Kim, J., & Gelegjamts, D. (2020b). Knowledge, attitude and self-efficacy towards palliative care among nurses in Mongolia: A cross-sectional descriptive study. *PloS One, 15*(7). https://doi.org/10.1371/journal.pone.0236390

Ko, E., Cho, S., Perez, R. L., Yeo, Y., & Palomino, H. (2013). Good and bad death: Exploring the perspectives of older Mexican Americans. *Journal of Gerontological Social Work, 56*(1), 6–25. https://doi.org/10.1080/01634372.2012.715619

Kostka, A. M., Borodzicz, A., & Krzemińska, S. A. (2021). Feelings and emotions of nurses related to dying and death of patients—A pilot study. *Psychology Research and Behavior Management, 14*, 705–717. https://doi.org/10.2147/PRBM.S311996

Kruglanski, A. W., Ellenberg, M., Szumowska, E., Molinario, E., Speckhard, A., Leander, N. P., Pierro, A., Di Cicco, G., & Bushman, B. J. (2023). Frustration–aggression hypothesis reconsidered: The role of significance quest. *Aggressive Behavior, 49*(5). https://doi.org/10.1002/ab.22092

Kübler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy, and their own families*. Macmillan.

La, I. S., Lee, M. C., Hinderer, K. A., Chi, I., Liu, R., Liu, M., & Fu, Y. (2021). Palliative care for the Asian American adult population: A scoping review. *The American Journal of Hospice & Palliative care, 38*(6), 658–670. https://doi.org/10.1177/1049909120928063

Lagman, R. A., Yoo, G. J., Levine, E. G., Donnell, K. A., & Lim, H. R. (2014). "Leaving it to God" religion and spirituality among Filipina immigrant breast cancer survivors. *Journal of Religion and Health, 53*(2), 449–460. https://doi.org/10.1007/s10943-012-9648-z

Lau, K. K. H., Randall, A. K., Duran, N. D., & Tao, C. (2019). Examining the effects of couples' real-time stress and coping processes on interaction quality: Language use as a mediator. *Frontiers in Psychology, 9*, 2598. https://doi.org/10.3389/fpsyg.2018.02598

Lee, M. C., Hinderer, K. A., & Alexander, C. S. (2018). What matters most at the end-of-life for Chinese Americans? *Gerontology & Geriatric Medicine, 4*. https://doi.org/10.1177/2333721418778195

Lee, S. K. (2009). East Asian attitudes toward death—A search for the ways to help East Asian elderly dying in contemporary America. *The Permanente Journal, 13*(3), 55–60. https://doi.org/10.7812/TPP/08-068

Lehrer, D. (2021). Trauma-informed care: The importance of understanding the incarcerated women. *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care, 27*(2), 121–126. https://doi.org/10.1089/jchc.20.07.0060

Leung, W. Y., Bhar, S., Reilly, A., & Pedell, S. (2021). Discrepancies between community-dwelling individuals with dementia and their proxies in completing the Cornell Scale for Depression in Dementia: A secondary data analysis. *Clinical Interventions in Aging, 16*, 281–289. https://doi.org/10.2147/CIA.S289595

Levensen, J. S., & Willis, G. M. (2018). Implementing trauma-informed care in correctional treatment and supervision. *Journal of Aggression, Maltreatment & Trauma, 28*(4), 481–501. https://doi.org/10.1080/10926771.2018.1531959

Lim, M. C., Jeffree, M. S., Saupin, S. S., Giloi, N., & Lukman, K. A. (2022). Workplace violence in healthcare settings: The risk factors, implications and collaborative preventive measures. *Annals of Medicine and Surgery*, *78*. https://doi.org/10.1016/j.amsu.2022.103727

Llor-Esteban, B., Sánchez-Muñoz, M., Ruiz-Hernández, J. A., & Jiménez-Barbero, J. A. (2017). User violence towards nursing professionals in mental health services and emergency units. *The European Journal of Psychology Applied to Legal Context, 9*(1), 33–40. https://doi.org/10.1016/j.ejpal.2016.06.002

Logan, T. K., & Walker, R. (2018). Advocate safety planning training, feedback, and personal challenges. *Journal of Family Violence, 33*(3), 213–225. https://doi.org/10.1007/s10896-017-9949-9

Lundorff, M., Holmgren, H., Zachariae, R., Farver-Vestergaard, I., & O'Connor, M. (2017). Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis. *Journal of Affective Disorders, 212*, 138–149. https://doi.org/10.1016/j.jad.2017.01.030

Malik, H., & Annabi, C. A. (2022). The impact of mindfulness practice on physician burnout: A scoping review. *Frontiers in Psychology, 13*. https://doi.org/10.3389/fpsyg.2022.956651

Mardani, A., Paal, P., Weck, C., Jamshed, S., & Vaismoradi, M. (2022). Practical considerations of PRN medicines management: An integrative systematic review. *Frontiers in Pharmacology, 13*. https://doi.org/10.3389/

fphar.2022.759998

Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual Review of Sociology, 41*, 291–310. https://doi.org/10.1146/annurev-soc-073014-112326

Matsui, M., Braun, K. L. (2009). Japanese Americans' death attitudes and preferences for end-of-life care. *Journal of Hospice and Palliative Nursing, 11*(6), 353–361. http://dx.doi.org/10.1097/NJH.0b013e3181bd03f1

Matsumura, S., Bito, S., Liu, H., Kahn, K., Fukuhara, S., Kagawa-Singer, M., & Wenger, N. (2002). Acculturation of attitudes toward end-of-life care: A cross-cultural survey of Japanese Americans and Japanese. *Journal of General Internal Medicine, 17*(7), 531–539. https://doi.org/10.1046/j.1525-1497.2002.10734.x

McCallum, K. J., Walthall, H., Aveyard, H., & Jackson, D. (2021). Grief and nursing: Life and death in the pandemic. *J Adv Nurs, 77*, 2115–2116. https://doi.org/10.1111/jan.14815

McElvaney, R., Lateef, R., Collin-Vézina, D., Alaggia, R., & Simpson, M. (2022). Bringing shame out of the shadows: Identifying shame in child sexual abuse disclosure processes and implications for psychotherapy. *Journal of Interpersonal Violence, 37*, 19–20). https://doi.org/10.1177/08862605211037435

McLean, E., Blystad, A., Mirkuzie, A. H., & Miljeteig, I. (2023). Health workers' experience of providing second-trimester abortion care in Ethiopia: A qualitative study. *Reproductive Health, 20*(1). https://doi.org/10.1186/s12978-023-01698-6

Mears, D., & Cochran, J. (2015). *Prisoner reentry in the era of mass incarceration*. Sage Publications.

Meier, E., Gallegos, J., Thomas, L., Depp, C., Irwin, S., & Jeste, D. (2016). Defining a good death (successful dying): Literature review and a call for research and public dialogue. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry, 24*(4), 261–271. https://doi.org/10.1016/j.jagp.2016.01.135

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Mercy, J. A., Hillis, S. D., Butchart, A., Bellis, M. A., Ward, C. L., Fang, X., & Rosenberg, M. L. (2017). Interpersonal violence: Global impact and paths to prevention (C. N. Mock, R. Nugent, O. Kobusingye, & K. R. Smith, Eds.). PubMed; The International Bank for Reconstruction and Development / The World Bank. https://www.ncbi.nlm.nih.gov/books/NBK525208/

Mistler, L. A., Ben-Zeev, D., Carpenter-Song, E., Brunette, M. F., & Friedman, M. J. (2017). Mobile mindfulness intervention on an acute psychiatric nit: Feasibility and acceptability study. *JMIR Mental Health, 4*(3), e34. https://doi.org/10.2196/mental.7717

Moors, A. (2017). Appraisal theory of emotion. Encyclopedia of Personality and Individual Differences, 1–9. https://doi.org/10.1007/978-3-319-28099-8_493-1

Mortazavi, S. S., Assari, S., Alimohamadi, A., Rafiee, M., & Shati, M. (2020). Fear, loss, social isolation, and incomplete grief due to COVID-19: A recipe for a psychiatric pandemic. *Basic and Clinical Neuroscience, 11*(2), 225–232. https://doi.org/10.32598/bcn.11.covid19.2549.1

Mughal, S., Azhar, Y., Mahon, M. M., & Siddiqui, W. J. (2019, March 25). *Grief reaction and prolonged grief disorder*. National Library of Medicine; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK507832/

Murray, J. (2023). *Grief and loss*. USQ Pressbooks. https://usq.pressbooks.pub/counselling/chapter/grief-and-loss/

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*(1), 51–59. https://doi.org/10.1111/inm.12012

Nakajima, S. (2018). Complicated grief: Recent developments in diagnostic criteria and treatment. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences, 373*(1754). https://doi.org/10.1098/rstb.2017.0273

National Academies of Sciences, Engineering, and Medicine, Division of Behavioral and Social Sciences and Education, Health and Medicine Division, Board on Children, Youth, and Families, Board on Global Health, & Forum on Global Violence Prevention. (2018). Public policy approaches to violence prevention: Proceedings of a workshop—in brief. In PubMed. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK482172/

National Institute of Mental Health. (2023). *Post-traumatic stress disorder*. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

Neelam, K., Duddu, V., Anyim, N., Neelam, J., & Lewis, S. (2021). Pandemics and pre-existing mental illness: A systematic review and meta-analysis. *Brain, Behavior, & Immunity - Health, 10*. https://doi.org/10.1016/j.bbih.2020.100177

NICE. (2015, May 28). Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE. Nice.org.uk; NICE. https://www.nice.org.uk/guidance/ng10

Nowrouzi-Kia, B., Isidro, R., Chai, E., Usuba, K., & Chen, A. (2019). Antecedent factors in different types of workplace violence against nurses: A systematic review. *Aggression and Violent Behavior, 44*, 1–7. https://doi.org/10.1016/j.avb.2018.11.002

O'Connor, M. F. (2019). Grief: A brief history of research on how body, mind, and brain adapt. *Psychosomatic Medicine, 81*(8), 731–738. https://doi.org/10.1097/PSY.0000000000000717

Oates, J. R., & Maani-Fogelman, P. A. (2022, September 18). *Nursing grief and loss*. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK518989/

Oostermeijer, S., Brasier, C., Harvey, C., Hamilton, B., Roper, C., Martel, A., Fletcher, J., & Brophy, L. (2021). Design features that reduce the use of seclusion and restraint in mental health facilities: A rapid systematic review. *BMJ Open, 11*(7). https://doi.org/10.1136/bmjopen-2020-046647

Oregon Health Authority. (2021). *Death with dignity act*. https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

Oregon Nurses Association. (2015). *ONA position statement: Assisted suicide*. https://cdn.ymaws.com/www.oregonrn.org/resource/resmgr/Docs/ONA-PosState_AsstSuicide.pdf

Orlovic, M., Smith, K., & Mossialos, E. (2018). Racial and ethnic differences in end-of-life care in the United States: Evidence from the Health and Retirement Study (HRS). *SSM - Population Health, 7*. https://doi.org/10.1016/j.ssmph.2018.100331

Pekurinen, V., Willman, L., Virtanen, M., Kivimäki, M., Vahtera, J., & Välimäki, M. (2017). Patient aggression and the wellbeing of nurses: A cross-sectional survey study in psychiatric and non-psychiatric settings. *International Journal of Environmental Research and Public Health, 14*(10), 1245. https://doi.org/10.3390/ijerph14101245

Peña-Vargas, C., Armaiz-Peña, G., Castro-Figueroa E. (2021). A biopsychosocial approach to grief, depression, and the role of emotional regulation. *Behavioral Sciences, 11*(8), 110. https://doi.org/10.3390%2Fbs11080110

Pereira, L., Radovic, T., & Haykal, K. A. (2021). Peer support programs in the fields of medicine and nursing: A systematic search and narrative review. *Canadian Medical Education Journal, 12*(3), 113–125. https://doi.org/10.36834/cmej.71129

Pitman, A. L., Stevenson, F., Osborn, D. P. J., & King, M. B. (2018). The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study. *Social Science & Medicine*, *198*, 121–129. https://doi.org/10.1016/j.socscimed.2017.12.035

Pollock, A., Campbell, P., Cheyne, J., Cowie, J., Davis, B., McCallum, J., McGill, K., Elders, A., Hagen, S., McClurg, D., Torrens, C., & Maxwell, M. (2020). Interventions to support the resilience and mental health of frontline health and social care professionals during and after a disease outbreak, epidemic or pandemic: A mixed methods systematic review. *The Cochrane Database of Systematic Reviews, 11*(11). https://doi.org/10.1002/14651858.CD013779

Pomey, M. P., Ghadiri, D. P., Karazivan, P., Fernandez, N., & Clavel, N. (2015). Patients as partners: A qualitative study of patients' engagement in their health care. *PloS One, 10*(4). https://doi.org/10.1371/journal.pone.0122499

Popa, I., Lee, L., Yu, H., & Madera, J. M. (2023). Losing talent due to COVID-19: The roles of anger and fear on industry turnover intentions. *Journal of Hospitality and Tourism Management, 54*, 119–127. https://doi.org/10.1016/j.jhtm.2022.12.010

Popovsky, M. (2007). Jewish ritual, reality and response at the end of life a guide to caring for Jewish patients and their families. Duke Institute on Care at the End of Life.

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine, 17*(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

Putri, N. K., Melania, M. K. N., Fatmawati, S. M. Y., & Lim, Y. C. (2023). How does the work-life balance impact stress on primary healthcare workers during the COVID-19 pandemic? *BMC Health Services Research, 23*(1), 730. https://doi.org/10.1186/s12913-023-09677-0

Qin, G., & Zhang, L. (2022). Perceived overall injustice and organizational deviance—Mediating effect of anger and moderating effect of moral disengagement. *Frontiers in Psychology, 13*. https://doi.org/10.3389/fpsyg.2022.1023724

Rabow, M. W., Huang, C.-H. S., White-Hammond, G. E., & Tucker, R. O. (2021). Witnesses and victims both: Healthcare workers and grief in the time of COVID-19. *Journal of Pain and Symptom Management, 62*(3). https://doi.org/10.1016/j.jpainsymman.2021.01.139

Radell, M. L., Abo Hamza, E. G., Daghustani, W. H., Perveen, A., & Moustafa, A. A. (2021). The impact of different types of abuse on depression. *Depression Research and Treatment.* https://doi.org/10.1155/2021/6654503

Rahmani, F., Hosseinzadeh, M., & Gholizadeh, L. (2023). Complicated grief and related factors among nursing staff during the Covid-19 pandemic: A cross-sectional study. *BMC Psychiatry, 23*(1), 73. https://doi.org/10.1186/s12888-023-04562-w

Ramacciati, N., Ceccagnoli, A., Addey, B., Lumini, E., & Rasero, L. (2018). Violence towards emergency nurses: A narrative review of theories and frameworks. *International Emergency Nursing, 39*, 2–12. https://doi.org/10.1016/j.ienj.2017.08.004

Ranjbar, N., Erb, M., Mohammad, O., & Moreno, F. A. (2020). Trauma-informed care and cultural humility in the mental health care of people from minoritized communities. *Focus (American Psychiatric Publishing), 18*(1), 8–15. https://doi.org/10.1176/appi.focus.20190027

Reardon, D. C. (2018). The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Medicine, 6*. https://doi.org/10.1177/2050312118807624

Reilly, P. M., & Shopshire, M. S. (2019). Anger management for substance use disorder and mental health clients: A cognitive-behavioral therapy manual. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/anger_management_manual_508_compliant.pdf

Richard, Y., Tazi, N., Frydecka, D., Hamid, M. S., & Moustafa, A. A. (2022). A systematic review of neural, cognitive, and clinical studies of anger and aggression. *Current Psychology*, 1–13. Advance online publication. https://doi.org/10.1007/s12144-022-03143-6

Richardson, S. K., Ardagh, M. W., Morrison, R., & Grainger, P. C. (2019). Management of the aggressive emergency department patient: Non-pharmacological perspectives and evidence base. *Open Access Emergency Medicine: OAEM, 11*, 271–290. https://doi.org/10.2147/OAEM.S192884

Rivara, F., & Le Menestrel, S. (2016, September 14). Preventive interventions. Nih.gov; National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK390407/

Robertson, R. A., Standley, C. J., Gunn, J. F., III, & Opara, I. (2022). Structural indicators of suicide: An exploration of

state-level risk factors among Black and White people in the United States, 2015–2019. *Journal of Public Mental Health, 21*(1), 23–34. https://doi.org/10.1108/jpmh-09-2021-0111

Rokach, A., & Chan, S. H. (2023). Love and infidelity: Causes and consequences. *International Journal of Environmental Research and Public Health, 20*(5), 3904. https://doi.org/10.3390/ijerph20053904

Rosen, M. A., DiazGranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *The American Psychologist, 73*(4), 433–450. https://doi.org/10.1037/amp0000298

Rosenberg, L. B., Goodlev, E. R., Izen, R. S. E., Gelfand, S. L., Goodlev, C. L., Lanckton, R. B., Skarf, L. M., Wershof Schwartz, A., Jones, C. A., & Tulsky, J. A. (2020). Top ten tips palliative care clinicians should know about caring for Jewish patients. *Journal of Palliative Medicine, 23*(12), 1658–1661. https://doi.org/10.1089/jpm.2020.0601

Sabri, B., Tharmarajah, S., Njie-Carr, V. P. S., Messing, J. T., Loerzel, E., Arscott, J., & Campbell, J. C. (2022). Safety planning with marginalized survivors of intimate partner violence: Challenges of conducting safety planning intervention research with marginalized women. *Trauma, Violence & Abuse, 23*(5), 1728–1751. https://doi.org/10.1177/15248380211013136

Saini, V. K., Gehlawat, P., & Gupta, T. (2020). Evaluation of knowledge and competency among nurses after a brief suicide prevention educational program: A pilot study. *Journal of Family Medicine and Primary Care, 9*(12), 6018–6022. https://doi.org/10.4103/jfmpc.jfmpc_984_20

Saxena, P., & Messina, N. (2021). Trajectories of victimization to violence among incarcerated women. *Health & Justice, 9*, 18. https://doi.org/10.1186/s40352-021-00144-8

Schleimer, J. P., Pear, V. A., McCort, C. D., Shev, A. B., De Biasi, A., Tomsich, E., Buggs, S., Laqueur, H. S., & Wintemute, G. J. (2022). Unemployment and crime in US cities during the coronavirus pandemic. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 99*(1), 82–91. https://doi.org/10.1007/s11524-021-00605-3

Schooley, A., & Kratovil, A. (2023). Exploration of ethical challenges in maternal health nursing. *Journal of Nursing Education, 62*(3), 187. https://link-gale-com.lib-proxy.jsu.edu/apps/doc/A743252956/HRCA?u=jack26672&sid=bookmark-HRCA&xid=df34748f

Scott, K. M., Koenen, K. C., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Benjet, C., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Iwata, N., Levinson, D., Lim, C. C., Murphy, S., Ormel, J., Posada-Villa, J., & Kessler, R. C. (2013). Associations between lifetime traumatic events and subsequent chronic physical conditions: A cross-national, cross-sectional study. *PloS One, 8*(11). https://doi.org/10.1371/journal.pone.00805

Shear, M. K., Reynolds, C. F., III, Simon, N. M., Zisook, S., Wang, Y., Mauro, C., Duan, N., Lebowitz, B., & Skritskaya, N. (2016). Optimizing treatment of complicated grief: A randomized clinical trial. *JAMA Psychiatry, 73*(7), 685–694. https://doi.org/10.1001/jamapsychiatry.2016.0892

Sinha, A., Deshwal, H., & Vashisht, R. (2023, January). End-of-life evaluation and management of pain. [Updated 2023 Feb 26]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK568753/

Six, S., Bilsen, J., & Deschepper, R. (2023). Dealing with cultural diversity in palliative care. *BMJ Supportive & Palliative Care, 13*(1), 65–69. https://doi.org/10.1136/bmjspcare-2020-002511

Smith, N. A., Voisin, D. R., Yang, J. P., & Tung, E. L. (2019). Keeping your guard up: Hypervigilance among urban residents affected by community and police violence. *Health Affairs (Project Hope), 38*(10), 1662–1669. https://doi.org/10.1377/hlthaff.2019.00560

Soreff, S., Gupta, V., Wadhwa, R., & Arif, H. Aggression. [Updated 2023 Apr 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448073/

Spencer, S., Johnson, P., & Smith, I. C. (2018). De-escalation techniques for managing non-psychosis induced aggression in adults. *The Cochrane Database of Systematic Reviews, 7*(7). https://doi.org/10.1002/14651858.CD012034.pub2

Staggs, V. S. (2015). Trends in use of seclusion and restraint in response to injurious assault in psychiatric units in U.S. hospitals, 2007–2013. *Psychiatric Services, 66*(12), 1369–1372. https://doi.org/10.1176/appi.ps.201400490

Stroebe, M., Schut, H., & Boerner, K. (2017). Cautioning health-care professionals: Bereaved persons are misguided through the stages of grief. *OMEGA - Journal of Death and Dying, 74*(4), 455–473. https://doi.org/10.1177/0030222817691870

Substance Abuse and Mental Health Services Administration. (2019, January 14). Trauma and violence. https://www.samhsa.gov/trauma-violence

Substance Abuse and Mental Health Services Administration. (2022, September 29). High-risk substance use among youth. https://www.cdc.gov/healthyyouth/substance-use/index.htm

Substance Abuse and Mental Health Services Administration. (2023, October). *Recognizing and treating child traumatic stress*. https://www.samhsa.gov/child-trauma/recognizing-and-treating-child-traumatic-stress

Sugimoto-Matsuda, J. J., & Braun, K. L. (2013). The role of collaboration in facilitating policy change in youth violence prevention: A review of the literature. *Prevention Science, 15*(2), 194–204. https://doi.org/10.1007/s11121-013-0369-7

Suttle, M., Hall, M. W., Pollack, M. M., Berg, R. A., McQuillen, P. S., Mourani, P. M., Sapru, A., Carcillo, J. A., Startup, E., Holubkov, R., Dean, J. M., Notterman, D. A., Meert, K. L., & Eunice Kennedy Shriver National Institute of Child Health and Human Development Collaborative Pediatric Critical Care Research Network (CPCCRN). (2022). Complicated grief, depression and post-traumatic stress symptoms among bereaved parents following their child's death in the pediatric intensive care unit: A follow-up study. *The American Journal of Hospice & Palliative Care, 39*(2), 228–236. https://doi.org/10.1177/10499091211015913

Suzuki ,H. (2012, December 12). *Death and dying in contemporary Japan*. Taylor & Francis. https://doi.org/10.4324/9780203095423

Tennant, K., & Toney-Butler, T. J. (2022). Active listening. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK442015/

Thomas, R., & Reeves, M. (2020). Mandatory reporting laws. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK560690/

Thompson, N., & Doka, K. (2017). Disenfranchised grief. In N. Thompson & G. R. Cox (Eds.), Handbook of the sociology of death, grief, and bereavement: A guide to theory and practice (pp. 177–190). Routledge/Taylor & Francis Group.

Tran, Q. N. H., Dieu-Hien, H. T., King, I. N., Sheehan, K., Iglowitz, M. L., & Periyakoil, V. S. (2019). Providing culturally respectful care for seriously ill Vietnamese Americans. *Journal of Pain and Symptom Management, 58*(2), 344–354. https://doi.org/10.1016/j.jpainsymman.2019.03.012

Twycross, R. (2019). Reflections on palliative sedation. *Palliative Care: Research and Treatment, 12*. https://doi.org/10.1177/1178224218823511

Tyrrell, P., Harberger, S., Schoo, C., & Siddiqui, W. (2023, February 26). Kubler-Ross stages of dying and subsequent models of grief. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK507885/

Ullman, S. E., & Peter-Hagene, L. (2014). Social reactions to sexual assault disclosure, coping, perceived control and PTSD symptoms in sexual assault victims. *Journal of Community Psychology, 42*(4), 495–508. https://doi.org/10.1002/jcop.21624

UN Women. (2020). *Violence against women*. https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

Üstükuş, A, & Eskimez, Z. (2021). The effect of death anxiety in nurses on their approach to dying patients: A cross-sectional study. *Perspect Psychiatr Care, 57*, 1929–1936. https://doi.org/10.1111/ppc.12768

Välimäki, M., Lantta, T., Lam, Y., Cheung, T., Cheng, P., Ng, T., Ip, G., & Bressington, D. (2022). Perceptions of patient

aggression in psychiatric hospitals: A qualitative study using focus groups with nurses, patients, and informal caregivers. *BMC Psychiatry, 22*, 344. https://doi.org/10.1186/s12888-022-03974-4

Valliani, K., & Mughal, F. B. (2022). Human emotions during COVID-19: A lens through Kubler-Ross grief theory. *Psychological Trauma: Theory, Research, Practice & Policy, 14*(2), 247–249. https://doi-org.lib-proxy.jsu.edu/10.1037/tra0001064

van Schalkwyk, G. I., Beyer, C., Johnson, J., Deal, M., & Bloch, M. H. (2018). Antipsychotics for aggression in adults: A meta-analysis. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 81*, 452–458. https://doi.org/10.1016/j.pnpbp.2017.07.019

Varkey, B. (2021). Principles of clinical ethics and their application to practice. *Medical Principles and Practice: International Journal of the Kuwait University, Health Science Centre, 30*(1), 17–28. https://doi.org/10.1159/000509119

Vasquez, A. (2022). *How to stop pushing loved ones away after a death: 5 tips*. Coping with Grief. https://www.joincake.com/blog/pushing-loved-ones-away-after-death/

Vento, S., Cainelli, F., & Vallone, A. (2020). Violence against healthcare workers: A worldwide phenomenon with serious consequences. *Frontiers in Public Health, 8*. https://doi.org/10.3389/fpubh.2020.570459

Victorian Agency for Health Information. (2016). *Managing personal, emotional, cultural and spiritual needs in palliative care*. Vic.gov.au. https://www.health.vic.gov.au/patient-care/managing-personal-emotional-cultural-and-spiritual-needs-in-palliative-care#culturally-and-linguistically-diverse-cald

Wang, Y. T., Hsu, Y. C., Hsu, H. C., & Hong, R. M. (2021). The lived experience of nurses applying with postmortem care: A qualitative evidence synthesis. *Journal of Clinical Case Studies, 7*(1). https://doi.org/10.16966/2471-4925.239

Wang, Z., Li, C., & Ai, K. (2022a). Family economic strain and adolescent aggression during the COVID-19 pandemic: Roles of interparental conflict and parent-child conflict. *Applied Research in Quality of Life, 17*(4), 2369–2385. https://doi.org/10.1007/s11482-022-10042-2

Wang, Z., Tocchi, C., Chyun, D., Kim, K., Cong, X., & Starkweather, A. (2022b). The association between psychological factors and self-care in patients with heart failure: An integrative review. *European Journal of Cardiovascular Nursing, 22*(6). https://doi.org/10.1093/eurjcn/zvac106

Warren, A., Blundell, B., Chung, D., & Waters, R. (2023). Exploring categories of family violence across the lifespan: A scoping review. Trauma, Violence & Abuse. Advance online publication. https://doi.org/10.1177/15248380231169486

Wessells, M. G., & Kostelny, K. (2022). The psychosocial impacts of intimate partner violence against women in LMIC contexts: Toward a holistic approach. *International Journal of Environmental Research and Public Health, 19*(21). https://doi.org/10.3390/ijerph192114488

Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2020). The therapeutic relationship in cognitive behaviour therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy, 93*(2), 276–291. https://doi.org/10.1111/papt.12232

Wong, P. T. P., & Yu, T. T. F. (2021). Existential suffering in palliative care: An existential positive psychology perspective. *Medicina, 57*(9), 924. https://doi.org/10.3390/medicina57090924

World Health Organization. (2014). *Preventing suicide: A global imperative*. https://www.who.int/publications/i/item/9789241564779

World Health Organization. (2021). *Violence against women*. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

World Health Organization. (2022, June 17). *Mental health*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Zare, A., Bahia, N. J., Eidy, F., Adib, N., & Sedighe, F. (2019). The relationship between spiritual well-being, mental

health, and quality of life in cancer patients receiving chemotherapy. *Journal of Family Medicine and Primary Care, 8*(5), 1701–1705. https://doi.org/10.4103/jfmpc.jfmpc_131_19

Zhong, S., Yu, R., & Fazel, S. (2020). Drug use disorders and violence: Associations with individual drug categories. *Epidemiologic Reviews, 42*(1), 103–116. https://doi.org/10.1093/epirev/mxaa006

Zulueta Egea, M., Prieto-Ursúa, M., Bermejo Toro, L. & Palmar-Santos, A. M. (2022). Dimensions of good palliative nursing care: Expert panel consensus and perceptions of palliative professionals. *Journal of Clinical Nursing, 32*(13–14), 3746–3756. https://doi.org/10.1111/jocn.16583

CHAPTER 10
Legal and Ethical Guidelines

FIGURE 10.1 Understanding all of the legal and ethical issues surrounding client care is critical to ensure the nurse can support a client who is unable to make their own choices and carry out their own actions. (credit: "Legal Gavel & Open Law Book" by "howtostartablogonline.net"/Wikimedia Commons, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION There are very important connections between psychiatry/mental health and the law. They both manage social behavior as well as responsibilities and relationships within society. Mental health care seeks to understand behavior and to improve or maintain quality of life. Law seeks to manage the outcomes of behavior to encourage functioning within groups of people in society. They both work together to ensure the safety of the individual and the group. The mental health nurse must understand the law to protect themselves, their clients, as well as society as a whole. Keeping clients and the nurses who care for them safe is of primary importance. The best way to protect nurse, client, and society is to be knowledgeable of the laws that govern practice at both the federal and state levels as well as the rights and responsibilities of the client.

10.1 Client Rights and Protections

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the importance of upholding HIPAA rules within the mental health practice setting
- Describe the protections put in place by the Patient Protection and Affordable Care Act

Mental health clients are potentially a vulnerable population and therefore need to be protected from exploitation or

abuse. There are federal and state statutes that lay out these protections as well as organizational policies and procedures intended to protect client rights. Client rights include concepts like confidentiality of protected health information, covered by the Health Insurance Portability and Accountability Act (HIPAA), and the right to purchase health insurance, covered by the Patient Protection and Affordable Care Act (PPACA). States can issue laws that offer additional protections, as long as they uphold the federal protections.

HIPAA

The federal government has enacted multiple legal protections so that protected health information remains private and protected. This has become very important in the digital age where health information is easier to access by health-care providers and clients, but also by those who would use the information for secondary gain.

In 1996, President Bill Clinton signed the **Health Insurance Portability and Accountability Act (HIPAA)** into law (U.S. Department of Health and Human Services, 2022b). This federal law (and accompanying regulations that implement the law) protects sensitive client health information from being disclosed without the client's consent or knowledge. This law covers clients' **protected health information (PHI)**, information included in a medical record that can be used to identify an individual and that was used, created, or disclosed in the process of providing a health-care service. Until 1996, confidentiality in medical records was minimally protected, though the records were harder to access since they were primarily paper-based (U.S. Department of Health and Human Services, n.d.). HIPAA gives clients more control over their health information by setting boundaries on and requiring written consent for the use and release of health records. At the time of the first visit to a provider and in the mail from the health plan, providers must offer clients a HIPAA notice—which must be signed acknowledging receipt—that describes how the health information is shared and includes health privacy rights. If a client refuses to sign the acknowledgment, this must be documented.

HIPAA requires covered health-care entities to provide training to staff to ensure understanding of HIPAA rules and regulations. Covered health-care entities are defined by the HIPAA rules as health plans, health-care clearinghouses, and health-care providers, but only if they transmit information related to financial or administrative activities related to health care. During HIPAA training, employees should be made aware of the possible penalties for HIPAA violations. Figure 10.2 lays out the three rules of privacy, security, and breach notification for HIPAA compliance.

Three Rules for HIPAA Requirements		
Privacy Rule	**Security Rule**	**Breach Notification Rule**
• Establishes national standards for protecting health information • Requires appropriate safeguards to protect the privacy of PHI • Sets limits and conditions on the uses and disclosures of PHI without an individual's authorization • Gives individuals rights over their own protected health information	• Establishes national standards to protect individuals' electronic PHI that is created, received, used, or maintained by a covered entity • Requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic PHI	• Requires HIPAA-covered entities and their business associates to provide notification following a breach of unsecured protected health information

FIGURE 10.2 The three rules of HIPAA compliance are the Privacy Rule, the Security Rule, and the Breach Notification Rule (Centers for Medicare and Medicaid Services, 2023). (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

REAL RN STORIES

Nurse: George B.
Years in Practice: Eight
Clinical Setting: Mental health inpatient facility

Geographic Location: Oregon

George is a nurse in a mental health inpatient facility in an affluent area that sometimes has wealthy people admitted for drug, alcohol, or psychiatric treatment. Recently, the facility admitted a celebrity; rumors spread among the staff, but they kept it quiet. George was not involved in this client's care and was not assigned to that unit during their stay. However, he was unable to avoid the temptation of looking into the person's medical record despite them being under an alias. He had undergone HIPAA training and knew it was wrong, but thought that he would not share the information, so what is the harm? After the client was discharged, regulators audited the chart and found that not only George, but four others who were not involved in this person's care had accessed the chart without appropriate cause, reason, or permission. George and the four others were fired for HIPAA violations and George was reported to his state board of nursing and is awaiting a determination of disciplinary action. All health-care professionals must be aware that they leave a "footprint" whenever they enter the records of a client.

HIPAA compliance rules apply to hospitals as well as a variety of other types of health-care treatment settings. There are four potential outcomes that may result from HIPAA noncompliance: (1) the employer may deal with the violation internally, (2) the violator could be terminated, (3) the violator could face sanctions from professional boards, and/or (4) the violator could face criminal charges, including fines and imprisonment.

Five common HIPAA violations include:

- the loss of a device, such as the theft of a computer that contains client information
- downloading a computer virus on a health-care agency computer that allows personal client information to be accessed or leaked such as through portable media or email
- employee dishonesty while accessing files, such as a nurse who accesses client information that they do not have the authority to see
- improper filing and disposing of documents, such as a nurse who throws lab results that include client-identifying information into the public trash receptacle at the nurse station
- releasing client information after the authorization to release period expires (Intraprise Health, 2023)

LINK TO LEARNING

The Top 20 Worst HIPAA Violations (https://openstax.org/r/77violations) includes real-life examples of some of the most severe HIPAA violations to date.

The Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) or Affordable Care Act (ACA) was signed into law in 2010 by President Barack Obama and continues to be a politically charged topic. Its original premise, which continues, is to expand access to health insurance to uninsured Americans. The main points of the law were to expand Medicaid eligibility, create a Health Insurance Marketplace, and prevent insurance companies from denying coverage due to preexisting conditions. The ACA also requires insurers to cover a list of essential health benefits. It was also designed to reform the insurance industry to reduce the costs of coverage and to include premium tax credits and cost-sharing reductions to help lower expenses for lower-income families and individuals. According to the Affordable Care Act (ACA), employers must provide health insurance to their employees. Certain small firms that meet the requirements can get tax credits. To assist consumers and small businesses in obtaining insurance, the law established insurance exchanges that are headquartered in multiple states. By the ACA law, young adults are allowed to remain on their parents' insurance policies until the age of 26. ACA creates state rate reviews for insurance premium increases, forbids lifetime financial ceilings on insurance coverage, and restricts the use of yearly caps. It forbids insurance companies from terminating or withdrawing coverage, as well as from refusing to cover children with preexisting conditions. The ACA improved access to insurance and health care for many Americans; it also added coverage for preventative care and preexisting conditions that was lacking in many existing prior plans. Some of the downsides include increases in premiums, new taxes to support costs, a limited enrollment period, and reduced hours of employees to avoid providing medical insurance (U.S. Department of Health and Human Services, 2022a).

10.2 Legal Issues Relating to Mental Health Nursing

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the laws applicable to nursing practice
- Explain the laws and rights protecting clients receiving health care
- Understand nursing challenges to protecting these client rights
- Describe the role of the nurse in forensic services

Nurses should understand and keep abreast of any legal issues that affect health care in order to protect their hard-earned licenses, jobs, institutions, and clients. Nursing practice changes frequently in terms of best practices and emerging evidence; it also changes as health care and technology innovations and political developments lead to new laws and ethical issues. Nurses are accountable to practice according to current laws and standards. Federal and state legislatures direct practice with laws relating to negligence or that require reporting child and elder abuse. Federal agencies, such as the Centers for Medicare and Medicaid Services, create regulations to supplement and detail compliance with the federal and state laws. These regulations cover topics like staff-to-client ratios, proper training, the use of seclusion and restraints, and much more. Moreover, state boards of nursing establish and maintain their own regulations governing the scope of nursing practice, including the requirements and limitations for nursing practice and licensure. The following sections describe the most significant legal topics that nurses may encounter while caring for clients. Knowledge and understanding of these concepts will help assist the nurse with decision-making and in providing better care.

Laws Applicable to Nursing

Nurses must follow federal and state laws, administrative regulations, institutional policies, and professional standards. In terms of federal and state laws, criminal law is a system of laws that punishes individuals who commit crimes. Conviction for a crime requires that the prosecution show evidence to prove that the defendant is guilty beyond a reasonable doubt. Civil law, on the other hand, focuses on the rights, responsibilities, and legal relationships between private citizens, and possibly involves compensation to an injured party. The evidentiary standard to prove wrongdoing in a civil case is lower than in a criminal case. Other standards nurses must follow include the state nurse practice acts, which set professional regulations for the scope of nursing practice, licensure requirements, and enforcement procedures within a given state.

Criminal Challenges

Nurses are not immune from criminal prosecution if they break the law. Nurses have been prosecuted for crimes, such as negligent homicide, insurance fraud, theft of narcotics, manslaughter, and falsifying medical records. There are many examples of nurses being charged with crimes. One example took place in November of 2021 and September of 2022 when a nurse in Pennsylvania took narcotics from clients and attempted to cover it up by tampering with records. She is now facing charges of theft of drugs and tampering of records (Oltmann, 2023). There are many other ways that nurses can face criminal charges for various crimes against their clients. It is the nurse's responsibility to practice responsibly, ethically, morally, and with care to protect themselves and their clients.

Torts

One type of civil case nurses may encounter in practice is a **tort**, an act of commission or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability. Tort law exists to compensate clients injured by negligent practice, provide corrective judgment, and deter negligence. An **intentional tort** is a wrong that the defendant knew (or should have known) would be caused by their actions. Examples of intentional torts include assault, battery, false imprisonment, slander, and libel. An **unintentional tort** occurs when a defendant's actions or inactions were reckless or unreasonably unsafe. Unintentional torts can result from acts of commission (i.e., doing something a reasonable nurse would not have done) or omission (i.e., failing to do something a reasonable nurse would do).

Assault and Battery

Assault and battery are intentional torts (not to be confused with the separate crimes of assault and battery). In a civil context, **assault** means intentionally putting another person in reasonable apprehension, that is fear, of

imminent harmful or offensive contact. The intentional causation of harmful or offensive contact with another person without that person's consent is called **battery**. Physical harm does not need to occur in order to be charged with assault or battery. In fact, assault does not even involve a physical touch, although battery does. Assault and battery often arise in health care in relation to a client's right to refuse treatment. For example, a hospitalized client can refuse to take prescribed medication. If a nurse forcibly administers medication without that client's consent, it could be ruled battery in a court of law. Keep in mind, however, that it may be justified to force administration of a medication based on a provider's order in an emergency situation to prevent imminent harm.

False Imprisonment

Another intentional tort is **false imprisonment**, defined as an act of restraining another person and causing that person to be confined in a bounded area. This tort often comes up in the use of restraints or seclusion, which is one reason why nurses must be vigilant in following agency policy related to the use of physical restraints and seclusion and must carefully monitor clients who are restrained or secluded.

Restraints are devices used in health-care settings, when alternative, less restrictive interventions are not effective, to prevent clients from causing harm to themselves or others. A restraint restricts a client's freedom of movement without the permission of the person. Seclusion, by contrast, is defined as the confinement of a client in a locked room or an area from which they cannot exit on their own. Seclusion should only be used to manage violent or destructive behavior. The chapter will revisit restraints and seclusion in more detail later.

Slander and Libel

Slander and libel are also intentional torts. Spoken defamation is called **slander**, and written defamation is called **libel**. Defamation of character occurs when an individual makes negative, malicious, and untrue remarks about another person to damage their reputation. Nurses must take care in their oral communication and documentation to avoid defaming clients or coworkers, or they risk a civil suit for damages. For example, if one nurse talked about a client to another nurse out loud saying, "Did you hear that this client did . . ." while knowing that it was untrue, it could be an example of slander. An example of libel is a nurse making an untrue social media post disparaging a client.

Fraud

When one individual deceives another for personal gain, it is called **fraud**. It is an intentional tort and can be charged as a crime. A nurse may be charged with fraud for documenting interventions not performed (in order to secure payment for them) or for altering documentation to cover up an error. Fraud can result in civil and criminal charges, as well as suspension or revocation of a nurse's license.

Negligence and Malpractice

Negligence and malpractice are unintentional torts and may be the area with which nurses are most familiar. The failure to exercise the ordinary care a reasonable person would use in similar circumstances is called **negligence**. For instance, a Wisconsin civil jury instruction states, "A person is not using ordinary care and is negligent, if the person, without intending to do harm, does something (or fails to do something) that a reasonable person would recognize as creating an unreasonable risk of injury or damage to a person or property" (Wisconsin Civil Jury Instructions Committee of the Wisconsin Judicial Conference, 2023). Negligence committed by a health professional with a license is called **malpractice**. When a nurse provides negligent care, it is an example of malpractice. The guidelines that create a baseline of appropriate (reasonable) professional conduct for nurses are the **standards of care**. For instance, a court will measure a nurse's behavior against the standard of care to determine if the behavior was negligent. The standard of care is generally defined by what a reasonable nurse in a comparable situation, with similar circumstances, education, and training would do.

Medical errors, a potential type of negligence, are a problem in nursing often highlighted in the media. Nurses are humans and make mistakes. How nurses and administration handle those mistakes is often the difference between being negligent or not. Potential for error is one reason why a system of checks and balances is built into medicine administration, with EMR systems with scanning systems, pharmacy systems and pharmacists, and two nurse verification for dangerous drugs.

But errors do not stop with medication administration. All areas of nursing practice can lead to errors, from documentation to equipment injuries, client falls, infections, and others. Even with all of the protections put into

place by law and policy, the human factor has its part and mistakes happen. For example, a nurse may grab the wrong antibiotic and skip steps due to being behind with their work and cause a reaction. A responsible nurse will then self-report the mistake as per facility policy and notify the client's provider as soon as the error is noted so that any possible adverse effect can be mitigated as soon as possible. Taking responsibility for an error may be the one thing that prevents the revocation of a nurse's license, though this is not guaranteed depending on the degree of the error and the level of adverse effect. If the error were to result in a client's death, there may be consequences no matter how responsible the nurse has been to self-report.

The best way to avoid malpractice is to be vigilant and follow protocol. There are some areas of negligence or malpractice that are specific to mental health. For example, a client may express thoughts of suicidal ideation. If the nurse does not act on those expressions and place the safeguards as per policy and the client acts on those thoughts, the nurse is responsible for the negligent action of not acting and therefore causing harm when it could have been avoided. Not performing timely and appropriate assessment and evaluation can also be malpractice. For example, not assessing the client who is restrained or not assessing for possibility of self-harm are forms of malpractice.

In order to determine the amount of money owed a victim of malpractice, courts examine economic damages, which are actual and measurable costs, disability or disfigurement, physical impairment, loss of life, and others. Courts also take "pain and suffering" into consideration, which is a more nebulous concept that is more difficult to quantify. For that reason, currently twenty-nine states have implemented tort reform, placing a cap on "pain and suffering" dollar amounts. The damages awarded vary greatly based on many factors, including severity of injury, the state that the case is brought in, the severity of the negligence, and the named plaintiffs.

REAL RN STORIES

Nurse: RaDonda Vaught
Years in Practice: Two
Clinical Setting: Large university hospital
Geographic Location: Tennessee

In March 2022, nurse RaDonda Vaught was found guilty of criminally negligent homicide and gross neglect of an impaired adult. The client was a seventy-five-year-old woman who was recovering from a brain injury. She was to get a PET scan in the radiology department prior to being discharged. She was prescribed Versed, a sedative, to calm her. The nurse, Vaught, mistakenly gave the client vecuronium, which is a powerful paralytic. This led to total muscle paralysis, stopped her from being able to breathe, and caused her death. Vaught also failed to monitor the client after administering the vecuronium, so she did not catch her error in enough time to reverse the paralysis. Despite the fact that the nurse did take the correct steps to report her error, in the peer review process at her institution, she was fired. After a subsequent review from the state board of nursing, she lost her license. The district attorney charged her with a crime, and the case went to court. She was sentenced to three years of supervised probation. It was a very public court case, watched by health-care professionals all over the United States.

Duty to Warn and Protect

In addition to state and federal criminal and civil laws regarding nursing practice, nurses and other mental health professionals have a **duty to warn** and protect third parties when they may be in danger from a client. This duty falls outside of HIPAA regulations, meaning that it does not violate privacy and confidentiality provisions. This duty includes assessing and predicting the likelihood of a client's threat of violence or harm toward another person or groups of people and taking action to protect the identified victims. Duty to warn entails notifying the threatened party and local authorities, such as police and the Department of Health and Human Services, of the threat so that they may put protections in place. The duty to protect is a little less formal than the duty to warn. It can include possible commitment, development of a "no-harm" contract, teaching or arranging for anger management, referring for medical evaluation, or increasing therapy sessions and/or telephone contact. The most common threats that trigger the duty to warn are injury and homicide, but it also has come up with regard to STIs, child abuse or neglect, incest, and battery.

Mandatory Reporting of Suspected Abuse or Neglect

Many states also require health professionals to report suspected neglect or abuse, called **mandatory reporting**. State laws vary, but they generally include a definition of reportable abuse, a list of professionals required to report abuse, and the government agency designated to receive and investigate the reports. Nurses and other health professionals are referred to as mandated reporters because they are required by state law to report suspected neglect or abuse of children, adults at risk, and older adults. Adults at risk are adults who have a physical or mental condition that impairs their ability to care for their own needs. This is also defined by state statute and will vary from state to state. Nurses need to know the law and their role in the reporting requirements for the population that they work with.

Nurse Practice Acts

The board of nursing is the state-specific licensing and regulatory body that enforces the state practice act and issues nursing licenses to qualified candidates. If nurses do not follow the standards and scope of practice set forth by the nurse practice act, they can have their nursing license revoked by that same board of nursing. Each state is different and has the power to create regulations to detail, implement, and enforce the more general state nurse practice act statutes, but regulations cannot violate the laws set forth by the state. Just like state laws cannot violate those laws set forth by the federal government. Each state's nurse practice act also determines the disciplinary action for violating the act, such as a fine, reprimand, reeducation, or loss of nursing license. It is up to the nurse to know the specific state laws for the state or states in which they are licensed.

Nursing students are legally accountable for the quality of care they provide to clients just as nurses are accountable. Students are expected to recognize the limits of their knowledge and experience and appropriately alert individuals in authority regarding situations that are beyond their competency. A violation of the standards of practice constitutes unprofessional conduct and can result in the board of nursing denying a license to a nursing graduate.

The Laws and Rights Protecting Clients

There exist both state and federal laws and regulations to shield client rights. One example, in addition to HIPAA and the ACA mentioned earlier, includes the Patient Safety and Quality Improvement Act of 2005, which encourages reporting medical errors. A **patient bill of rights** lists the minimum standards for the ways that clients can expect to be treated by health-care professionals.

Patient's Bill of Rights Overview

Client rights serve as a guideline for client and staff professional behavior. There are four fundamental client rights—the right to courtesy, the right to respect, the right to dignity, and the right to timely, responsive attention to client needs—but they have been elaborated upon and expanded over time and with changes in society and health care.

In 1973, the Patient's Bill of Rights was first adopted by the American Hospital Association (AHA) to protect clients. Client rights were developed with the expectation that hospitals and health-care institutions would support these rights while delivering effective client care. Although not legally binding, the Patient's Bill of Rights provides clients with goals and expectations on how they are to be treated during a hospital stay. The Patient's Bill of Rights embraces key areas regarding client rights related to treatment decisions, respect and nondiscrimination, access to and confidentiality of medical records, refusal of treatment, and the least restrictive treatment. Clients with psychiatric-mental health disorders have the same rights as other persons.

The AHA Patient's Bill of Rights title was replaced with the name Patient Care Partnership (PCP) in 2001 to promote the concept that health care is a partnership between a client and a provider. The PCP utilizes plain language to inform clients about what they should expect during a hospital stay regarding rights and responsibilities. The PCP states that any hospitalized client has the right to quality hospital care, such as a clean and safe environment, involvement in care planning and decision-making, protection of privacy, assistance when discharging or leaving the hospital, and assistance with billing claims (AHA, 2003).

LINK TO LEARNING

The Patient Care Partnership (https://openstax.org/r/77PtCarePartner) replaced the Patient Bills of Rights in 2001.

Mental Health Bill of Rights

Psychiatric-mental health clients deserve to be treated with dignity and have the same rights and protections as other health-care clients. Historically, individuals with mental health conditions have endured abuse and discrimination. According to Mental Health America (MHA), "From leaving people to languish in overcrowded state hospitals to lobotomies and forced sterilization, the treatment of those with mental health conditions is a dark stain on our history as a nation," (2023, para 2) The Mental Health Bill of Rights recognizes that psychiatric-mental health clients may be at increased risk for mistreatment and abuse. With that in mind, the Mental Health Bill of Rights includes liberty and autonomy, protection from seclusion and restraint, community inclusion, access to services, and privacy (MHA, 2023). Clients have the following rights:

- the right to be informed promptly of their rights at the time of admission and periodically thereafter, in language and terms appropriate to such person's condition and ability to understand
- the right to assert grievances with respect to infringement of the rights, including the right to have such grievances considered in a fair, timely, and impartial grievance procedure provided for or by the program or facility
- the right of access to any available rights protection service within a program, facility, or state mental health system designed to protect and advocate the rights of individuals with mental illness, and the right to a qualified advocate for the purpose of receiving assistance to understand, exercise, and protect the rights described in this section and in other provisions of law
- the right to exercise one's rights without reprisal, including reprisal in the form of denial of any appropriate, available treatment
- the right to referral as appropriate to other providers of mental health services upon discharge (Conlon et al., 2019)

LINK TO LEARNING

The Bill of Rights for Mental Health (https://openstax.org/r/77MentalHltBOR) was enacted by the U.S. government and is updated on a regular basis. Its purpose is to guide mental health professionals in providing care that is safe, that maintains autonomy and dignity, and that is appropriate and reasonable.

Client Right to Treatment

The right to mental health treatment includes two components: the right to appropriate treatment and the right to an individualized, written treatment or service plan. The right to appropriate treatment and related services means that treatment occurs in a setting and under conditions that support personal liberty and restrict such liberty only when necessary to comply with treatment needs, laws, and judicial orders. The right to an individualized, written treatment plan means that the provider develops it promptly after admission, that treatment is based on the plan, that the health-care team periodically reviews and reassesses the treatment plan, and that the team appropriately revises the plan (Pirotte, 2022). The health-care team will include the professionals involved with the care for the client, including doctors, nurses, and therapists, and generally includes the client and family being involved in decision-making with the nurse maintaining the role of client advocate at such meetings.

All clients have the right to participate in the planning of mental health services provided, including the development and periodic revision of the plan of care. They also have the right to be provided with a reasonable explanation for the treatment plan, in terms and language appropriate to their mental condition and general physical condition and ability to understand. The treatment plan should also outline the goals of treatment, the nature and significant possible adverse effects of recommended treatments, the rationale for why a particular treatment is considered appropriate, reasons why access to certain visitors may be restricted, and any appropriate and suitable substitute treatments, services, and types of providers of mental health services (Figure 10.3).

Treatment Plan	
NAME: Jordan	*This is a sample completed treatment plan of a fictitious client, Jordan*
Type of treatment plan	☒ Initial ☐ Update *Please select "Update" as the type of treatment plan when documenting changes to the initial plan.*
Area(s) of focus (check all that apply)	☒ Mental health/psychiatric ☒ Substance use or misuse
Presenting problem	Client is experiencing sadness, fatigue, anhedonia, depression, and increased alcohol use impacting work and interpersonal relationships. Symptoms have persisted for more than six months following a breakup with a boyfriend.
TREATMENT GOAL #1	"I want to decrease my depression so that I won't have problems at work and can enjoy my life again."
Objectives for Goal #1	*For the Objectives: Include smaller steps that the client agrees to work on to accomplish their goal(s). Objectives should be specific, measurable, and realistic with estimated time frames for completion. You may use the client's words or your own.* • Client will learn at least two new ways to cope with stressors as evidenced by a decrease in feelings of burden on others. • Complete mutually agreed upon homework activities at least 50% of the time over the next four sessions.
TREATMENT GOAL #2	Explore impact of drinking on life and potential for change.
Objectives for Goal #2	• Attend court hearing for DWI/DUI in November and successfully follow legal recommendations as directed and on time. • Over the next month, journal mood and depressive symptoms at least five days a week to identify patterns and triggers for alcohol use.
Interventions	*Describe the modalities, services, approaches, techniques, tools, and/or practices you will use.* Therapeutic approaches will include motivational interviewing, CBT, and DBT delivered via telehealth. Homework activities to be completed outside of therapy sessions will be discussed with the client each week, and resources such as web links, apps, and exercises will be shared.
Plan	Weekly 1:1 psychotherapy. Will re-evaluate treatment progress and adjust goals as needed after one month or 4th session.
The client actively participated in developing this treatment plan	☒ Yes ☐ No

FIGURE 10.3 This sample mental health treatment plan clearly states the treatment goals and measurable objectives. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Emergency Treatment

Emergency treatment is the client right to receive care in the event they are in a life-or-death situation that requires medical attention before providers can obtain consent. There are circumstances where a client is not able to knowingly understand and intelligently make a decision. There are many reasons that a person may not have capacity to make their own decisions, from trauma and medical reasons to mental health reasons, including dementia, psychosis, substance misuse and acute intoxication or overdose, mania, among others. In these cases, providers need to assess capacity, and if that person is deemed to lack capacity, the decisions for care usually can be made by a surrogate decision-maker, such as a spouse or an adult child. There are certain circumstances when emergency exceptions apply:

- a life- or limb-threatening situation
- the client is without capacity to make decisions
- there is no surrogate decision-maker available
- time is of the essence, for example imminent risk of harm
- under the circumstances, a reasonable person would consent

Once the emergency has passed, providers can reassess capacity and if the client remains without capacity, the health-care team can connect with a surrogate decision-maker.

The client right to treatment also includes continuity of care. An example of continuity of care is following up with clients after discharge. Haggerty et al. (2003) identified three types of continuity: informational continuity, management continuity, and relational continuity. Informational continuity involves tailoring a client's care based on their past events and personal circumstances. Management continuity involves reassessing the approach to ensure consistency in care as the client's needs change. Relational continuity involves maintaining the therapeutic relationship between a client and their providers (Haggerty et al., 2003).

The Right to Be Treated Fairly and with Respect

Every individual has the right to be treated fairly and with dignity and respect, meaning that a client has the right to be free from any threats and violence, the right to treatment without discrimination, and the right to be treated equally, regardless of age, gender, race, ethnicity, color, or disability. For example, when a nurse requests permission to enter a client's room or asks a client how they would like to be addressed, this communicates respect for the client as an individual. Respect also involves nurses introducing themselves to clients, specifying what they plan to do, and showing gratitude to clients who entrust them with their care (World Health Organization [WHO], 2023).

The Right to Obtain One's Medical Record

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, discussed earlier in the chapter, provides clients with a legal, enforceable right to see and receive copies upon request of their medical and other health records, including bills maintained by their health-care providers and health plans. A client can also request someone else's medical records if given permission in writing to act as their representative in accessing records. Health-care providers are required to provide copies of medical records within thirty days of the written request (HHS.gov, n.d.).

The Right to Refuse Treatment

Clients have the right to refuse treatment in the absence of informed, voluntary, written consent, except during an emergency documented by written order of a responsible mental health professional or in the case of a client committed by a court to a treatment program or facility. Clients also have the right to refuse to participate in research without an informed, voluntary, or written consent, and the right to appropriate protections in connection with participation. There are certain circumstances where the client cannot consent (or refuse) for themselves, such as clients with advanced dementia or intellectual disability. In these cases, a surrogate decision-maker is put in place to consent or refuse treatment.

The Right to the Least Restrictive Treatment

As a corollary to the idea that all clients have the right to be treated humanely in an environment that offers privacy and protection from harm (CorpusLegalis.com, n.d.), all clients also have the right to the least restrictive treatment. As mentioned earlier, nurses play a crucial role in the implementation of restrictive practices, such as seclusion and restraint. Guidelines vary by state and facility, but all agree that seclusion and restraints should only be used as a last resort after the providers have exhausted all attempts and techniques to de-escalate a situation. De-escalation techniques that nurses may use include using simple, nonthreatening language, setting clear boundaries, decreasing environmental stimuli, and providing diversions. Another option could be to offer the client an antianxiety medication. If no less restrictive measures work to de-escalate a situation, individuals who are at risk for behaviors that may result in harm to self or others may require the use of restraints (physical, chemical, environmental).

In the event a client needs restraints, the nurse must follow the facility's policies and procedures and secure a medical order. In an extreme emergency, such as when a serious threat of harm to the client or others exists and only after all alternative interventions were unsuccessful, a nurse can apply the restraints without a medical order

for nonviolent restraints. The provider must put in place an order for the restraints as soon as possible after their application, however, and the provider or trained RN must complete an in-person assessment within one hour of initiation of restraints or seclusion and every twenty-four hours to renew the order. For violent or self-destructive restraints, which are used for an imminent physical risk of harm to self or others, the provider must evaluate the client in person prior to, during, and immediately after initiation of the restraint as well as place the order.

Federal regulations regarding seclusion and restraints require the client to be evaluated by an RN or provider within four hours for adults, two hours for children and adolescents between the ages of nine and seventeen, and one hour for children under nine years old (called the "4/2/1 rule"). A new order and a face-to-face evaluation are required every twenty-four hours by the provider if restraints are still required (Electronic Code of Federal Regulations, 2023). Federal regulations also prevent the health-care provider from writing PRN (as necessary) orders for restraints. This means that if a client is in restraints and then has them removed, and then later needs restraints reapplied, this requires a new order. The procedure must be followed each time restraints are applied.

LINK TO LEARNING

These guidelines from *American Nurse Today* (https://openstax.org/r/77restraints) include some practical examples of restraint use, a restraint use decision tree, and critical thinking suggestions for restraint use.

Another consideration when using restraints involves required nursing care and documentation. A nurse must understand and follow agency policy, which should meet or exceed guidelines set by federal and state laws and regulations. For example, when a client is in restraints, the nurse must assess the client every fifteen minutes and check vital signs, provide range-of-motion exercises, check skin integrity under the restraints, and provide fluids and toileting every two hours. When documenting, the nurse must document the type of restraints, the reason for the restraints, how long the client is in restraints, the care offered and provided during restraint use, and times care is offered or provided. Documentation is part of the client record and is considered a legal document.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Application of Restraints

Topic (QSEN)	Nonbehavioral Restraints	Violent or Self-Destructive Restraints
Clinical Justification (Client-Centered Care)	• Pulling at lines • Pulling at tubes • Removal of equipment • Removal of dressing • Inability to respond to direct requests or follow instructions	Used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the client, staff, or others.
Alternatives Attempted (Teamwork and Collaboration)	Alternatives to restraints will be considered and/or attempted (and documented in the medical record) prior to the application of restraints.	

TABLE 10.1 Restraints (123Helpme, n.d.)

Topic (QSEN)	Nonbehavioral Restraints	Violent or Self-Destructive Restraints
Provider Evaluation/ Order (Safety)	A written order based on an examination of the client by the provider is entered into the medical record prior to initiation of restraints.*	The physician/provider must evaluate the client prior to, during, or immediately after initiation of restraints. The provider must: • document an evaluation of the client's immediate situation • document an evaluation of the client's reaction to the intervention • document an evaluation of the client's medical and behavioral condition • determine whether the restraint should be continued • supply an order for the restraint
	* NOTE: A qualified RN may apply restraints in response to an unanticipated event prior to a physician order. The provider who is primarily responsible for that client's care must then be notified immediately and a provider order obtained.	
PRN Orders Are *Not* Allowed		
Provider Order Notification (Teamwork and Collaboration)	The use of restraints is based on a current assessment. The qualified RN will: • notify the provider and obtain an order prior to application (unless emergent, in which case an order should be obtained during or immediately after initiating restraints) • notify and consult with the provider as soon as possible after restraints are initiated • document provider notification in the medical record	
Time Duration/ Limits of Order (Client-Centered Care)	The order for nonbehavioral restraints will last as long as the restraints are in place. A new order is required before restraints can be reapplied after being removed.	Orders are time limited based on age: • up to four hours for clients ages eighteen and older • up to two hours for children ages nine to seventeen • up to one hour for children eight and under
Reevaluation and Continued Use (Teamwork and Collaboration)	If a client is to be kept in a restraint, a certified registered nurse must assess the client at least once every shift to see if the restraint is still clinically warranted.	The client is evaluated by a qualified RN or provider at least every: • four hours for adults eighteen and older • two hours for children and ages nine to seventeen • one hour for children under nine The RN must notify the provider if continued use of restraints is required and a new order is entered by the provider. However, the provider *must* conduct a face-to-face evaluation no less than every twenty-four hours prior to renewing behavioral restraints. At that time, the provider shall reevaluate the efficacy of the client's treatment plan and work with the client to identify ways to help him/her regain control.

TABLE 10.1 Restraints (123Helpme, n.d.)

Topic (QSEN)	Nonbehavioral Restraints	Violent or Self-Destructive Restraints
Monitoring/ Care of Client (Safety)	The client will be observed at least every two hours (or more frequently based on assessed needs).	Direct continuous observation is required (i.e., a sitter at bedside). In-person assessments must be documented every ten to fifteen minutes, with no time lapse of greater than fifteen minutes.
	• Monitoring of clients in restraints will be performed by a staff member who has completed the required restraint training and competency assessment. • Care is provided based on the assessed needs of the client. Care will include: - offering liquids and nutrition - toileting - temporary release that occurs for the purpose of caring for a client's needs (for example, toileting, feeding, and range of motion) - other interventions as indicated by assessment findings • Clients transported off the unit must be assessed for needs by a qualified RN and be accompanied by an individual qualified to provide monitoring and care identified in the assessment. • Clients restrained with a lap or waist belt must have continuous observation.	
Nursing Documentation (Informatics)	Nonbehavioral Restraint Flowsheet (in EHR) • verification of restraint order • modification of the plan of care • individual client assessments and reassessments • clinical justification • intervention used (restraint type) • education • monitoring results • staff concerns regarding safety; risks to the client, staff, or others that necessitated the use of restraint (if applicable) • any injuries to the client	Violent or Self-Destructive Restraint Flowsheet (in EHR) • verification of restraint order • modification of the plan of care • provider Notification • individual client assessments and reassessments • clinical justification • intervention used (restraint type) • education • monitoring results • staff concerns regarding safety risks to the client, staff, or others that necessitated the use of restraint (if applicable) • any injuries to the client (if applicable) • application participants

TABLE 10.1 **Restraints** (123Helpme, n.d.)

Topic (QSEN)	Nonbehavioral Restraints	Violent or Self-Destructive Restraints
Nursing Interventions (Client-Centered Care)	• Obtain appropriate provider order. • Explain to the client and/or the client's family (including significant other) the reason for the use of the restraint device. • Notification of family, if not present, is recommended (if appropriate). • Apply restraints in manner that avoids undue physical discomfort, harm, or pain. 1. If a client is restrained in a supine position, the client's head should be free to rotate from side-to-side and, when possible, the head of the bed should be elevated to prevent risk of aspiration. 2. If a client is restrained in a prone position, the client's airway must be unobstructed at all times and the expansion of the client's lungs not restricted. • Ensure call light is readily accessible to any client without continuous observation. • Provide emotional/psychological support. • Explain and assist the client in meeting safety and/or behavior criteria for the discontinuation of restraints. • Maintain proper body alignment. Individualize the client's plan of care to include continuous regard for the client's rights of privacy, dignity, and attention to safety and physical and psychological needs.	
Removal (Client-Centered Care)	• A restraint shall be discontinued or the level of restraint reduced by a qualified RN as warranted by client condition and by nursing reassessment findings at the earliest possible time, regardless of the expiration time of the written order. • A temporary release that occurs for the purpose of caring for a client's needs (e.g., toileting, feeding, and range of motion) is not considered a discontinuation of the intervention. • Upon removal of restraints, nurses must document discontinuation of the restraint and complete the restraint order in the EMR.	
Repeat Episode (Safety)	A new provider order is needed if a client's restraints are taken off and they return to exhibiting behavior that requires restraint.	

TABLE 10.1 Restraints (123Helpme, n.d.)

The Right to Informed Consent

The communication between a client and a health-care provider that results in agreement and permission by the client for treatment or services is called **informed consent**. Every client has a right to understand and ask questions prior to consenting to treatment. Informed consent, generally governed by state law and regulation, is the fundamental right of an individual to fully understand their health-care decisions before making those decisions. Most states allow a client to sue for battery if providers do not obtain consent before providing medical treatment. Informed consent requires that the client must voluntarily provide consent, must be mentally capable to consent and of legal age (eighteen or older), and must be properly informed. Proper information generally includes the client understanding the provider's explanation of the diagnosis, the reason for the treatment or procedure, chances of success, and available alternative treatments and their risks. The client also has the right to change their mind at any time.

More specifically, the five elements required for documentation of informed consent include (1) disclosure of the nature of the procedure, (2) competency and comprehension of risks and benefits, (3) reasonable alternatives and voluntariness, (4) competence and understanding of risks or benefits of alternatives, and (5) the client's understanding of elements one through four as evidenced by the written consent (Shah et al., 2022). Disclosure is when a health-care provider offers information to clients about treatments or tests regarding the process, risks, and benefits, and allows a client to make informed decisions whether to undergo such treatments or tests. Client

competency and comprehension mean that the client is able to and understands the risks and benefits. It includes having the knowledge and skills needed to understand risks and benefits and decide effectively. Reasonable alternatives refer to the provider fully explaining available alternatives so that the client knows the options. Voluntariness refers to clients giving their agreement free of any coercion or pressure. A written form that includes all of this information is the actual informed consent.

There are several exceptions to the requirements of informed consent. One exception is when a client is incapacitated, in which case the surrogate decision-maker provides the informed consent. Another exception is a life-threatening emergency where there is not enough time to obtain consent. The law assumes that an unconscious person would consent to emergency care if the client were conscious and able to consent. Likewise, "there is no duty to disclose if the patient is so upset or mentally unstable that the provider reasonably believes that disclosure would be detrimental to the patient's well-being. The burden of proof is on the provider to prove this." (Lawshelf.com, 2023, para 30). Another exception is when a client voluntarily waives or gives up the right to consent. In addition, a legally emancipated child may provide their own informed consent, although legislation regarding minors and informed consent may vary by state (Shah et al., 2022).

LINK TO LEARNING

Temple Health published a toolkit on informed consent that contains a lot of helpful information, including a checklist (https://openstax.org/r/77InformConsent) to assess and evaluate the informed consent form.

One point to keep in mind is that in order to give legitimate informed consent, a client must have capacity and be legally competent to do so. Legal competency is a determination made by a judge about a person's legal ability or inability to make medical decisions, stand trial, or sign a contract, among other legal decisions. Capacity, by contrast, is assessed by a health-care provider and is a clinical opinion regarding a client's ability to make health-care decisions. Capacity can be determined by a provider by performing a few structured assessments, including cognitive testing and a competency assessment. For those deemed not competent to give informed consent, a legal guardian or person with medical power of attorney can be authorized to offer the consent.

PSYCHOSOCIAL CONSIDERATIONS

Competency to Stand Trial and the Insanity Defense

Mental health clients have a right to a determination of whether or not they are competent to make decisions on their own behalf. This comes up in informed consent but also arises when these clients have encounters with the law. They have the right to an evaluation of their mental state before they endure a trial and to determine if they can be held legally accountable for a crime.

In cases where there are questions about an individual's mental competency and/or ability to stand trial, for example, the court system may order that the offender be evaluated for their competency to stand trial. To be competent to stand trial, a person must be able to understand the character and consequences of the proceedings against them and able to properly assist in their defense. The evaluation is performed by a psychiatrist or psychologist certified in forensic psychology.

In another circumstance, when evaluating for an offender's mental condition at the time of an alleged crime, the evaluator must examine the person and review records, both medical and psychological, to determine if the person's mental state at the time of the crime met the requirements for a major mental disease or defect. They then have to give an opinion if that condition majorly impaired the offender's ability to appreciate the wrongness of the criminal act that they are accused of, if the offender's mental condition substantially impaired their capacity to behave within the requirements of the law, or both.

A person who has been found to be legally mentally incompetent when they committed a crime may be found "not guilty by reason of insanity." Or the person may be found guilty but receive a lessor or different punishment due to their mental impairment. The defendant must prove to the court that they did not understand what they were doing,

did not know right from wrong, acted on an uncontrollable impulse, or all of these factors.

LINK TO LEARNING

An article by Cornell Law School Legal Information Institute about the insanity defense (https://openstax.org/r/77insanityplea) gives an overview and history of this affirmative defense.

The Right to Privacy and Confidentiality

Another client right, **client confidentiality** is the expectation that information shared with the health-care providers or organization will not be divulged. Closely connected, so discussed together here, the **right to privacy** refers to the belief that one's personal information is protected from public access. As a client advocate, a nurse is responsible for protecting client confidentiality and privacy.

CULTURAL CONTEXT

Ethics in Using an Interpreter

Age and culture may affect the steps a nurse takes to ensuring client confidentiality. For example, a sensory deficit, such as hearing loss, or cultural differences, such as language barriers, may require an interpreter to be present when explaining and providing care. This may compromise client confidentiality.

The International Medical Interpreters Association created an interpreter Code of Ethics (https://openstax.org/r/77interprtethic) to help maintain standards of conduct. Some of the tenets included relate to maintaining confidentiality, accurately interpreting the client's message in their preferred language, keeping their own opinions out of the interpretations, and engaging in client advocacy to ensure accurate communication of cultural differences or preferences (International Medical Interpreters Association, 2006).

All clients have the right to confidentiality and privacy. This includes respecting someone's privacy and abstaining from sharing personal or potentially sensitive information about an individual, especially if that information was shared in confidence or during a professional relationship. In the psychiatric-mental health setting, there may be additional exceptions to disclosure of information. For example, if the client is a risk to self or others, or in situations to protect the client or others from harm, it may be necessary to disclose confidential information with the duty to inform.

On a residential or inpatient care basis, the right to privacy and confidentiality includes the right to speak with others in private, to view visitors during regularly planned hours, and to have fair and easy access to the phone and mail, except when a mental health professional determines that denial of access to a particular visitor is necessary for treatment purposes. The mental health professional may, for a specific, limited, and reasonable period, deny such access in writing and incorporate the order in the treatment plan. An order denying such access should include the reasons for such denial.

Only members of the health-care team who are involved in a client's care have the right to access client information. The client must provide written consent for the information to be shared with anyone outside the treatment team. The Privacy Act of 1974 prohibits the disclosure of a client's medical record without written consent of the individual unless the disclosure is based on one of twelve exceptions. Transfer of information must be done carefully and by facility procedure; inappropriate disclosure of information may constitute a breach of client confidentiality (Conlon et al., 2019). Client confidentiality is protected under the law and if that is breached without authorization, and causes harm to the client, then the client may have cause to take legal action against the responsible party or group. For example, suppose a parent of a minor client calls for information and the parent is not the legal guardian, if the parent is still given the information requested, this is a breach of confidentiality. Another breach of confidentiality takes place when a parent of an adult calls for an update on a client in a residential treatment facility and is given information without there being client authorization on file to provide that parent with that information.

LINK TO LEARNING

There are twelve exceptions of the Privacy Act of 1974 (https://openstax.org/r/77privacyexcept) that dictate when a client's medical record can be disclosed without written consent of the individual.

Client Rights in Facilities

Clients with acute mental health symptoms, or those who are at risk for hurting themselves or others, may be hospitalized. They are often initially seen in the emergency department for emergency psychiatric care. Clients may seek voluntary admission, or in some situations, may be involuntarily admitted after referral for emergency evaluation by law enforcement, schools, friends, or family members. Incarceration facilities are other settings where a number of mental health clients reside. In all facilities, voluntary or not, these clients have specific rights under federal and state laws and regulations.

Caring for the Client in a Hospital Setting

Acute care psychiatric units in general hospitals are typically locked units on a separate floor of the hospital with the purpose of maintaining environmental safety for clients. State-operated psychiatric hospitals serve clients who have chronic serious mental illness. They also provide court-related care for criminal cases where the client was found "not guilty by reason of insanity." This judgment means the client was deemed to be so mentally ill when they committed a crime that they cannot be held responsible for the act, but instead require treatment.

Commitment

There are two types of commitment for care and treatment in inpatient or outpatient mental health facilities. Voluntary admission happens when a person agrees to treatment in a mental health facility and is not an immediate threat to themselves or others. They are admitted and are free to leave at any time. Involuntary commitment can also be either inpatient or outpatient, but the person is confined against their will. In an involuntary hold, a person may be held for up to seventy-two hours (may vary by state), but the client must be a danger to themselves or others. After the seventy-two hours, the case/situation must go to the court system to determine if the hold should continue.

The specifics of the laws as far as how long and the reasons for a person to be committed vary by state. In general, a person must be a danger to the public or themselves. There are several types of involuntary commitment. In an emergency hospitalization, the client is held for a limited time in response to a crisis situation. In an inpatient civil commitment, there is a longer-term hold while the courts determine if the client meets the criteria for continued commitment. The last option is outpatient civil commitment (available in all states except Maryland and Massachusetts) where the person may be required to participate in outpatient treatment.

With an involuntary commitment, the client is not permitted to check out of their own accord from a health-care facility. When a client leaves an inpatient facility without permission, including if they fail to return from an authorized leave, it is called **absconding**. This is a significant health and safety issue to the client, the facility, client families, and, potentially, the public. Good therapeutic communication between clients and clinical teams helps reduce the occurrence of absconding events. Absconding has been linked to an increased risk of self-harm and suicide (Verma et al., 2020).

Caring for the Client in a Punitive Setting

The United States has the largest number of people incarcerated in the world. Almost 870 out of every 100,000 people in the United States are in jail or prisons (Davis et al., 2018). This population has very high rates of psychiatric conditions, substance use disorders, as well as many other acute and chronic health conditions. These individuals require care by nurses. One of the largest roles of nurses in corrections facilities is advocacy. It can be a challenge for nurses in this setting to provide the care that is needed on limited budgets. Some of these people have very serious psychological issues or psychiatric illnesses that require monitored medication regimens. Others have substance misuse issues that are high risk for serious complications of withdrawal. The nurse must be prepared to screen and handle these clients as well as advocate for the care that is needed and may be lacking.

Nursing Challenges When Upholding Client Rights

There are many legal and ethical challenges in health care. Vigilantly keeping client confidentiality in a digital age is a challenge legally and ethically. From a mental health viewpoint, maintaining the client's autonomy while ensuring their safety can be a challenge, especially when their competency or capacity is in question.

CLINICAL JUDGMENT MEASUREMENT MODEL

Applying the CJMM to Legal Guidelines

Rachel is a psychiatric nurse working in an inpatient psychiatric unit. She is assigned to care for Walter, a thirty-five-year-old male with a history of schizophrenia who was admitted involuntarily due to paranoid delusions and aggressive behavior. Walter has a history of noncompliance with medication and has been refusing to take his antipsychotic medication during his current hospitalization. Rachel is responsible for ensuring Walter's safety and providing therapeutic interventions to address his symptoms.

Using the Clinical Judgment Measurement Model, we can analyze Rachel's clinical judgment in this scenario.

CJMM Step	CJMM Data
Recognize Cues	Rachel recognizes the cues indicating Walter's paranoid delusions and aggressive behavior, including his refusal to take medication, agitation, and verbal threats. She assesses his mental status and identifies potential risks to his safety and the safety of others on the unit.
Analyze Cues	Rachel analyzes Walter's behavior in the context of his psychiatric history and current symptoms. She considers the potential consequences of his noncompliance with medication, including worsening psychotic symptoms and the risk of harm to himself or others.
Prioritize Hypotheses	Rachel prioritizes the need to address Walter's noncompliance with medication and manage his paranoid delusions and aggressive behavior. She considers the underlying factors contributing to his refusal and develops a plan to engage him in treatment while ensuring safety.
Generate Solutions	Rachel develops a therapeutic relationship with Walter, using communication techniques to build trust and rapport. She educates him about the importance of medication adherence and explores his concerns and fears related to taking medication. Rachel collaborates with the treatment team to explore alternative interventions, such as psychosocial interventions and medication adjustments, to address Walter's symptoms effectively.
Take Action	Rachel implements the plan of care, including ongoing monitoring of Walter's mental status and behavior, therapeutic communication, and collaboration with the treatment team. She intervenes promptly to address any escalation of symptoms or safety concerns, ensuring a proactive approach to managing Walter's care.
Evaluate Outcome	Rachel evaluates the effectiveness of interventions by assessing Walter's response to treatment, including changes in his symptoms, behavior, and medication adherence. She documents his progress and any modifications to the plan of care, collaborating with the treatment team to adjust interventions as needed.

In psychiatric-mental health nursing, several legal issues could arise in this case:

- Involuntary hospitalization: Walter was admitted involuntarily due to his psychotic symptoms and risk of harm to himself or others. Rachel must ensure that Walter's rights are protected and that all legal requirements for involuntary hospitalization are met, including proper documentation and adherence to

due process.
- Medication administration: Walter's refusal to take medication raises legal and ethical considerations regarding his right to refuse treatment. Rachel must follow institutional policies and legal guidelines for managing medication refusal, including documenting Walter's decision-making capacity and exploring less restrictive alternatives to involuntary medication administration.
- Client safety: Rachel is responsible for ensuring Walter's safety and the safety of others on the unit. She must take appropriate measures to prevent harm, including implementing de-escalation techniques, enlisting support from security or crisis intervention teams when necessary, and documenting any incidents or interventions related to safety concerns.
- Confidentiality: Rachel must adhere to laws and regulations governing client confidentiality, including the Health Insurance Portability and Accountability Act (HIPAA). She must ensure that Walter's personal health information is protected and shared only with authorized individuals involved in his care.

In this use of the CJMM, Rachel demonstrates effective clinical judgment in managing Walter's symptoms of schizophrenia and addressing his refusal to take medication. However, she must also navigate legal issues related to involuntary hospitalization, medication administration, client safety, and confidentiality. By applying the Clinical Judgment Measurement Model and adhering to legal standards, psychiatric-mental health nurses like Rachel can provide high-quality care while protecting client rights and minimizing legal liability.

Challenges to Maintaining Confidentiality and Privileged Communication

All health-care providers have a critical responsibility to maintain the clients' right to security, privacy, and protection of client health-care information. Nurses must be mindful all of the time and careful not to discuss clients in any setting where they can be overheard. Keeping laptops with any personal health information secure and protected is imperative. Dispose properly of any paper that has any identifying information. Maintaining confidentiality is challenging for all nurses in all areas. Discussing clients with other nurses who are not involved in their care to decompress, or to confer with a question can easily breach confidentiality. Avoid posting anything on social media related to a client. Leaving messages for clients on possibly unsecure voicemail or with another person is also inappropriate. Nurses must be aware of the surroundings when talking to a client to make sure that they cannot be overheard if asking about confidential information. In mental health, it is particularly easy to breach confidentiality, because talking is a large part of the treatment and the situations can be very personal.

Any communication taking place within a therapeutic relationship between a client and the provider or counselor, among others, is considered to be **privileged communication**. In some states, this confidentiality extends to nurse-client relationships as well. Conversations and relayed information should remain confidential unless the client reports a threat to themselves or others. Information that falls under the confidential umbrella cannot be the subject of testimony in any legal proceedings unless the client has waived the privilege. Parties who are considered to have privileged communication cannot be legally compelled to divulge anything that is discussed between the parties, with the exception of the duty to warn or in case of the client being a danger to themselves.

Challenges with Mandatory Reporting

Many states require health professionals to report suspected neglect or abuse. For example, in Wisconsin, suspected neglect or abuse is reported to Child Protective Services (CPS), Adult Protective Services, or law enforcement. Nurses should be aware of the county or state agencies to whom they should report suspected abuse. Reporting to authorities is not without its own set of difficulties. There can be issues with the reporter feeling guilt about reporting, worrying that they are sending a child or adult into a worse situation of the "system" rather than the known difficulties of the home. There is also the guilt of reporting if not absolutely sure that there is abuse. Even harder still, if the abuse is not reported and something happens, the nurse can be held liable for not reporting. There are also times when a nurse suspects abuse and they are not supported by the provider or their management staff; this is a difficult situation. Reporting sexual abuse can be very difficult when the client does not want to report it. If the nurse is in a mandatory reporting state, they do not have a choice but to report it because they can be held responsible for not reporting. This can be very difficult to explain to a client, particularly one already in distress or who has been convinced by their abuser that there will be consequences to telling. There is rarely an easy answer when it comes to abuse of any kind.

LINK TO LEARNING

Consider some of the circumstances that involve mandatory reporting (https://openstax.org/r/77mandatedreprt) for nurses.

Challenges to Boundaries

Professional boundaries are very important for nurses to maintain particularly when working in mental health. It is not uncommon for those with mental health struggles to have difficulty setting their own boundaries, so it makes it even more important for the nurse to have firm boundaries. At the same time, the professional standing and access to private information that nurses possess creates a power imbalance between the nurse and the client. In order to maintain a client-centered relationship while being mindful of the power imbalance, nurses must make every effort to set and uphold clear boundaries. When the client's needs and the nurse's needs are not clear, it can create boundary conflicts, such as:

- sexual misconduct
- inappropriate touching of clients
- romantic relationships with clients
- violation of HIPAA privacy regulations
- conflicts of interest
- accepting and giving gifts
- overinvolvement with clients
- social media communication between nurses and clients

Priorities must start with client safety. A nurse should speak with a dependable supervisor or colleague if a health-care professional is acting in an unprofessional manner or if the nurse is unclear of how to interpret a particular circumstance. Nurses should promptly and completely document any such events. It is imperative that nurses adhere to professional standards in their practice. It is critical for nurses to possess expertise in defining and upholding professional limits.

Challenges When Treating Clients Who Have Committed Crimes

Working with clients who have committed crimes can be very challenging. When providing nursing care to incarcerated clients, for instance, nurses may encounter people who have perpetrated violent crimes, such as sexual abuse of minors. Maintaining professionalism is of primary importance, as is taking a step back to recognize and regulate emotions that may arise with the interaction.

PSYCHOSOCIAL CONSIDERATIONS

Mindfulness and Reflection for Self-Care and Awareness of the Nurse

There are several tools nurses can use to care for themselves when feeling morally ambivalent about treating clients who have committed crimes. One tool is journaling. Writing about an experience and their feelings about the experience in private and without judgment is a way to gather perspective, sort out emotions, and determine a path forward.

Another method nurses use is reflecting with colleagues and peers. By sharing potentially common experiences with others, it gives the nurse different viewpoints and unique takes on how different people handle similar situations. It broadens the nurse's perspective and offers options the nurse may not have thought about previously.

A third tool practitioners use is reflecting in the moment. Slowing down, where possible, and taking a second to think and, importantly, listen before acting can make a difference in a nurse's approach (Aussie Nurse, 2020).

Challenges Regarding Payment for Services in Mental Health Care

Payment is another legal/ethical consideration nurses face when treating clients who may or may not have insurance. Insurance is the primary way clients pay for mental health care, including private insurance, Medicaid,

and Medicare. For those who do not have insurance or have insurance that does not cover mental health, paying for treatment may be very expensive. Nurses should familiarize themselves with the options in their communities. In many areas, there are free clinics, community mental health centers, local nonprofits, and local safety net health-care systems. Many of these options require applying for the services or working with the hospital for a payment plan. Many nonprofit hospitals have charity care to provide a certain amount of care for free or at a discount. Nonprofit hospitals that accept Medicare and Medicaid are required to offer a certain amount of charity care each year. Another set of options includes support groups and hotlines. Many mental health providers offer some pro bono services as well. All of these options can be found online, by calling nonemergency help lines, or through community social workers.

Keep in mind, however, that if a person has an emergency mental health condition or is determined to be dangerous to self or others, they cannot be turned away from an emergency room or transferred to another hospital; that is known as "dumping." They must be stabilized or admitted and stabilized until the emergency medical condition no longer exists.

The Role of Health Insurance

Nurses should be aware of the critical role health insurance plays in treatment and in treatment decisions. Here is a brief summary of insurance options; veterans also may qualify for their own insurance arrangements.

- Medicaid and Medicare cover mental health care for those who qualify.
- Medicaid coverage is based on multiple factors, including income.
- Medicare covers those over the age of sixty-five and those who are disabled and have received Social Security for at least two years.
- Private insurance covered, at least in part, by an employer.
- Insurance purchased through the private market, paid monthly. Private market plans may have high deductibles and high out-of-pocket visit costs.

Disability Benefits for Mental Health Clients

Mental and psychological disabilities are conditions that can qualify individuals for benefits from the Social Security Administration (SSA). To qualify for benefits, a client must have a formal diagnosis of a potentially disabling condition, one that will cause a disability for twelve months or longer. The SSA performs a detailed review to evaluate each disability application. Each illness that is eligible has a severity level requirement and the specific medical information needed to support the claim. For most mental illnesses, the client needs to demonstrate that they have been on medication for two years without their condition improving.

Forensic Services in Mental Health Nursing

Forensic psychiatric nursing is a developing specialty. These nurses play a key role in linking health care to the judicial system. Historically, forensic nurses worked with crime victims during examinations, preserving evidence and providing court testimony. Now, a forensic psychiatric nurse can provide a psychiatric evaluation intended for use by the judicial system. They also frequently connect offenders with medical and social services that are needed to assist with the offender's rehabilitation. There is some crossover in roles with correction nurses who provide care in correctional institutions.

10.3 Ethical Standards in Mental Health Nursing

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Recall the key ethical principles related to nursing practice
- Outline the role of the nurse's own moral philosophy in providing care to clients

Nursing and ethics are intertwined and inseparable; even student nurses encounter situations where they must make ethical decisions. The personal values that a person has, perhaps based on their religious or moral perspectives, influence any ethical decisions they may have to face. Ethical values differ from laws. Rather, they are universal rules of conduct that provide a practical and moral basis for identifying appropriate actions, intentions, and motives. Taking into consideration the complexity of mental health nursing, ethical issues abound. Nurses must deliver quality care and make quick decisions while juggling the client, families, and other health-care professionals.

Health-care workers must make constant judgments, staying true to their own morals and values while staying within the laws and ethical standards that govern practice. To complicate matters, clients will likely have had different life experiences shaping their own moral compasses. Nurses must manage to balance their own moral philosophies with those of their clients. Being open-minded and understanding of the moral, religious, and philosophical differences will allow the nurse to provide holistic and ethical care for their clients.

The concept of nursing ethics has been around since the 1870s and became more formal in the 1950s with the ANA Code of Ethics (Haddad & Geiger, 2023). It was not until the 1970s, however, that ethics began being taught in the nursing curriculum. Over the years, nursing ethics has evolved from a generalized list of responsibilities to a guide for nurses in their decisions and conduct. By 2015, the Code "address[ed] individual as well as collective nursing intentions and actions; it require[d] each nurse to demonstrate ethical competence in professional life" (American Nurses Association [ANA], 2015, p. vii).

Ethical Principles

Ethical principles are used to define right from wrong action. Although there are many ethical principles that guide nursing practice, foundational ethical principles include respect for autonomy (self-determination), beneficence (do good), nonmaleficence (do no harm), justice (fairness), fidelity (keep promises), and veracity (tell the truth).

Autonomy

The ethical principle of autonomy recognizes each individual's right to self-determination and decision-making based on their unique values, beliefs, and preferences. The American Nurses Association (ANA) defines **autonomy** as the ability to make decisions with one's own free choice, if competent to do so. One of the nurse's primary ethical obligations is to uphold client autonomy. Based on this principle, clients have the right to give informed consent and to refuse nursing care and medical treatment. In mental health care, there may be barriers to maintaining autonomy if the client is a danger to themselves or others or lacks capacity. A person may be declared incompetent and therefore not have the ability to make their own decisions. In this case, the surrogate decision-maker can act to respect the autonomy of the person by acting on the person's previously expressed wishes. In the case of a person who is under involuntary commitment, they cannot leave the inpatient setting, but they can have a part in making decisions on what they choose to participate in. They also have the right to refuse medications or treatments as long as they are not a danger to themselves or others.

Beneficence

The concept of **beneficence** is the act of helping others or taking them out of harm's way, doing good for others beyond that which is required by law. When caring for clients with mental health disorders, nurses practice beneficence when, for example, they advocate for evidence-based treatment for clients' mental health and make sure that client does not come to any harm.

Nonmaleficence

Opposite of beneficence, **nonmaleficence** is an ethical idea that dictates that providers not cause any detriment to clients. A classic example of doing no harm in nursing practice is reflected by nurses checking medication rights three times before administering them. Another example in mental health-care nursing is ensuring that clients are not harmed by adverse effects of psychotropic medications.

Justice

The ethical principle of justice is a moral duty to treat everyone in society in a fair and equitable manner. The principle of justice requires that health-care providers care for all people in a fair and equitable way, providing treatment and care for all those who need it. Nurses provide quality care for all individuals with the same level of fairness despite their personalities or characteristics, such as financial status, cultural beliefs, religion, gender, or sexual orientation. An example of a nurse using the principle of justice in mental health-care settings is ensuring provision of quality care to all clients, even those who do not have the cognitive ability to communicate their needs.

Fidelity

Role **fidelity** means responsible for providing competent nursing care and being loyal to the profession and to clients. An example of role fidelity in nursing is remaining up-to-date with evidence-based practice and implementing effective mental health interventions.

Veracity

The ethical principle of **veracity** simply means telling the truth. An example of veracity in health care is providing informed consent. Nurses ensure that clients have a good understanding of the benefits and risks of a prescribed procedure or psychotropic medication.

The Role of the Nurse's Moral Philosophy in Ethical Caring

Nursing care entails that the nurse must see the client as a person, forming relationships, and taking responsibility. Caring can only happen with person-to-person contact. Lack of caring creates a disconnect that leads to poor client satisfaction and leads the client to feel like an object or like they are not a participant in their care. Leininger (1988) states that care is "one of the most essential and powerful forces to help people recover from illnesses, maintain health, and survive" (p. 11). Watson (1985) saw caring as a science, developed from a humanistic philosophy, which is at the core of nursing. Hildegard Peplau felt that nurses create a shared experience with a client that empowers the client to be engaged in their care (Nursing Theory, 2023).

A nurse's beliefs, attitudes, and values, together with their reasons for entering the field, become their nursing philosophy. A person's moral background, perhaps based in part on their religious values, leads to the ethical decisions that they make. In general, people take their moral feelings and beliefs and act on them to make ethical decisions and actions. People can learn to make critically thought-out ethical decisions, but it takes training and practice.

The ANA Scope and Standards of Practice, most recently revised in 2022, is updated on a routine basis. Wrapped into the scope of practice is the code of ethics. Since 2004, the scope of practice includes specific competencies that are measurable for each standard of professional practice. In terms of ethics, within the "what" involves advocacy for the care of individuals, groups, families, communities, and populations. The "why" involves outcomes and the obligation to society to care. Relationships and obligations are themes that run through both the scope of practice and the code of ethics and bind them together.

LINK TO LEARNING

The Code of Ethics for Nurses with Interpretive Statements (https://openstax.org/r/77nurseethics) is a guide for nurses that assists with ethical dilemmas and decision-making.

Summary

10.1 Client Rights and Protections

Maintaining understanding and compliance with the tenets of HIPAA is critical for client safety and trust. Under HIPAA, PHI cannot be used or shared without the client's written permission. This is one of the client rights provided under federal law. Other client rights offered under federal statute include those in the Affordable Care Act. Its original premise, which continues, is to expand access to health insurance to uninsured Americans. The main points of the law were to expand Medicaid eligibility, create a Health Insurance Marketplace, and prevent insurance companies from denying coverage due to preexisting conditions.

10.2 Legal Issues Relating to Mental Health Nursing

Legal issues in mental health can be complicated and overwhelming. The best way to protect yourself, your license, your clients, your community, and society is to know as much as possible about the laws and regulations that apply to your job. Another way to accomplish this is to surround yourself with others who are knowledgeable by joining professional organizations, keeping up-to-date with your board of nursing, having mentors, and engaging with trusted professionals.

Nurses can come into contact with the legal system in a variety of manners. They can face criminal charges, such as battery, if they touch a client without receiving informed consent. Or they may face civil liability for negligence if, for instance, they make a medication error that leads to damages. Diligence in treating clients is the best way to avoid professional legal or disciplinary action. The legal system also affects nursing when a client is not equipped to make decisions on their own about their treatment and when clients need to be assessed for fitness to make those decisions. Nurses should familiarize themselves not only with pertinent state and federal laws, but also with professional boundaries, hospital policies, and relevant nursing board regulations.

10.3 Ethical Standards in Mental Health Nursing

Ethics in nursing is all about providing caring, quality, and responsible care to clients. This sounds simple but frequently is not. There are many gray areas in ethics, and it is important to provide care that takes into consideration the ethics, values, and morals of the nursing profession, the client, and the nurse. It is the human connection that provides the most healing in nursing, but professional and ethical boundaries are imperative to protecting both nurses and clients.

Key Terms

absconding leaving an inpatient facility without permission, which can include failing to return from an authorized leave
assault intentionally putting another person in reasonable apprehension of imminent harmful or offensive contact
autonomy ability to make decisions with one's own free choice, if competent to do so
battery intentional causation of harmful or offensive contact with another person without that person's consent
beneficence doing or producing good for others
client confidentiality expectation that information shared with the health-care providers or organization will not be divulged
duty to warn professional responsibility to warn another person if they are being threatened
false imprisonment confining a person without the consent of the person or legal authority
fidelity devotion to obligations and duties
fraud deceiving another for personal gain
Health Insurance Portability and Accountability Act (HIPAA) federal law that requires the creation of national standards to protect sensitive client health information from being disclosed without the client's consent or knowledge
informed consent communication between a client and a health-care provider that results in agreement and permission by the client for treatment or services
intentional tort wrong that the defendant knew (or should have known) would be caused by their actions
libel published untrue statement that damages a person's reputation
malpractice when a professional fails to exercise their duty of care to a client

mandatory reporting obligation to report to stated authorities when neglect or abuse is suspected
negligence failure to exercise care that a reasonable person in the same circumstances would have exercised
nonmaleficence doing no harm
patient bill of rights minimum standards for the ways that clients can expect to be treated by health-care professionals
privileged communication confidential conversations between parties deemed to be protected
protected health information (PHI) any information in the medical record that can be used to identify an individual and that was created, used, or disclosed while providing a health-care service
right to privacy belief that one's personal information is protected from public access
slander false statement that harms a person's reputation
standards of care guidelines that create a baseline of appropriate (reasonable) professional conduct for nurses
tort commission or omission that harms someone, creating a civil case for courts to adjudicate liability
unintentional tort wrong that occurs when a defendant's actions or inactions were reckless or unreasonably unsafe
veracity telling the truth

Assessments

Review Questions

1. What is a potential HIPAA infringement and unsecured PHI breach? Select all that apply.

a. disclosing PHI in a conversation with someone outside of the health department
b. accessing the computer to get information on a neighbor
c. releasing a copy of a record to an unauthorized recipient
d. asking the client if it is appropriate to share information

2. What is another name for the Patient Protection and Affordable Care Act (PPACA)?

a. Trumpcare
b. the Affordable Care Act
c. HIPAA
d. QSEN

3. In what circumstance does the nurse have a duty to warn?

a. when a client is upset at a caregiver
b. when a client is threatening another person
c. when a client is using drugs
d. when a client is pregnant

4. What are examples of invasion of privacy by nurses? Select all that apply.

a. searching a client's belongings without permission
b. reviewing the plan for client care in the lunchroom
c. discussing health-care issues for an unconscious client with his power of attorney
d. releasing client health information to local newspaper reporters

5. The nurse's role as the client's advocate is to ensure that "safe, effective care" is provided in accordance with what guidelines?

a. State Board of Medicine
b. American Nursing Association (ANA)
c. Nurse Practice Act
d. Board of Nurse Examiners (BNE)

6. A disoriented and irrational client who is tugging at tubes and drains is placed into soft wrist restraints by the nurse. What is the nurse's next step to get the provider to write a prescription for a restraint?

a. obtain a twenty-four-hour, PRN prescription to avoid calling the provider during the night
b. obtain a verbal or telephone prescription for restraints within one hour of initiation
c. obtain a written prescription for restraints that is valid for forty-eight hours
d. obtain a written prescription for restraints within twenty-four hours of initiation

7. What is the term for the client's independent freedom to choose or consent?
a. fidelity
b. autonomy
c. veracity
d. nonmaleficence

8. What is the term for duty to do no harm or prevent harm?
a. fidelity
b. autonomy
c. veracity
d. nonmaleficence

9. What is meant by the term veracity?
a. to verify
b. to lie
c. to tell the truth
d. to be caring

10. How do nurses know if an action is within their scope of practice?
a. Nurses should refer to the ANA's scope and standards of practice.
b. Nurses should refer to their employer.
c. Nurses should ask the medical provider.
d. Nurses should do an online search.

11. Who determines the nursing scope of practice?
a. hospital policies and procedures
b. local government
c. the U.S. government
d. professional nursing organizations

12. What does the term justice mean?
a. to be fair and equitable
b. a reasonable action
c. to be right no matter the situation
d. to take action against someone who is wrong

Check Your Understanding Questions

1. When caring for a client, the nurse answers a phone call from the neighbor of the client asking when he is getting home in order that arrangements can be made for his return home. Is this a breach of confidentiality if the nurse provides this information?

2. When caring for an older adult who is hearing impaired, the nurse speaks louder than normal. Clients in surrounding areas overhear the conversation. How is this compromising client confidentiality?

3. Describe the concept of false imprisonment.

4. What are some ways that a nurse might reflect on their feelings?

5. A client who the health-care team knows is unable to read is given a copy of discharge instruction to follow at home and asked to sign upon receipt. The client is alone and lives alone. What are some legal implications in

this situation?

6. What is the purpose of the ANA's Code of Ethics?

Reflection Questions

1. With a hearing-impaired client, what could the nurse do differently to ensure good communication?
2. A nurse in a corrections facility has a client who is convicted of child abuse. How can that nurse keep that knowledge from affecting their care of the client?
3. How should and does a nurse provide "caring" in their daily routine?

What Should the Nurse Do?

Carla, a twenty-eight-year-old female, seeks care at a local mental health clinic due to recent symptoms of persistent sadness, decreased energy, and changes in sleep patterns. Carla has a history of depression and anxiety and is currently taking medication prescribed by her psychiatrist. During the initial assessment, her vital signs are stable, with a blood pressure of 120/80 mm Hg, a heart rate of 75 beats per minute, and a respiratory rate of 16 breaths per minute. As part of her care plan, the nurse is required to discuss treatment options and share information with other health-care providers while ensuring compliance with HIPAA rules within the mental health practice setting.

1. What nonverbal cues might Carla exhibit during the assessment that indicate her awareness or concern about maintaining privacy? How can the nurse recognize and respond to these cues effectively?
2. If the nurse successfully maintains HIPAA rules, what specific indicators of positive outcomes would you monitor to assess the effectiveness of the nurse's actions? How can the nurse measure Carla's satisfaction and sense of privacy throughout her mental health care?

Theresa, a sixty-five-year-old female, arrives at the community health clinic seeking medical attention. She presents with a history of chronic back pain and has been experiencing increased discomfort over the past month. Theresa explains that her primary care physician prescribed a new pain medication, but she is hesitant to take it due to concerns about potential side effects. She expresses worry about the impact of the medication on her overall well-being. Theresa has a medical history of hypertension and osteoarthritis. Her vital signs include a blood pressure of 140/90 mmHg, heart rate of 82 bpm, respiratory rate of 18 breaths per minute, and temperature of 98.6°F (37°C).

3. What cues from Theresa's case suggest potential ethical concerns related to her pain management?
4. As a nursing student, what specific actions would you take to implement the selected solution and address Theresa's concerns?
5. How would you evaluate the success of the chosen interventions in meeting Theresa's pain management needs and addressing ethical considerations?

Competency-Based Assessments

1. Consider a client who is concerned about losing a job and its related health insurance coverage due to a preexisting condition. Draft an explanation to the client of the protections under the Patient Protection and Affordable Care Act to address their concern.
2. You are a nurse who has been asked to speak to a group of student nurses to briefly explain the difference between restraint and seclusion. Provide brief explanations.
3. In a scenario where a client's right to refuse treatment conflicts with your obligation as a nurse to provide necessary care, critically analyze the ethical considerations. How can you navigate these situations while upholding both legal and ethical principles?
4. Analyze how the ethical principles of beneficence and nonmaleficence apply to your role as a nurse in managing Theresa's pain while considering her medical history.
5. Write about a situation where your own moral philosophy might conflict with a client's preferences or decisions. How would you navigate this ethical dilemma?

References

123Helpme. (n.d.). *What is patient restraint (QSEN Competencies in patient restraint)?* https://www.123helpme.com/essay/What-Is-Patient-Restraint-QSEN-Competencies-In-703345

42 USC 9501: Bill of rights. (n.d.). https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section9501&num=0&edition=prelim#sourcecredit

Agency for Healthcare Research and Quality. (2022, August). *Module 5: Response and disclosure AHRQ communication and optimal resolution toolkit*. Retrieved January 2, 2023, from https://www.ahrq.gov/patient-safety/settings/hospital/candor/modules/guide5/notes.html

Akhbari, K. (2013, February 20). *Damages in medical malpractice cases*. LegalMatch Law Library. Retrieved November 12, 2023, from www.legalmatch.com/law-library/article/medical-malpractice-damage-awards.html

American Client Rights Association. (2023). *Do you have the right to refuse treatment?* Retrieved February 24, 2023, from https://www.americanpatient.org/do-you-have-the-right-to-refuse-medical-treatment/

American Hospital Association. (2003). The patient care partnership: Understanding expectations, rights and responsibilities. https://www.aha.org/system/files/2018-01/aha-patient-care-partnership.pdf

American Nurses Association. (2015). *Code of ethics for nurses with imperative statements.* Retrieved January 14, 2023, from https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

American Psychiatric Association. (2023). *Stigma, prejudice, and discrimination against people with mental illness*. Retrieved February 24, 2023, from https://www.psychiatry.org/patients-families/stigma-and-discriminationhttps://www.psychiatry.org/patients-families/stigma-and-discrimination

American Psychiatric Nurses Association. (2022, March). *APNA Standards of Practice: Seclusion and Restraint*. https://www.apna.org/standards-of-practice-seclusion-and-restraint/

Aussie Nurse. (2020). *Reflection an outstanding tool for nurses*. https://aussienurse.com.au/reflection-an-outstanding-tool-for-nurses/

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics*. (6th ed.). Oxford University Press.

Bennett, F. R. (2010). RN competencies outlined in newly revised ANA nursing: Scope and standards of nursing practice coming this month. *American Nurse, 42*(4), 20.

Centers for Medicare and Medicaid Services. (2023). *HIPAA basics for providers: Privacy, security, and breach notification rules*. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/hipaaprivacyandsecurity.pdf

Conlon, D., Raeburn, T., & Wand, T. (2019). Disclosure of confidential information by mental health nurses, of patients they assess to be a risk of harm to self or others: An integrative review. *International Journal of Mental Health Nursing*, *28*(6), 1235–1247. https://doi.org/10.1111/inm.12642

Cornell Law School Legal Information Institute. (n.d.). *Mens rea*. Retrieved May 17, 2023, from https://www.law.cornell.edu/wex/mens_rea

CorpusLegalis.com (n.d.). §10841. *Restatement of bill of rights*. Retrieved January 14, 2023, from https://corpuslegalis.com/us/code/title42/restatement-of-bill-of-rights

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D. T., & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook, 55*(3), 122–131. https://doi.org/10.1016/j.outlook.2007.02.006

Cross Cultural Health Care Program. (2023). Medical interpreter program. Retrieved February 24, 2023, from https://xculture.org/medical-interpreter-training/

Davis, D. M., Bello, J. K., & Rottnek, F. (2018, November 15). Care of incarcerated patients. *Am Fam Physician*, *98*(10), 577–583.

Electronic Code of Federal Regulations, (2023, January 12). *Title 42: § 483.358 Orders for the use of restraint or seclusion*. Retrieved January 6, 2023, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-G/section-483.358

Epstein, B., & Turner, M. (2015). The nursing code of ethics: Its value, its history. *Online Journal of Issues in Nursing, 20*(2), 33–41. https://doi.org/10.3912/OJIN.Vol20No02Man04

Haddad, L. M., & Geiger, R. A. (2023, August 14). Nursing Ethical Considerations. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK526054/

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *BMJ (Clinical Research Ed.)*, *327*(7425), 1219–1221. https://doi.org/10.1136/bmj.327.7425.1219

Hammarström, L., Häggström, M., Devik, S. A., & Hellzen, O. (2019, December). Controlling emotions-nurses' lived experiences caring for patients in forensic psychiatry. *Int J Qual Stud Health Well-being, 14*(1),. https://doi.org/10.1080/17482631.2019.1682911

Hawaii Pacific University. (2023). *Client rights and the essential roles of nurses*. Retrieved February 25, 2023, from https://online.hpu.edu/blog/patient-rights/https://online.hpu.edu/blog/patient-rights/

HealthCare.gov (n.d.). *Client protection and Affordable Care Act*. Retrieved February 24, 2023, from https://www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/

HHS.gov (n.d.). *Individuals' right under HIPAA to access their health information 45 CFR § 164.524*. Retrieved February 25, 2023, from https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

Huynh, A. P., & Haddad, L. M. (2022, July 18). Nursing practice act. In: StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing; 2022 January. Retrieved December 2, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK559012/

International Medical Interpreters Association. (2006). IMIA code of ethics. https://www.imiaweb.org/code/

Intraprise Health. (2023). 5 Most common HIPAA privacy violations. https://intraprisehealth.com/5-most-common-hipaa-privacy-violations/

Kenton, W. (2023, September 22). Affordable Care Act (ACA): What it is, key features, and updates. *Investopedia*. www.investopedia.com/terms/a/affordable-care-act.asp#toc-the-bottom-line.

Lawshelf.com. (2023). *Foundations of law: Duty of care part 1*. https://lawshelf.com/coursewarecontentview/duty-of-care-part-1

Leininger, M. M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly, 1*, 152–160.

Lorenz, S. G. (2007). Protection: Clarifying the concept for use in nursing practice. *Holistic Nursing Practice*, *21*(3), 115–123. https://doi.org/10.1097/01.HNP.0000269148.42861.62

Martin, T., Maguire, T., Quinn, C., Ryan, J., Bawden, L., & Summers, M. (2013). Standards of practice for forensic mental health nurses—Identifying contemporary practice. *Journal of Forensic Nursing,* 9(3), 171–178.

McCall, M. (2023, June 25). *Involuntary commitment: Patient and public rights*. Find Law. Retrieved May 10, 2023, from https://www.findlaw.com/healthcare/patient-rights/involuntary-commitment-patient-and-public-rights.html

Mental Health America, Inc (n.d.-a). *Mental health rights.* https://mhanational.org/issues/mental-health-rights

Mental Health America, Inc (n.d.-b). *Paying for care*. Retrieved May 21, 2023, from https://mhanational.org/paying-care

Mental Health Association of Maryland. (n.d.). *Applying for disability benefits with a mental illness*. Retrieved May 21, 2023, from https://www.mhamd.org/information-and-help/paying-for-care/applying-for-disability-benefits-with-a-mental-illness

Merriam-Webster. (n.d.). Compassion. In Merriam-Webster.com dictionary. Retrieved February 4, 2023, from https://www.merriam-webster.com/dictionary/compassion

Mitchell, G. (2004). Legal and professional issues in mental health nursing practice. Chapter 25. In Kirby, S., Hart, D., Cross, D., & Mitchell, G. (Eds.). Mental health nursing competencies for practice. pp. 357–370. Palgrave MacMillan.

Mulka, A. (2022, September 2). West Michigan nurse charged after failing to report medication error at veterans home. *Midland Daily News*. www.ourmidland.com/news/article/West-Michigan-nurse-charged-after-failing-to-17412884.php.

National Council of State Boards of Nursing, Inc. (2018). *A nurse's guide to professional boundaries*. https://www.ncsbn.org/public-files/ProfessionalBoundaries_Complete.pdf

National Council of State Boards of Nursing, Inc. (2023). *NCSBN clinical judgment measurement model*. Retrieved December 23, 2022, from https://www.nclex.com/clinical-judgment-measurement-model.page

Nursing School Degrees. (n.d.). *Forensic psychiatric nurse career*. Retrieved May 14, 2023, from https://www.nursing-school-degrees.com/nursing-careers/forensic-psychiatric-nursing/

Nursing Theory. (2023). *Peplau's theory of interpersonal relations*. https://nursing-theory.org/theories-and-models/peplau-theory-of-interpersonal-relations.php

Olejarczyk, J. P., & Young, M. (2022). Patient rights and ethics. [Updated 2022 Nov 28]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Retrieved February 24, 2023, from https://www.ncbi.nlm.nih.gov/books/NBK538279/

Oltmann, K. (2023, October 2). Sharpsville nurse accused of stealing oxy in Youngstown. wfmj.com. www.wfmj.com/story/49756184/sharpsville-nurse-accused-of-stealing-oxy-in-youngstown. Accessed 12 Nov. 2023

Östman, L., Näsman, Y., Eriksson, K., & Nyström, L. (2019, February). Ethos: The heart of ethics and health. *Nurse Ethics*, *26*(1), 26–36.

Pajnkihar, M., Štiglic, G., & Vrbnjak, D. (2017, February 7). The concept of Watson's carative factors in nursing and their (dis)harmony with patient satisfaction. *PeerJ, 5.* https://doi.org/10.7717/peerj.2940

Pierce, L. (2019). Malpractice 101. *Colorado Nurse*, *119*(4), 14–15.

Pirotte B. & Benson S. (2022 July 25). *Refusal of Care*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK560886/

Psychology: IResearchNet. (2016, October 9). *Duty to warn and protect*. https://psychology.iresearchnet.com/counseling-psychology/counseling-skills-training/duty-to-warn-and-protect/

Sanabria, L. (2023, August 30). *Insanity defense*. Find Law. Retrieved May 17, 2023, from https://www.findlaw.com/criminal/criminal-procedure/insanity-defense.html

Shah, P., Thornton, I., Turrin, D., & Hipskind, J. E. (2022). Informed consent. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK430827/

U.S. Department of Health and Human Services. (2022a). *About the Affordable Care Act*. https://www.hhs.gov/healthcare/about-the-aca/index.html

U.S. Department of Health and Human Services. (2022b). *Summary of the HIPAA Privacy Rule*. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

U.S. Department of Health and Human Services. (n.d.). *The HIPAA Privacy Rule*. https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

Verma, D. K., Khanra, S., Goyal, N., Das, B., Raja, C., Khess, J., Munda, S. K., & Ram, D. (2020). Absconding during inpatient care from a tertiary psychiatric hospital: A comparative study. *Indian Journal of Psychological Medicine, 42*(5), 456–463. https://doi.org/10.1177/0253717620929182

Watson, J. (1985). *Nursing: Human science and human care, a theory of nursing.* Appleton-Century-Crofts.

Wilkie, T., Penney, S. R., Fernane, S., & Simpson, A. I. F. (2014). Characteristics and motivations of absconders from forensic mental health services: A case-control study. *BMC Psychiatry, 14*, 91. https://doi.org/10.1186/1471-244X-14-91

Wisconsin Civil Jury Instructions Committee of the Wisconsin Judicial Conference. (2023). *Wisconsin Civil Jury Instructions*. Retrieved January 22, 2024, from https://wilawlibrary.gov/jury/civil/

World Health Organization. (2023). *The right to be treated fairly and with respect*. Retrieved February 24, 2023, from https://www.who.int/tools/your-life-your-health/know-your-rights/rights-across-life-phases---later-adulthood/right-to-be-treated-fairly-and-with-respect

Wortzel, H. (2006, December 1). The right to refuse treatment. *Psychiatric Times*, *23*(14). Retrieved May 10, 2023, from https://www.psychiatrictimes.com/view/right-refuse-treatment

CHAPTER 11
Court Involvement

FIGURE 11.1 Understanding all of the legal and ethical issues surrounding client care is critical to ensure the nurse can support a client who is unable to make their own choices and carry out their own actions. (credit: "Legal Gavel & Open Law Book" by "howtostartablogonline.net"/Wikimedia Commons, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION Nurses have a responsibility to uphold ethical and legal practices, and, when complex issues arise and cause dispute, courts of law can intervene. The need for psychiatric care itself may become one of these complex issues. Federal and state laws provide for involuntary mental health services when a person's mental health status presents a danger to themselves or other people or if they are gravely disabled. These laws vary by state (Legal Information Institute, 2023) and there is an expectation that nurses will understand their state requirements and nursing practice expectations.

States have an interest in protecting the public and the individual. At the same time, individuals have the right to refuse treatment. Involuntary care poses the fundamental right to refuse treatment against the rights of public safety and the safety of the individual. While striving to preserve autonomy, the law must balance rights with risks. If a person's health state includes symptoms that alter their ability to make rational decisions—that is, resulting in harm to self or others—it may justify involuntary treatment. Nevertheless, in order to impose involuntary treatment on a person without their expressed consent, they must first be adjudicated incompetent.

11.1 Reasons for Court-Ordered Treatment

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Cite the reasons for court-ordered therapy
- Give examples of the types of court-ordered therapy
- Outline the process for putting involuntary court-ordered treatment in place

The basic reason for court-ordered treatment is that an individual presents a danger to self or others or is unable to perform self-care due to mental illness. Each state determines its own guidelines, so they differ in some details. Being referred for involuntary assessment and treatment with conditions of release is not a crime. It is a function of civil, not criminal law. In terms of criminal law, there is a branch of psychiatry for forensic cases, wherein the person may have criminal charges or eventually be adjudicated "not guilty by reason of insanity." In those cases, the individual convicted of a crime may be ordered to receive psychiatric services as well.

The term **civil commitment** denotes a legal process that keeps involuntary hospitalization from qualifying as false imprisonment. Those seeking the commitment bear the burden of proof to justify the need for this care and the care must be offered in the least restrictive environment. Nurses have a significant responsibility to act as advocate for persons and families throughout the processes described in this section. Nursing care also comes into play as education, emotional support, and collaborative care with the health-care team. Nurses maintain the therapeutic relationship with persons and families and adhere to professional practice guidelines. Nurses in these situations should be mindful to reflect on their own perceptions and be self-aware of how these relationships are affecting them in order to maintain self-care.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Teamwork and Collaboration

One QSEN competency is teamwork and collaboration, which stresses the importance of working in teams effectively and with the shared goal of quality client care. Consider how the nurse will monitor the therapeutic relationship in situations of court-ordered treatment.

Knowledge	Skills	Attitudes
• Analyze client's and family's response to the situation. • Describe strategies for client care. • Explain to clients, families, and significant others the process of involuntary hospitalization: physician initiates the civil commitment, the health-care team completes the process, social workers follow up with legal and ethical aspects.	• Initiate direct care for client admission, therapeutic relationship, and care planning. • Demonstrate delegation to mental health workers for the client's basic care and monitoring for safety. • Act as liaison between client and members of the treatment team. • Assume team member role with pharmacists for medication management and adherence to treatment protocols.	• Value relationships among team members. • Respect the client and family as central to team function. • Contribute to risk reduction and conflict resolution. • Acknowledge the nurse's own feelings in the process.

TABLE 11.1 **Therapeutic Nurse Skills in Court-Ordered Treatment** (QSEN Institute, n.d.; Fariba & Gupta, 2023)

Reasons for Court-Ordered Therapy

When people are not able to care for themselves due to mental illness and/or drug abuse (in certain circumstance),

courts of law may intervene and legally compel the person into treatment. Treatment may be inpatient in a facility, outpatient in the community, or in a clinic setting.

Court-ordered therapy is mandated and compulsory. The court may keep track of the person's compliance, holding providers accountable to report the person's progress. The individual receiving treatment and/or their health insurer is responsible for the payment for the services. The person or their representative must inform the court of financial hardship in order to receive financial aid. Persons mandated for treatment who do not adhere to the plan of care may be found in contempt of court, apprehended, and potentially incarcerated, hospitalized, or face further legal repercussions. The most common reasons for court-ordered therapy include custody disputes and custody issues involving abuse or neglect, being convicted of a sex crime, an alternative to jail for someone with a mental illness or who misuses drugs, a condition of release from jail, or presenting a threat to oneself or others.

PSYCHOSOCIAL CONSIDERATIONS

Court-Mandated Treatment in Custody Cases

One type of court-ordered mental health treatment involves child custody cases and divorce proceedings. Due to their understanding of child developmental stages and needs at each stage, courts sometimes consult psychologists to evaluate children's best interests in family law proceedings. Required interviews, observations in the home or other settings, and formal psychological testing can collect data for the evaluation, along with medical records and reports from child welfare agencies or schools. Confidentiality guidelines provide for access to these documents. Information gathered can inform custody arrangements, visitation, and other facets of divorce proceedings.

Types of Court-Ordered Treatment

Each state designates the guidelines for mental health treatment when necessitated by court order. These directives address circumstances, length of time, and individual rights. Court-ordered treatment may take place inside a health-care facility, out in the community (whether residential or day treatment, including mandatory support group attendance), or in visits to mental health-care providers (Substance Abuse Mental Health Services Administration [SAMHSA], 2019a). In all these settings, providers document the client's progress toward established treatment goals, which includes them adhering to medications as prescribed and obtaining appropriate laboratory test results. A long-acting injectable (LAI) antipsychotic medication may also be legally mandated for the client to receive on a schedule. Courts have access to the medical record.

When a person's behavior affects others or has legal implications, a court may order various types of mandated treatment rather than incarceration. If treatment is not completed as ordered, incarceration may still occur. While in mandated treatment, the client may receive medication and work with a therapist. Table 11.2 outlines various forms of mandated therapy.

Program	Indication
Diversion programs	Therapy and education, generally for first-time offenders with minor offenses, to avoid the criminal justice system. Participants remain liable for restitution, community service, or the cost of the program. The legal charge may be dismissed at completion of the program.
Drug court	Scheduled appearances before a judge who sets a treatment program due to drug use. When conditions are met, the individual is eligible to have legal consequences reduced.
Victim impact panel	Attendance at a panel of volunteer individuals who have been impacted by DWI/DUI accidents. Generally, first offenders may be referred to help them understand the pain and suffering caused by their actions.

TABLE 11.2 Forms of Mandated Therapy (Psychology Today, 2024)

Program	Indication
Anger-management classes	Legal charges related to aggressive or violent behaviors. Group and individual therapy sessions for emotional regulation, conflict resolution, and effective communication. The court is kept apprised of the client's progress.
Parent's therapy	Evaluation and therapy in child custody cases, due to addiction, abuse, or criminal conviction, with the goal of maintaining or restoring custody.
Reunification therapy	Family conflict, due to separation or abuse, with the goal of reintegration and improved communication and parenting. Involves family therapy, with sessions for children.

TABLE 11.2 Forms of Mandated Therapy (Psychology Today, 2024)

Emergency Admission and Treatment Orders

Some states permit **emergency treatment orders (ETO)**, which allow provision of medically prescribed treatment with or without consent. ETO are obtained from the provider when the person's behavior presents a danger to self or others. Interventions under emergency orders are time-limited and require ongoing assessments and special documentation. Documentation should include approaches providers tried prior to the emergency order. These orders have serious legal and ethical implications.

Persons received under **emergency admission** are reasonably determined to have mental illness making them dangerous to self or others. Persons admitted on an emergency basis remain in the facility for a waiting period of twenty-four to seventy-two hours for a psychiatric assessment and crisis treatment; this is typically known as a **psychiatric hold**. The action is legally and ethically justified due to the emergency aspect of the person's need. Every U.S. state sets its own criteria for hospitalization due to mental health emergency. Generally, such clients should only be involuntarily admitted if they can benefit from the hospitalization and if it is the least restrictive means for treatment.

LINK TO LEARNING

The Treatment Advocacy Center has compiled a survey of the mental health commitment laws of the states (https://openstax.org/r/77mentalhlth) looking at the types of involuntary admission laws, as well as issues such as outpatient commitment.

During an emergency admission, a mental health-care team is available to the person for medical and psychosocial care. Psychiatrists, social services professionals, mental health nurses, and care managers participate in coordinating and planning the person's stabilization. After the required waiting period, some persons may be released from the facility into the care of their family members or to another treatment setting. Some persons agree to remain on a voluntary basis for continued treatment. Still others may be kept in custody through **involuntary commitment**—involuntary hospitalization of a client—which is the legal means to hold an individual in a psychiatric-mental health facility for a mental illness without that person's consent. Involuntary stays can be days or weeks as determined by the attending psychiatrists and courts.

Mandated Treatment in the Community

One form of civil commitment within the community, not confined to a facility is **assisted outpatient treatment (AOT)**. It is intended to reduce rehospitalization and assist community reentry. Again, programs vary by state. This care is mandated by the court and sometimes results in return to the hospital environment if the individual does not adhere to the mandates.

Persons may be referred to community care after release from a facility. The best candidate for community care is one who has stabilized from treatment and has a support system of people in the community. Persons in AOT may receive case management, home visits, therapy sessions, medication, and housing support. Community treatment can have benefits to the person, such as avoiding hospitalization, feeling less restricted, and experiencing less

stigma, according to Mikellides et al. (2019).

LINK TO LEARNING

Review this guideline to involuntary commitment (https://openstax.org/r/77invcommit) from SAMHSA, called *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*.

Process of Involuntary Evaluation and Treatment

There are two processes to initiate involuntary commitment: (1) emergency and (2) judicial. The emergency process, mentioned previously, arises when an individual poses immediate harm because of their mental illness. The commitment happens immediately. The judicial process is not an emergency, but begins when someone concerned determines that a person requires mental health treatment that they will not willingly obtain. There may be a wait while the court decides whether or not to grant the order (Disability Rights South Carolina, 2023).

Family members or other concerned individuals may call local law enforcement, clerks of court in the county where the individual resides, or the person's primary care physician or mental health professional to initiate this judicial process and an involuntary examination to determine need for treatment. Clerks of court can file petition for an ***ex parte*** (meaning that all the parties are not yet involved) order asking a judge to authorize a psychiatric evaluation.

If the person needs an escort to the mental health-care facility, this may involve civil arrest, being taken by law enforcement (possibly in handcuffs, in a patrol car) to a psychiatric receiving facility or medical hospital emergency department. Additional resources regarding court-ordered mental health treatment include:

- Call 211 United Way referral line
- Call 988 Suicide and Crisis Lifeline
- Veterans Crisis Line: call 1-800-273-TALK (8255) and press 1; or text 838255
- Crisis Text Line: text the word 'Home' to 741741

LINK TO LEARNING

The Policy Surveillance Program compiled information by state for short-term emergency commitment. Their map, containing the data, provides sample questions (https://openstax.org/r/77srttrmEmer) the data answers.

With variations in state laws, upon completion of the involuntary psychiatric evaluation, the person may:

- be released
- give express and informed consent to stay for treatment on voluntary status
- be held for treatment on involuntary status
- be referred for mandated community treatment, a form of **conditional release/discharge**, meaning that the person must adhere to prescribed treatment (medication, counseling, follow-up appointments) or be returned to the hospital

If the person has health insurance, the cost of treatment will be billed to the insurance company. Sometimes, the state pays the facility to care for the person, or the court may order another source of funding.

Facilities Used for Court-Ordered Evaluation and Treatment

Determined by the individual states, facilities may include acute care general hospitals, psychiatric hospitals, designated treatment centers, crisis centers, and specialty services, such as women's centers or child/adolescent facilities. Hospitals without psychiatric services may hold persons in the emergency department while awaiting psychiatric placement. Persons in jail will wait for forensics units or hospitals that will receive them. Due to the overrepresentation of individuals with mental illness in corrections settings in the United States (National Alliance on Mental Illness [NAMI], 2023), many clients may be found in any of these settings, depending on the state.

11.2 Violence and Safety

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Recall issues relating to mental health and safety
- Outline approaches that are used to deal with safety in the clinical setting
- Understand approaches to ensuring staff safety in clinical settings

Safety is paramount for both clients and staff at mental health-care facilities. Sometimes clients in mental health treatment settings can pose a threat to themselves or others. It is incumbent upon nurses to understand the circumstances surrounding potential safety issues and to know how to approach them from therapeutic, ethical, legal, and environmental perspectives. Maintaining a safe environment for clients and staff is, in part, a nursing responsibility guided by professional standards and by the principles of person-centered care.

Mental Health and Safety Issues

Client safety is a nursing priority. Nursing assessment involves analysis of cues in the client's presentation that could put the client or others at risk. This leads to planning effective care. Nurses must remain self-aware, considering their own biased assumptions and the influence of others regarding safe practice and safe environments. Medical diagnosis and prior experience cannot stand alone as predictors of client behaviors; every individual comes from unique circumstances and has their own reactions to different triggers.

To be clear, most people with serious mental illness do not perpetrate violence, and when they do, it is often related to other coexisting issues, such as substance use or abuse (DeAngelis, 2021). Nevertheless, nursing interventions at early signs of client distress can mitigate violent events. Nursing assessment can easily identify overtly aggressive behaviors, such as posturing, gesturing, shouting, or physical contact. But just as important is nursing recognition of clients' levels of anxiety, physical agitation, suspicion, fear, and emotional reactions to others. Nursing awareness of clients' tolerance to environmental stimuli, such as visitation time, meal times, competitive activities, or crowding and noise can provide cues to nursing action.

Risk Factors for Aggression or Violence in Serious Mental Illness

Nurses should be aware of and understand risk factors in each client's history in order to inform preventative care. Medical causes, such as substance withdrawal or hypoxia, or metabolic conditions, such as fever or delirium, may also contribute to uncooperative or acting-out behaviors. Early childhood events, exposure to trauma (including traumatic brain injury), and substance use can shape behavior and mental health in general. These factors may contribute to potential for violence due to acquired protective responses, learned ineffective coping behaviors, dysregulated neurological responses, substance influence or substance withdrawal, work demands, or stressors in the home. Other risk factors for aggression by clients with mental illness are related to mental health symptoms, including persecutory delusions often related to schizophrenia, grandiosity and mania, and antisocial personality traits (DeAngelis, 2021).

Cues in Types of Behavior

According to the Centers for Disease Control, there are a number of common cues indicating an increased potential for violence (2020). They include screaming or loud talking, cursing, menacing voice, uncared-for physical appearance, pacing, panting, arm crossing, hand clenching, staring, looking fearful, throwing items, or being drunk or high.

Some behaviors distressing to the person may not appear as problematic to others. Behaviors such as social withdrawal, silence, or guarded body posture may not be reported by family members or seen as relevant by health-care workers. Yet these behaviors, especially if noticed as a change, could be outward expressions of fear or pain that nurses should note in the context of safety. Highly active, disruptive behaviors, such as damaging property or threatening others, are likely to draw more attention. Impulsivity may be driven by paranoia or hallucinations or the energy of a manic episode. Socially inappropriate remarks, insults, or actions that evidence disregard for others may be associated with disorders of conduct or personality, or may be learned intimidation behaviors. Persons with low self-esteem and ineffective coping abilities may present as deceitful or manipulative. Medications that are ineffective or not taken or have agitation as a side effect can also account for client behaviors. No matter the cues, respect for client autonomy and early detection are key to appropriate interventions.

LINK TO LEARNING

Nurses have to be aware of boundary issues with clients, particularly if there is the potential for any violent and aggressive behavior. This informative brochure from the National Council for State Boards of Nursing (https://openstax.org/r/77boundary) provides information on boundaries in the therapeutic relationship.

Handling Aggression and Violence in the Clinical Setting

The Joint Commission (2019), an accrediting body for health-care organizations, has identified de-escalation of aggressive behaviors in health-care settings as a safety initiative, including interventions that are verbal, physical, or involve medication. Other partners in this initiative include Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS), as well as professional organizations worldwide (Lim et al., 2022).

For psychiatric-mental health nurses, management of aggressive behavior starts with the therapeutic relationship and ongoing assessment. Nurses act as educators and mentors to other health-care staff through role modeling and direct instruction. Interventions for these behaviors are taught to staff members through in-service instruction. Methods and rationale are also reviewed and reinforced during debriefing after events.

Least Restrictive Alternatives to Managing Aggression

The foundational guideline to handling aggressive behavior is that providers must use the least restrictive measures that are safe. Nursing management of aggressive behaviors starts with client-centered care, which includes an introduction, respectful interview processes, and professional exchange of information at handoff of care reports. Nurses must have a keen awareness of their own body language, like where they place their hands, and their own tone of voice when interacting with clients.

Early nursing interventions, such as distraction and redirection, engaging the client in problem-solving, managing environmental stimuli, offering calming techniques, and providing comfort measures or physical activity can be highly effective, unrestrictive methods to redirect behaviors away from violence. Honest praise for the client's ability to maintain personal control is part of these interventions. Taking a break from a situation through having time-outs, which are temporary, brief removals from adverse stimulation to reduce stressors, and medications are also less restrictive alternatives to managing aggression. With a **time-out**, the client is offered a choice to withdraw from a stressful situation and go to another location. This may be to the client's bedroom, a designated quiet room, or a recreation area. A client in time-out is free to leave the time-out area at their will.

Stress reduction teaching, another less restrictive method of managing aggression and often used in conjunction with medication, is most effective approximately thirty minutes after medication administration, when the client will be getting some benefit from the pharmacological effect. This, together with the calming techniques prompted by the nurse, gives the client a chance to experience personal success. Such empowerment can transfer to future situations.

The Use of PRN Medication

Medication works best when offered to clients in early stages of anxiety before escalation of aggression. The term **PRN** is a medical abbreviation for the Latin *pro re nata*, meaning, "as it is needed." In many situations, clients request PRN medications, such as needed for headache, sleep, or pain. Psychiatric nursing is somewhat unique in this regard in that PRN medications can be part of the nursing intervention when the nurse recognizes cues of potential aggressive behavior during assessment. Clients may not ask for antianxiety medication and may not be able to ask for antipsychotic medication, so the nurse determines the need. Nurses should offer PRN medication along with supportive interaction within the therapeutic relationship.

Nurses should not administer medication covertly, such as hiding it in food, or misrepresenting the type of medication or its action to the client. An ethical dilemma exists, however, for families and care providers when a client refuses medication as part of their illness or incapacity for decision-making, and the person's health is deteriorating. Each state provides guidelines for administration of medication without the client's consent. Only situations where there is an extreme threat to safety to the client or others merit this type of medication

administration, and it requires specific documentation. Medical staff and supervisory nursing staff must be part of this decision and the documentation must clearly show what information was provided to the client and the client's response (Latner, 2022).

Emergency medication orders are interim measures only, with care planning ongoing.

Nurses should confer with mentors and colleagues regarding trauma-informed care during mandated medication administration. Medication in these situations will likely be administered by intramuscular injection. The client's movement may be stabilized by physical holds or restraint devices, though best-case scenario involves the client accepting the injection. Statements such as, "you need this," or "we have to give this to you" are unhelpful, as is leaving the client alone after medication administration. Nurses should remain with, or near, the client after the medication is given to monitor medication effects and provide support.

Medications to treat severe mental illness have significant side effects and some potential lethality. Ideally, persons in need of these medications should be full participants in treatment decisions. The rationale for medically and legally ordered medications without the person's consent is that with improvement from the medication, the person will be able to engage in their own care.

LINK TO LEARNING

Review this list of medications commonly used with clients who are violent (https://openstax.org/r/77violentmed) from Neuroscience Research Australia.

The Use of Seclusion

The American Psychiatric Association Resource Document Seclusion or Restraint (2022, page 2) describes seclusion or restraint as interventions "of last resort in the management of severe agitation" (e.g., violence). Both are highly regulated by local, state, and federal law and other health-care accreditation organizations, and both carry significant risks. As one of the most restrictive methods to manage aggressive behavior, seclusion is one form of coercive treatment. Restraint is the other most restrictive form. The ethical and legal challenges posed by these interventions should prompt mental health nurses to invest fully in the therapeutic relationship and embrace the role of client advocate.

While time-out is an intervention that the client can choose at the lower stages of anxiety, seclusion, by contrast, is staff placement of the client in a room designed for protective confinement. If there is furniture, it is generally fixed to the wall or floor. If there are windows, the covering is of a safety material. There are no electrical outlets or light switches and the door cannot be opened from inside once it is closed or locked from the outside. A ceiling light fixture and a security camera will be encased and the door may have a small, covered opening for observation or an intercom. Some seclusion rooms have padded covering on the walls and floor; some have drain openings in the floor. The person must be escorted out to toilet facilities, and there should be emergency resuscitative equipment nearby. Seclusion has traditionally been used when clients are dangerous to others or self-destructive and less restrictive measures have not proven effective. The person must be observed continually by staff or via camera with frequent documentation and provision of care.

LINK TO LEARNING

The American Psychiatric Association has published a resource document on the practices of seclusion and restraint (https://openstax.org/r/77restraint) in psychiatric care. (Key points are summarized on pages 14 and 15.)

Using Restraints

A measure designed to confine the person's bodily movements and, subsequently, access to their own body is called a restraint. There are a number of different types of restraints: soft restraints, chemical restraints, medical restraints, behavioral restraints, and environmental restraints. In medical/surgical care facilities, some of these types of restraints prevent dislodging medical support interventions, such as oxygen masks, intravenous lines, or feeding tubes. Chemical restraint is the sedating effect of medication. All types of restraints are intended to limit the

person's movement, require specific documentation and provider orders, and present ethical and legal considerations.

Devices applied to the person's limbs or body may be made of soft material, hard rubber, plastic, canvas, or leather. Straps of leather or fabric are buckled or tied to a fixed object, generally a bed or chair. The client may be positioned supine or sitting in standard or semi-Fowler's position. Prone position is not safe or ethical.

In general, restraint in psychiatry has been used when clients are injurious to themselves or others. Time in restraint should be minimal with continuous nursing assessment. According to the APA, "these details ('last resort,' 'less restrictive means' and 'minimum time requirement') are codified in many state and federal laws" (2022, page 4). Nursing judgment can determine when clients can demonstrate personal control. As with seclusion, the restrained person must be observed continually by staff, and staff must document their observations. During a restraint episode, the nursing observations include assessment of the limbs, circulation, food, water, toileting, and when and how to know when the client can be released from the restraint.

Individual facilities have specific guidelines for application of restraints, and the cleaning, storage, and maintenance of the devices. Employees usually learn these guidelines during new employee and annual skills training. This training includes care of the person in restraints, such as provision of hygiene. Hygiene entails inspection of the client's skin, nourishment, airway protection, proper positioning, and assessment for release. Additionally, each state sets specific guidelines regarding provider orders, documentation, and time limits on seclusion or restraints. All will likely contain the following:

- Intervention must be ordered by licensed practitioners permitted by the state and the facility.
- Least restrictive emergency safety interventions are required.
- Verbal orders must be verified in a signed, written form, outlining all details.
- The provider must be available for contact and consultation.
- Orders for restraints and seclusions should be renewed every four hours for adults over the age of eighteen, every two hours for children and adolescents ages nine to seventeen, and every hour for children under the age of nine.
- Within one hour, a licensed practitioner permitted by the state and the facility must conduct a face-to-face assessment to determine physical and psychological well-being.
- Staff must document the intervention in the health record:
  - the time the intervention began and ended
  - the time and results of the one-hour face-to-face assessment
  - the emergency safety situation that required the intervention
  - the names of the staff involved in the emergency safety intervention
- The facility must maintain records of each emergency safety situation, the interventions used, and their outcomes (Legal Information Institute, 2001).

Seclusion and restraint may cause substantial detrimental psychological and physical outcomes, including death. The therapeutic relationship, and early intervention in clients' anxiety and stress states, can preclude the need for seclusion and restraint. They are emergency safety measures of last resort.

LINK TO LEARNING

Review *Position: The Use of Seclusion and Restraint* (https://openstax.org/r/77APAseclusion) from the American Psychiatric Nurses Association, which they revised in 2022.

Staff Safety When Dealing with a Violent Client

Agitation and violence are behaviors driven by emotion, not logic. Therefore, staff working with acting-out clients should strive to address the emotion and not to engage in debate. Clients may feel disrespected if staff utilize restrictive methods too quickly in the process and this can lead to increased agitation. Physical intervention by staff (escorting to seclusion room, application of restraints) may reinforce to the client that violence is a form of conflict resolution. As soon as an assessment reveals violent behavior to be imminent, or it begins, staff should manage the

situation to increase privacy for the client and focus for the staff. The acting-out person may accept the nurse's invitation to "walk with me," and agree to leave a populated area. Walking will discharge some physical energy and reinstate the relationship between the client and the nurse. Prevention of escalation is key to staff, client, and environmental safety. Employees are entitled to a safe work environment. Even though some clients may escalate quickly, or enter the facility in agitated states, the treatment goal is still person-centered, trauma-informed care.

All staff approach to the violent client should be with open body posture (hands visible and open, stand on slight diagonal to the client, do not block doorways), no taunting or challenging, accepting and validating the client's feelings without justifying the behavior, for example, "I can see your point; help me understand; we can't let anyone get hurt."

REAL RN STORIES

Nurse: Sydney O., RN BSN
Years in Practice: 4 years
Clinical Setting: Crisis intervention unit
Geographic Location: Mississippi

I witnessed the Clinical Nurse Leader of a psychiatric unit where I worked de-escalate a tense situation. The client was backed up against a wall by five male staff members who were shouting at him to calm down and be quiet. The CNL walked up to the scene, stood close enough to make eye contact with the client, and said, "Hey, Arnell. What's going on right now?" The client answered, "They're trying to keep me in here! I wanna get outta here! I got to get outta here!"

The CNL motioned for the other staff to step aside, and she held out her hand to the client, saying, "I believe you; you don't want to stay here any longer than necessary. I can help you with that; let's do it the right way." The client stepped forward and walked with the CNL to an open seclusion room where the client sat on the bed and the CNL brought in a chair, sat down, and said to the client, "Arnell, I'm going to ask Dina to bring you some medicine. Do you want a soda with that?" The client smiled and said, "A soda would be great." The CNL talked to the client while the med nurse brought the medication and a soda; within 20 minutes, the client was back in his room and the crisis had been averted. The CNL continued to check in with the client throughout the shift and included him in the change of shift report, where she said to the oncoming nurse, "Arnell has been concerned about his discharge plans, and we agreed that he will speak to his social worker in the morning." The oncoming nurse continued the therapeutic relationship by saying, "Arnell, sounds like you really handled yourself well today."

I saw a lot of techniques in the nurses' approach that day, and I have always tried to be this effective in my own practice.

Staff Training

Many health-care settings teach the "Management of Aggressive Behavior," sometimes abbreviated MAB. These programs have several concepts in common, with specifications made for child/adolescent, older adults, or forensic populations. Early programs (1970–1980s) were largely based on self-defense techniques, relying on blocking attacks or releasing from holds. Currently, programs present more therapeutic interventions. Some may be provided as part of first responder training, or are based on trauma-informed care, such as the Safe Crisis Management (SCM) Program. The following programs are available for MAB training.

- Association for Psychological Therapies (https://openstax.org/r/77/APT)
- Crisis Prevention Institute (CPI)/Nonviolent Crises Intervention (NCI) (https://openstax.org/r/77/CPINCI)
- Essentials of Aggression Management (https://openstax.org/r/77/EOAM)
- Healthcare Aggression Response Training (https://openstax.org/r/77/HART)
- Mandt (https://openstax.org/r/77/Mandt)
- MOAB (https://openstax.org/r/77/MOAB)
- Professional Assault Response Training (https://openstax.org/r/77/PART2000)
- TEAM (https://openstax.org/r/77/TEAM)
- Therapeutic Options, Inc. (https://openstax.org/r/77/TherOpt)

These models may be part of the organization's quality improvement process and chosen based on feasibility and cost. General concepts of MAB include that staff should:

- communicate clearly and in a nonthreatening manner
- allow the client time to process the information; repeat information
- listen to the client; validate their feelings
- use open-ended questions; ask for the client's input
- provide the client with alternative solutions

If there is a potential need for more restrictive interventions, consider and plan them in advance:

- Only one staff person should give direction.
- Members of the staff group should move quickly and efficiently to escort the client away from the scene to the area of seclusion or restraint.
- Room and equipment should be readily available.
- Attend to other clients.

Ulrich et al. (2018) make the point that the environment itself (furniture type and placement, light, sound, and space) can be a form of prevention of aggressive behavior and reduction of need for most restrictive interventions. Features like an accessible garden, nature paintings, low density communal settings, and noise reduction design have been proven to decrease the need for the most restrictive interventions. Mental health treatment settings can offer newly admitted clients a questionnaire to complete, designating which stress reduction methods they find helpful (Ulrich et al., 2018).

The Use of Security Staff in Clinical Situations

Safety officers in health-care facilities likely see their role as prevention, protection, and security by patrolling, monitoring, and managing threats (Parker et al., 2020). When called to client situations, they may be more prepared for hands-on rather than therapeutic communication. In reality, the role of security officers may by defined in facility policy (Lawrence et al., 2018). Still health-care workers in various departments may have differing views of the role of security staff.

From a nursing perspective, if security personnel are called to assist with client care, they should be functioning under direction of the nurse. The relationship dynamic between nursing staff and security staff may be one of respect and cooperation, or not. Resentment can be part of the scenario if security staff believe they are called for hands-on interventions and the nurses are "still talking" to the client. Psychiatric-mental health nurses should participate in planning management strategies that involve security staff with client-centered care in mind. These efforts should be proactive in nature and well communicated to all stakeholders in the organization.

An alternative to assistance of security personnel for mental health clients is implementation of **behavioral emergency response teams (BERT)**. Based on the concept of rapid response teams' proactive intervention for medical status changes, BERT offers the opportunity to bring specialized knowledge and care to an urgent situation wherein the client is experiencing extreme psychological stress. BERTs have been proven to assist with reducing assaults directed at staff and advancing staff cooperation, client satisfaction, and client and staff safety (Rajwani et al., 2023). A BERT's multidisciplinary team may include clinicians, social workers, and counselors, who will learn or improve their skills, which in turn may reduce the need for the BERT (Choi et al., 2019).

Debriefing after a Violent Incident

Violent incidents are critical events and should be followed with debriefing measures similar to a cardiac code or client injury. The focused, purposeful discussion employed to enhance education or make improvements is called **debriefing** (Edwards et al., 2021). In this case, it will assist all staff members to process the event to help them cope and recover. It will offer resources for further assistance in order to prevent post-traumatic stress and burnout. It will involve a review of all elements of the event, prior and during, including areas in need of improvement. It will include a brainstorming session about how the incident could have been handled better operationally. The debriefing should also consider the client's perspective and offer staff members emotional support and an opportunity to express feelings, fears, and learning needs.

11.3 Powers of Attorney and Advance Directives

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the purpose of a power of attorney and its application to mental health nursing
- Outline how a proxy directive can be used in a mental health situation
- Define psychiatric advance directives and the way in which they are utilized in mental health care

Individuals and families can make plans in advance of the need for action in mental health crisis situations. They can create an **advance directive**, which is a document that allows a person to make decisions when they are still capable of making them; they include three components: power of attorney, living will, and health-care proxy. These instructions allow for decision-making by designated others when a person is not capable of self-care, including making decisions on their care. It is important to become aware of the implications, limitations, and benefits of advance directives for those with mental illness.

Power of Attorney (POA)

Variable by state, a **power of attorney (POA)** is a written designation of authority to act for another person in specified matters (Table 11.3). It is one type of advance directive. Medical or health-care power of attorney gives the designee (agent), who must be over the age of 18, the permission to make decisions in the event the designator (principal) is incapacitated. A person living with mental illness may experience episodes of incapacity for decision-making, whether this involves psychological detachment from reality, extreme social withdrawal, or mental health crisis, including self-harm or danger to others, so it often makes sense to appoint a power of attorney in case these situations arise. Limitations of the POA are that no one can transfer authorization and no decisions can take place after the death of the principal.

Type	Definition	Uses
Durable	May be used for persons with or without capacity for decision-making	Financial affairs management Estate planning
Springing	Becomes effective upon a predetermined date or event	In advance of a potential incapacity or physical absence
Special	Takes effect only for selected duties	When expertise may be needed, i.e., legal contracts, banking, real estate
Medical	Allows medical decision-making for the person	Health-care decisions, emergencies when the person may not be capable

TABLE 11.3 Types of Power of Attorney

Power of attorney status, in general, authorizes the agent to manage personal and business matters for a principal person. These matters may include financial, personal property, real estate, or contracts. The **health-care power of attorney** can speak for the person if the person cannot make their own health-care decisions. The health-care POA will follow the person's known wishes or directions as documented in the advance directive. Agents only make decisions if the principal is unable to do so. Agents may have access to the medical record and make decisions regarding admission/discharge, treatment, and medication.

Psychiatric Advance Directives

The application of the health-care POA to mental health nursing involves **psychiatric advance directives (PAD)**, a legal document, variable by state, created by the person for use if the person becomes unable to make their own mental health-care decisions. The PAD can specify the person's choices regarding hospital admission, treatment, and medication in the case of a mental health emergency.

Living Will

Upon signing POA documents, the principal specifies their wishes, usually via a **living will**, a document that

identifies acceptable medical treatment, especially at end of life. For persons living with mental illness who may have a potential need for assisted or assumed decision-making, a living will sets forth the person's wishes while the person is stable to decide. A person's directions specified in the living will document are intended to apply when medical care is proposed to prolong life for an uncertain time frame to prevent death.

End-of-life care and hospice care directions may be part of the living will document. These directions include treatments the person wishes to avoid, such as artificial feeding intubation, defibrillation, and so forth. If the person cannot communicate at end of life, the living will can designate what treatment is acceptable. This may include the person's preferences about resuscitation and organ donation after death.

Issues Related to Making Life Better

Quality of life is defined by the person themselves, and loved ones may or may not agree. For a person living with mental illness, quality of life may involve aspects of treatment, personal freedoms, and a sense of personal control.

Autonomy is an ethical principle and an important factor in quality of life (Varkey, 2021). advance directive with power of attorney designation can communicate a person's preferences for their future if the person becomes incapable of making their own decisions. The hope and belief may be that the representative decision-makers will make the "right" decision at the right time, though this is not guaranteed. Faced with medical decisions, input from others, fear, uncertainty, and financial concerns, family members may struggle with these decisions, despite knowing what the person may have wanted. A person's autonomy can conflict with loved ones' guilt or concerns about the need for institutional care.

The Patient Self Determination Act of 1990 in the United States required health-care facilities accepting Medicare and Medicaid to inform consumers of their rights to make preferences known. PAD can accomplish this and create a partnership between the person and systems of care, possibly balancing the person's independence with obligations of health-care providers. Resources available for individuals and families regarding advance directives are available at:

- Substance Abuse and Mental Health Services Administration (2019) A Practical Guide to Psychiatric Advance Directives (https://openstax.org/r/77advdirective)
- National Resource Center on Psychiatric Advance Directives (2023) State by State Information (https://openstax.org/r/77PsychAdvDir)
- American Psychiatric Association (2023) What Is a Psychiatric Advance Directive (PAD)? (https://openstax.org/r/77APAdirective)

Proxy Directives

Proxy means representative. As with all advance directives, proxy designation varies in the United States by state. A **health-care proxy**, also called durable medical power of attorney or health-care surrogate, is a person with legal authorization to represent a client in their health-care decisions. The proxy will decide as the person would have decided. The designated health-care proxy may have limited or broad authority, as designated by the principal, including whether any other persons may be involved in decisions. An alternative proxy can be named, should the primary proxy be unreachable at a needed time. In mental health-care situations, proxies are often involved with decisions regarding quality of life and end-of-life care.

According to Medicare Rights (2023), there are specifics to consider when planning for representation in health-care matters, such as:

- Someone designated as health-care proxy may have access to the person's medical record. Any limits on this access should be designated.
- Persons should ensure the proxy is aware of their beliefs and attitudes about care during illness and end of life, as well as preferences for facilities or providers. Documents should be updated if preferences change.
- The person may change the proxy. If so, a new document is required.

Laws and guidelines vary by state, so persons should be aware that:

- The proxy is a decision-maker for health care; arrangements concerning health-care costs and health insurance may be categorized as financial decisions.
- State law may designate a decision-maker in the absence of the person's documented directives.

- States may combine the living will and health-care proxy in the single advance directive document.

Domingues et al. (2022) advocate for the person diagnosed with a mental health disorder to outline health-care proxies and advance directives during periods of stability. A person faced with death may cycle through thoughts and reactions related to multiple emotions. These changing emotional states may not coincide with actions specified in the advance directive. In these cases, or in periods of exacerbation of psychiatric symptoms, some forms of paternalism within the health-care systems may not sanction death without intervention for a person diagnosed with a mental illness (Domingues et al., 2022). While acknowledging that medical education and research should address these concerns, Domingues et al. (2022) assert that persons' autonomy is fundamental to health care.

In a comprehensive literature review, Wilkinson et al. (2007) describe end of life as a "value-laden issue" due to the many aspects of chronic disease and the multiple methods of prolonging and sustaining a living state. End-of-life issues also apply to those clients who may have a mental health problem. Wilkinson et al. (2007) cite the concern of significant others to those with psychiatric diagnoses and found that "facilitated discussion" was helpful. Further, this review of literature found studies to support the interest and ability of persons living with mental illness to complete advance directives for psychiatric care. Specific to end-of-life care, nearly half of older persons studied who were diagnosed with depressive disorders had "do not resuscitate" orders and more than 10 percent rejected ventilation at end of life (Wilkinson et al., 2007).

Concerning designation of proxy decision-makers, Wilkinson et al. (2007) cited a community study of those living with mental illness, which found more than 70 percent supported the idea of proxy and more than 60 percent were able to select a proxy.

Concepts for end-of-life care include:

- safety and comfort
- client's self-determination
- client may be offered a life review with a therapist
- pain management
- spiritual care
- support for survivor grieving

LIFE-STAGE CONTEXT

Considerations at End of Life

For clients nearing the end of life, nurses should self-reflect, focus on self-care, and honor their therapeutic relationship with their clients in the following ways:

- begin by asking clients about their beliefs related to end-of-life care
- be aware of their own personal biases that can interfere with therapeutic communication
- convey empathy, provide information, follow the client's cues
- assure the client of provision of symptom relief
- allow time for clients to express themselves and ask questions
- reassure family members as indicated
- perform ongoing psychosocial assessment for changing needs
- intervene on acute distress, hopelessness, pain, or refusal of care with emotional support, stress reduction techniques, collaboration with other providers for change in plan of care

(Vazquez & Santone, 2011)

Implications of Psychiatric Advance Directives

According to the Substance Abuse Mental Health Services Administration (SAMHSA, 2023), psychiatric advance directives (PAD) must comply with the state guidelines and typically include a notarized signature page with two additional witnesses signing. Frequently, the PAD may contain a statement of the person's intent in creating the

PAD; the designation of another decision-maker if the person is adjudicated incompetent; designation of a guardian if a court appoints one; the person's preferences for hospitalization, alternatives to hospitalization, specific medications, or the use of electroconvulsive therapy; the person's preferences for emergency interventions, which may address the use of seclusion, restraint, and emergency medication administration; willingness to participate in experimental studies or research; people to notify upon the person's admission to a psychiatric facility; the person's preferences regarding visitation if hospitalized and the care of dependent family members or pets; and the person's right to suspend or terminate an advance directive while incapacitated, as allowed by state law (SAMHSA, 2023).

When conducting client and family education with regard to PAD, nurses should discuss the following benefits and barriers to encourage informed decision-making. Collaborative care with social services and counselors is helpful. Benefits and barriers associated with PAD as defined by the Joint Commission (2023) include:

- Benefits
  - client's autonomy
  - improved relationships with providers
  - treatment adherence
  - less coercive interventions, especially if the person has specified certain medication
  - better follow-up after discharge
- Barriers
  - lack of safe storage or ready access to the document
  - lack of awareness or understanding by others
  - lack of communication among treatment staff, especially emergency response teams
  - some state laws provide for court petition to overrule the PAD

Nursing Responsibility Regarding PAD

According to Chan et al. (2019), completion rate in American states for advance directives is approximately 26 percent of the general population. Because acceptance of the idea is higher than the completion rate, this creates a teaching opportunity for nurses. Especially in psychiatric-mental health nursing where nurse-client interaction is basic care, the nurse can teach and advocate for clients interested in completing a PAD. Nurses can listen to clients as they identify their values and assist them to access resources. This education may include involvement of the family or trusted others. Nurses should evaluate client understanding of the process and provide additional instruction or referral as appropriate. Nurses should also ensure that advance directives are included as a portion of the client's care plan. They should review them with the clients in their first meeting and regularly thereafter to ensure accuracy and currency. Nurses also should document advance directives in the medical record and communicate their existence and content to all members of the interdisciplinary team.

Collaborative Care in Mental Health Advance Directives

Mental health case managers, social workers, therapists, counselors, and medical, nursing, and legal professionals should work together in assisting clients and families to create a PAD. Collaboration may be through team treatment meetings, through referrals, or in clinic-based care in community settings.

11.4 Guardianship and Conservatorship

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the role of a guardian/conservator
- Outline the process for appointing a guardian/conservator
- Discuss ethical concerns in appointment of a guardian/conservator

Guardianship and conservatorship processes will vary in the United States by individual states.

A **guardianship** is created through the courts to manage financial, legal, and personal matters for a person who lacks capacity to do so. A **conservatorship** is similar but can be created due to the absence of responsible parties, such as for children with absent parents, and may focus more specifically on financial aspects. Both guardianship and conservatorship are court-appointed, legally protected designations and both have ethical implications in nursing practice. Conservators are paid to serve, and these funds come from the person's estate, or the court may designate the payment arrangement. Conservators can act as a neutral party if there are conflicts in the person's

family about the person's care. Conservatorship is a matter of public record, which may raise privacy concerns (Family Caregiver Alliance, 2012).

Defining Guardianship and Conservatorship in Relation to Mental Health

The guardian or conservator is the court-appointed agent to represent the declared-incompetent person as decision-maker, on a temporary or permanent basis, in legal, financial, and/or personal matters. Barton et al. (2014) acknowledge that definitions vary across American states, though a common definition of **competency** in guardian and conservator cases is the ability for self-care, with decision-making and communication as essential components. The person still has the right to participate in their own care to the extent of their ability (Barton et al., 2014). In some states, a health-care proxy may take precedent over an appointed guardian by state law.

PSYCHOSOCIAL CONSIDERATIONS

Reasons for Having a Guardian or Conservator

Here are some examples of instances when a guardian/conservator may be required:

- mental illness impairs judgment to make legal, financial, and personal decisions
- unable to meet basic needs for health or housing
- cognitive impairment, intellectual disability, dementia
- frail older adult or impaired by illness or injury
- medical conditions, such as traumatic brain injury or stroke
- vulnerable to exploitation

(Copenhaver, Ellet & Derrico, n.d.)

Suitable Guardians

The guardian or conservator must be someone willing to take the responsibility as an officer of the court. The guardian or conservator should be someone the person chooses and often is a family member. If the court finds the guardian or conservator unsuitable, another relative of the person or even an attorney may be court-appointed. Recognizing variations by state, guardians may be required to submit ongoing reports to the court on the person's status. More than one guardian may be appointed and some guardianships and conservatorships may be temporary or limited in scope (Barton et al., 2014).

Alternatives to Guardianship

As discussed, psychiatric advance directives can be a method to designate a personal representative while the person is capable of making decisions, prior to an emergency need. Short-term guardianships (for such time as the parent or responsible party is absent) and supported decision-making agreements (authorizing a trusted other) can be created with legal advice within each state.

Appointing a Guardian or Conservator

Courts must be petitioned for guardianship or conservatorship, and each state has established procedures for seeking these designations. According to the U.S. Department of Justice, most states allow "any person" to file a court petition for guardianship. Persons who file may be friends or family members, health-care providers, or members of the community, including organizations and agencies of the government. In general, after the individual or agency files a petition, the person in question receives notification and attends a court hearing. An investigation may proceed the hearing, and the entire process can take weeks to months (Barton et al., 2014).

Ethical Concerns

Actions that are legally allowed may still raise ethical concerns. Guardianships and conservatorships are forms of surrogate decision-making, wherein the person being represented is removed from personal and material decisions and loses control in the process. Another concern involves how competence and capacity, which both mean "ability," are evaluated and whether the status can change. Competency is usually considered to be a legal term, while capacity is regarded as being a medical term (Libby et al., 2023). A competency hearing in court includes expert testimony from mental health professionals and statements from the person and significant others. The

witnesses may offer evidence of how the person made decisions that had harmful effect. The court may question the person to determine understanding of the information presented and may be asked to verbalize the significance of the situation. So even though there are objective criteria for a legal determination of incompetence, there still exists a subjective component to it, which creates an ethical challenge.

In addition, conflicts of interest may exist between clients and their potential guardians; the court is responsible for determining potential sources of conflict. Conflicts may arise over custody of children, inheritance awards, property ownership, or residence. Cultural values or religious beliefs likewise could pose conflicts between persons and those appointed to be their guardians or conservators. There is also no central tool to evaluate the process.

Nursing Role

In care of clients under guardianship or conservatorship, nurses may feel a conflict between two essential concepts in client care: autonomy and safety. While respecting the need for protection for vulnerable clients, nurses may struggle with the loss of aspects of the person's self-determination. This may be especially so when clients show improvement in treatment.

Catlin et al. (2021) found clinicians' (including nurses) experience with guardianships was variable, though seen as generally positive. Overall, the study revealed that clinicians view guardianship as appropriate to resolve issues for persons unable to make their own decisions. Nurses reportedly feel unprepared to address issues of guardians' neglect or mismanagement of clients' affairs and such distress could even contribute to burnout in the profession (Catlin et al., 2021). Nurses are encouraged to connect with mentors and colleagues for support and to stay informed in these aspects of client care.

CLINICAL JUDGMENT MEASUREMENT MODEL

Recognize Cues: What Findings Require Action?

What does the nurse notice about the client and family and what seems to matter most?

The nurse collects the data that the family member expresses guilt about seeking guardianship for their loved one. The nurse invites the family member to talk and share their concerns. The nurse processes with the family member what options for the client's safety had been available and what may have been the outcome if guardianship were not established. The nurse takes the action of determining what information about guardianship the family requires and what supportive resources can be obtained.

Summary

11.1 Reasons for Court-Ordered Treatment

The reasons for court-ordered treatment can be complex. If a person is thought to be a danger to themselves or others, or has a grave incapacity, they may be treated on an involuntary basis. This involves court recommendations and the continual monitoring of the client through the medical and court system. Each state designates the guidelines for mental health treatment when necessitated by court order. These directives address circumstances, length of time, and individual rights. Court-ordered treatment may take place inside a health-care facility, out in the community (whether residential or day treatment, including mandatory support group attendance), or in visits to mental health-care providers. There are two types of processes to initiate involuntary commitment: (1) emergency and (2) judicial. Some states permit emergency treatment orders, which allow provision of medically prescribed treatment with or without consent.

11.2 Violence and Safety

Nurses should not assume that clients are choosing to act violently; often clients may not be in control of personal responses. Ongoing nursing assessment with early intervention at lower stages of clients' anxiety will contribute to safety for everyone involved. Further, appropriate nursing care includes teaching to increase the client's self-management ability.

Though policies and procedures vary across facility settings in all states, safety for clients and staff and ethics in nursing practice are the truest guides. Person-centered, trauma-informed care directs nursing action. Least restrictive methods for management of aggressive behavior include the therapeutic relationship, time-out, and PRN medication. Most restrictive measures include the use of medication by court order, seclusion, and restraint.

11.3 Powers of Attorney and Advance Directives

Powers of attorney, health-care proxies, and other advance directives address decision-making by designated others when a person is not capable of making decisions themselves. State law varies as it applies to these concepts in terms of who a client can designate and the manner and documentation that must be used to designate them. The rate of psychiatric advance directives completion is low in the United States, which may suggest an opportunity for education in nursing practice. The nurse as advocate and educator is in position to inform individuals and families of the option to make an advance directive for mental health care.

11.4 Guardianship and Conservatorship

Guardianships and conservatorships are created through the courts to manage financial, legal, and personal matters for a person who lacks competence to do so. Competence is a determination also made by the courts; it is defined by state law, and these laws vary. Someone can petition a court to secure a guardian for a client for a number of reasons, such as mental illness impairing judgment to make legal, financial, and personal decisions; inability to meet basic needs; cognitive impairment; or impaired by illness. While the purpose of guardianships is to honor the person's wishes by appointing someone to make decisions in line with what they might have wanted, ethical considerations abound. Nurses grapple with the loss of autonomy experienced by these clients as weighed against ensuring their safety.

Key Terms

advance directive document that allows a person to make decisions when they are still capable of making them; includes the living will, power of attorney, and health-care proxy
assisted outpatient treatment (AOT) form of civil commitment within the community, not confined to a facility
behavioral emergency response team (BERT) multidisciplinary group trained to respond to emergent behavioral incidents in treatment facilities
civil commitment legal process that keeps involuntary hospitalization from qualifying as false imprisonment
competency ability for self-care with decision-making and communication as essential components
conditional release/discharge person must adhere to prescribed treatment (medication, counseling, follow-up appointments) or be returned to the hospital
conservatorship created through the courts due to the absence of responsible parties, such as for children with

absent parents, and may focus more specifically on financial decisions

debriefing focused, purposeful discussion after an incident used to enhance education or make improvements

emergency admission hospital admission for persons reasonably determined to have mental illness and, due to this, are deemed to be dangerous to self or others

emergency treatment orders (ETO) allow medically prescribed treatment to be provided, with or without consent

ex parte a court order where all of the parties are not yet involved

guardianship created through the courts to manage financial, legal, and personal matters for a person who lacks capacity to do so

health-care power of attorney can speak for the person if the person cannot make their own health-care decisions

health-care proxy legal authorization to represent a person in their health-care decisions; the proxy will decide as the person would have decided

involuntary commitment kept in custody without consent after a waiting period

living will document that identifies acceptable medical treatment, especially at end of life

power of attorney (POA) written designation of authority to act for another person in specified matters

PRN medical abbreviation for the Latin *pro re nata* meaning, "as it is needed"

psychiatric advance directives (PAD) legal document, variable by state, created by the person for use if the person becomes unable to make their own mental health-care decisions

psychiatric hold persons received under emergency situations remain in the facility for a waiting period of twenty-four to seventy-two hours for a psychiatric assessment and crisis treatment

time-out temporary, unconfined, and brief removal from adverse stimulation to reduce stressors

Assessments

Review Questions

1. What term means that all parties have not been involved at this point?
   a. psychiatric hold
   b. conditional release
   c. *ex parte*
   d. commitment

2. If a person in a psychiatric hospital has been adjudicated incompetent, what is true about their care?
   a. They have the right to refuse treatment.
   b. They must give informed consent for all care.
   c. They may sign out with a family member.
   d. They may have treatment imposed on them.

3. What statement by a family member tells the nurse that they need further education about conditional release?
   a. "Conditional release means no more medication or therapy."
   b. "Conditional release means mandated community treatment."
   c. "Conditional release means leaving the hospital with other requirements."
   d. "Conditional release means the psychiatric evaluation is complete."

4. When approaching an angry client, what would be the nurse's best assessment to evaluate the risk for violence?
   a. try reasoning with the client to explain why behavior must change
   b. move quickly to subdue the client before escalation occurs
   c. address the client's emotions and offer to walk with the client
   d. remain in populated areas so all staff is available

5. A nurse in orientation in the mental health unit asks the preceptor, "Why is medication considered a form of restraint?" What would preceptor's best response be?

a. "The sedating effect limits the client's movements and thought processes."
b. "It is not really a restraint."
c. "Because nurses can use medication PRN."
d. "Because medication can be hidden in the client's food."

6. When reviewing information from a transferring hospital, what would the nurse recognize as a risk factor for violent behavior in the client's history?
a. hypertension controlled with medication
b. membership in a support group
c. part-time employment
d. traumatic events in childhood

7. What is the purpose of a power of attorney (POA) in mental health care?
a. to make decisions after a person's death
b. to designate a decision-maker if the person is not able to make decisions for themselves
c. to prevent social withdrawal associated with mental illness
d. to enforce a national standard of care

8. What characteristic is true of proxy directives?
a. Proxy means representative and may have limited authority.
b. Proxy directives are the same throughout the United States.
c. Proxy cannot include any other persons or have an alternative proxy.
d. Proxy directive is the same as a living will.

9. In a community mental health clinic, a client asks the nurse, "What is a psychiatric advance directive?" What is the nurse's best response?
a. "It is a legal document, according to our state laws, that appoints a financial advisor for you."
b. "It is a legal document, according to our state laws, but not necessary if you have family."
c. "It is a legal document, according to our state laws, that you can only complete after you have had several involuntary hospital admissions."
d. "It is a legal document, created in compliance with state law, that you can create to have someone make your treatment choices known if you cannot make your own decisions."

10. What is the role of a guardian or conservator?
a. The guardian or conservator is the court-appointed agent to represent the incapacitated person as decision-maker in legal, financial, and personal matters.
b. The guardian or conservator is the court-appointed agent to prevent involuntary treatment under the law.
c. The guardian or conservator is the court-appointed agent who keeps the person from participating in their own care.
d. The guardian or conservator is the court-appointed agent who can never be taken over by a health-care proxy.

11. What are steps in the process to appoint a guardian or conservator?
a. Twenty-four hours after a court petition is filed, an investigation is conducted, and the agent is authorized to represent the person.
b. Conservators sign up for payment, a hearing is held, and the person is notified.
c. The court petition is filed, the person is notified, and a court hearing, with possible investigation, is held.
d. In federal court, a hearing is held, fees are paid, and the person is released.

12. An experienced mental health nurse is working with a new graduate nurse. What statement by the new nurse would the experienced nurse recognize as an ethical concern?
a. "That client has a conservator who helps manage their finances."

b. "That client's guardian seems helpful and involved in his treatment."
c. "That client hasn't consistently taken her medication, but she has kept her job."
d. "That client was not eating due to delusional thinking, so now she's getting help."

Check Your Understanding Questions

1. What is the primary rationale for court-ordered therapy?
2. List examples of situations where court-ordered therapy may be mandated.
3. In several sentences, describe debriefing after a violent episode in a mental health unit.
4. How does a health-care proxy function in mental health situations, and what decisions can a designated proxy make?
5. Explain the role of a guardian or conservator in managing the affairs of a person who lacks the capacity to make decisions for themselves.

Reflection Questions

1. The nurse, Jorri, meets with an older adult client who will be discharged from the hospital later today. The discharge plan includes assisted outpatient treatment, mandated as a condition of the client's release. The client, Edward, sits without speaking, arms crossed, looking down at the floor. The nurse opens a conversation:

   Jorri: It seems to me you have something on your mind. If so, can we talk about it?

   Edward: What's there to talk about? All my decisions are made for me.

   Jorri: Your decisions . . . ?

   Edward: Yeah, like how I live when I get out of here. Going to therapy appointments every week and even having somebody come to my house to check on me. Like I'm not a grown man!

   Jorri personally feels community care is appropriate for Edward, though Jorri can see Edward's distress. Consider the QSEN competency regarding the limits and boundaries of therapeutic client-centered care. In this scenario, what knowledge, skills, and attitudes should the nurse consider to guide a response to the client?

2. How can nursing assessment increase safety with clients in mental health care?
3. Why is client safety a nursing priority, and what factors should nurses consider in assessing potential risks?
4. Give examples of how you would take action to meet nursing responsibilities associated with psychiatric advance directives in the categories of client teaching, client advocacy, and therapeutic relationship.
5. In a few sentences, describe nurses' possible reactions to appointment of a guardian or conservator for a person living with mental illness, and offer strategies to address these.

What Should the Nurse Do?

Elin, a forty-five-year-old female, has been brought to the outpatient mental health clinic by her family. She has a history of severe alcohol use disorder and has been involved in multiple legal incidents related to her substance misuse. These incidents range from driving under the influence (DUI) charges to public intoxication and altercations related to her aggressive behavior. Family members have expressed great concern about her safety as well as the safety of others, highlighting the urgency of a comprehensive intervention. She presents with symptoms of anxiety, depression, and occasional episodes of aggression. Elin's medical history includes chronic liver disease due to her alcohol consumption. She has previously engaged in outpatient treatment for substance misuse, but has struggled to maintain sobriety.

1. Considering Elin's history of legal incidents and the potential threat to her own safety and others, discuss why court-ordered therapy might be deemed necessary for her case. How do the legal implications of her substance misuse contribute to the decision for involuntary intervention, and, what ethical considerations

should be taken into account?

2. Given Elin's complex needs, provide examples of specific types of court-ordered therapy that could be beneficial in her case. How might inpatient rehabilitation, dual diagnosis treatment, and counseling programs address the multifaceted challenges presented by her severe alcohol use disorder, chronic liver disease, and co-occurring anxiety and depression?
3. What legal criteria and procedures would need to be considered when initiating involuntary court-ordered treatment for Elin? Identify and discuss the steps involved in determining whether she meets the necessary criteria for involuntary intervention.

Alexandra, a thirty-five-year-old female, has presented at the emergency department (ED) seeking assistance for escalating symptoms of severe anxiety and depression. She reports experiencing persistent feelings of hopelessness, insomnia, and a significant loss of interest in daily activities. Alexandra has a history of bipolar disorder and is currently prescribed mood stabilizers. Her medical history also includes a recent hospitalization due to a suicide attempt. In the ED, Alexandra's vital signs reveal an elevated heart rate of 110 beats per minute, blood pressure of 150/90 mmHg, and shallow breathing. Given her history and the acuity of her symptoms, staff safety is a concern. Alexandra appears agitated, and her affect is labile.

4. Identify three specific mental health issues that Alexandra is currently facing based on her reported symptoms and history. How do these issues contribute to concerns regarding her safety in the emergency department?
5. Outline at least three immediate approaches nurses can employ in the ED to address Alexandra's safety concerns based on her elevated vital signs and agitated state. How can the physical environment and communication strategies contribute to ensuring her safety during this encounter?
6. Considering Alexandra's case, what specific challenges might nurses face in ensuring their own safety while providing care? How can interdisciplinary collaboration and clear communication contribute to enhancing staff safety in the context of this emergency situation?

Sunil, a fifty-five-year-old male, has been admitted to the psychiatric unit with a history of bipolar disorder. He presents with symptoms of severe mood swings, impulsivity, and decreased need for sleep. Sunil has a well-documented psychiatric history, including multiple hospitalizations due to manic episodes. Upon admission, his vital signs are stable, with a heart rate of 78 beats per minute, blood pressure of 120/80 mmHg, and normal respiratory rate. Given the recurrent nature of his condition, Sunil has a comprehensive mental health-care plan that includes a power of attorney designating his sister as his legal representative. Additionally, he has a living will specifying preferences for treatment during periods of incapacitation. Sunil has also provided a psychiatric advance directive outlining his preferences for specific psychiatric interventions in various scenarios.

7. Sunil's psychiatric history includes multiple hospitalizations due to manic episodes. How might the power of attorney designated to his sister play a crucial role in ensuring continuity of care during his hospitalizations? Discuss specific scenarios where the sister's involvement might be essential.
8. Sunil has a living will specifying treatment preferences during periods of incapacitation. How can the nurse effectively communicate and collaborate with Sunil's sister to tailor his care to his preferences while balancing the legal and ethical aspects of mental health nursing?
9. Define the role of psychiatric advance directives in mental health care. How might Sunil's psychiatric advance directive influence decision-making in specific psychiatric interventions, and what challenges could arise in implementing these directives within the clinical setting?

Geraldine, a sixty-eight-year-old female, has been admitted to the hospital with a diagnosis of advanced Alzheimer's disease. She presents with symptoms of severe cognitive decline, including disorientation, memory loss, and difficulty performing activities of daily living. Geraldine's medical history includes a gradual deterioration of cognitive function over the past two years, leading to increased dependency on others for basic care. During this admission, her vital signs are within normal ranges, with a heart rate of 80 beats per minute, blood pressure of 130/78 mmHg, and a regular respiratory rate. Due to the progression of her Alzheimer's disease, concerns have arisen about Geraldine's ability to make decisions regarding her health care and living situation.

10. Given Geraldine's advanced Alzheimer's disease and cognitive decline, how would you define the role of a guardian or conservator in her situation? Consider the specific responsibilities and decision-making authority that a guardian or conservator might have in managing her health care and living arrangements.
11. Outline the step-by-step process for appointing a guardian or conservator for Geraldine, taking into account

her advanced Alzheimer's disease. Consider the legal and procedural aspects involved in initiating and completing this process.

12. In Geraldine's case, how might the appointment of a guardian or conservator impact her overall well-being, considering not only medical decisions but also aspects of her daily life and personal preferences? Discuss potential benefits and drawbacks of such an appointment.

Competency-Based Assessments

1. What are the steps involved in initiating involuntary court-ordered treatment?
2. Why is client safety a nursing priority, and what factors should nurses consider in assessing potential risks?
3. What are some early nursing interventions to address aggressive or violent behaviors, and why are they considered effective?
4. How can health-care staff ensure their safety when working with clients exhibiting mental health diagnoses and symptoms?
5. What is a psychiatric advance directive (PAD), and how does it contribute to mental health-care decision-making?
6. What is the general process for appointing a guardian or conservator, and why might it be necessary to seek such designations?
7. What ethical concerns may arise in the appointment of a guardian or conservator, and how might these concerns impact the individual under guardianship or conservatorship?

References

Adeniyi, O. V., & Puzi, N. (2021, October 27). Management approach of patients with violent and aggressive behaviour in a district hospital setting in South Africa. *S Afr Fam Pract (2004)*, *63*(1), e1–e7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8603198/

American Psychiatric Association. (2022, February). *Seclusion or Restraint*. https://www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Document-Seclusion-Restraint.pdf

Arbury, S., Zankowski, D., Lipscomb, J., & Hodgson, M. (2017). Workplace violence training programs for health care workers: An analysis of program elements. *Workplace Health & Safety*, *65*(6), 266–272. https://doi.org/10.1177/2165079916671534

Barton, R., Lau, S., & Lockett, L. (2014, May 29). *The use of conservatorships and adult guardianships and other options in the care of the mentally ill in the United States*. Family Members as Guardians for Mentally Ill Patients World Guardianship Congress, Arlington, VA, United States. https://www.guardianship.org/IRL/Resources/Handouts/Family%20Members%20as%20Guardians_Handout.pdf

Catlin, C. C., Connors, H. L., Teaster, P. B., Wood, E., Sager, Z. S., & Moye, J. (2021, January 18). Unrepresented adults face adverse healthcare consequences: The role of guardians, public guardianship reform, and alternative policy solutions. *J Aging Soc Policy*, *34*(3), 418–437. https://doi.org/10.1080/08959420.2020.1851433.

Centers for Disease Control and Prevention. (2020, February 7). Be attuned to patient behaviors. *Workplace Violence Prevention for Nurses*. https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit6_7

Chan, C. W. H., Wong, M. M. H., Choi, K. C., Chan, H. Y. L., Chow, A. Y. M., Lo, R. S. K., & Sham, M. M. K. (2019, January 28). Prevalence, perception, and predictors of advance directives among Hong Kong Chinese: A population-based survey. *Int J Environ Res Public Health*, *16*(3), 365. https://doi.org/10.3390/ijerph16030365

Choi, K. R., Omery, A.K., & Watkins, A. M. (2019). An integrative literature review of psychiatric rapid response teams and their implementation for de-escalating behavioral crises in nonpsychiatric hospital settings. *J Nurs Adm*, *49*(6), 297–302.

Congressional Research Service. (2023). *Involuntary civil commitment: Fourteenth Amendment due process protections*. https://crsreports.congress.gov/product/pdf/R/R47571

Copenhaver, Ellett & Derrico. (n.d.). When you need a guardianship & conservatorship. https://cedlawfirm.com/when-you-need-a-guardian-conservatorship/

Cronenwett, L., Sherwood, G., Barnsteiner J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D., Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook, 55*(3)122-131.

DeAngelis, T. (2021, April 1; updated 2022, July 11). Mental illness and violence: Debunking myths, addressing realities. *Monitor on Psychology, 52*(3), 31. https://www.apa.org/monitor/2021/04/ce-mental-illness

Disability Rights South Carolina. (2023). *Involuntary mental health commitments*. https://www.disabilityrightssc.org/involuntary-mental-health-commitments/

Domingues, V. N., Castro, L., Monteiro, M. D., Cordero da Silva, J. A., Rego, F., & Rego, G. (2022, February 23). Advance directives: Knowledge of the topic among psychiatrists. *Front Public Health*, *10*:822577. https://doi.org/10.3389/fpubh.2022.822577

Edwards, J. J., Wexner, S., & Nichols, A. (2021, November 18). Debriefing for clinical learning. *PSNet Primers*. https://psnet.ahrq.gov/primer/debriefing-clinical-learning

Family Caregiver Alliance. (2012). *Conservatorship and guardianship*. https://www.caregiver.org/resource/conservatorship-and-guardianship/

Fariba, K. A., & Gupta, V. (2023, April 24). Involuntary commitment. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 at https://www.ncbi.nlm.nih.gov/books/NBK557377/

Galappathie, N., Khan, S. T., & Hussain, A. (2017, June). Civil and forensic patients in secure psychiatric settings: A comparison. *BJPsych Bull*, *41*(3),156–159. https://doi.org/10.1192/pb.bp.115.052910

Harris, J. C. (2003). Pinel delivering the insane. *Arch Gen Psychiatry, 60*(6), 552. https://doi.org/10.1001/archpsyc.60.6.552

Hedman, L. C., Petrila, J., Fisher, W. H., Swanson, J. W., Dingman, D. A., & Burris, S. (2016). State laws on emergency holds for mental health stabilization. *Psychiatric Services*, *67*(5), 529–535. https://doi.org/10.1176/appi.ps.201500205

Kuniavsky, M., Kadmon, I., & Chinitz, D. (2015, November 24). Being a legal guardian - the nursing perspective. *Isr J Health Policy Res, 4*(59). https://doi.org/10.1186/s13584-015-0056-1

Latner, A. W. (2022). *Court looks at when medication may be administered without patient consent*. https://www.empr.com/home/features/court-looks-at-when-medication-may-be-administered-without-patient-consent/

Lawrence, R. E., Perez-CosteStan, M. M., Arkow, D., Appelbaum, P. S., & Dixon, L. B. (2018). Use of security officers on inpatient psychiatry units. *Psychiatric Services, 69*(7), 777–783. https://doi.org/10.1176/appi.ps.201700546

Legal Information Institute. (2001). 42 CFR § 483.358 - Orders for the use of restraint or seclusion. Cornell Law School. https://www.law.cornell.edu/cfr/text/42/483.358

Legal Information Institute. (2023). Involuntary civil commitment. Cornell Law School. https://www.law.cornell.edu/wex/involuntary_civil_commitment

Libby, C., Wojahn, A., Nicolini, J. R., & Gillette, G. (2023). *Competency and capacity*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK532862/

Lim, M. C., Jeffree, M. S., Saupin, S. S., Giloi, N., & Lukman, K. A. (2022, May 13). Workplace violence in healthcare settings: The risk factors, implications and collaborative preventive measures. *Ann Med Surg (Lond)*, *78*:103727. https://doi.org/10.1016/j.amsu.2022.103727

Medicare Rights. Medicare Interactive. (2023). *Health care proxies*. https://www.medicareinteractive.org/get-answers/planning-for-medicare-and-securing-quality-care/preparing-for-future-health-care-needs/health-care-proxies

Mikellides, G., Stefani, A., & Tantele, M. (2019, November). Community treatment orders: International perspective.

BJPsych Int, *16*(4), 83–86. https://doi.org/10.1192/bji.2019.4

National Alliance on Mental Illness. (2023). *Mental health by the numbers*. https://nami.org/mhstats

Parker, C. B., Calhoun, A., Wong, A., Davidson, L., & Dike, C. (2020.) A call for behavioral emergency response teams in inpatient hospital settings. *AMA J Ethics*, *22*(11), E956-964. https://doi.org/10.1001/amajethics.2020.956

Psychology Today. (2024). *Court-ordered therapy*. https://www.psychologytoday.com/us/basics/therapy/court-ordered-therapy

QSEN Institute. (n.d.). *QSEN competencies*. https://www.qsen.org/competencies-pre-licensure-ksas

Rajwani, A., Clark, N., & Montalvo, C. (2023). Understanding best practices in implementation of behavioral emergency response teams through a scoping review. *Journal of the American Psychiatric Nurses Association*, *29*(5), 375–388. https://doi.org/10.1177/10783903221114335

Rueve, M. E., & Welton, R. S. (2008, May). Violence and mental illness. *Psychiatry (Edgmont) 5*(5), 34–48. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686644/

Stone, D. (2016). There are cracks in the civil commitment process: A practitioner's recommendations to patch the system. *43 Fordham Urb. L.J. 789*. https://ir.lawnet.fordham.edu/ulj/vol43/iss3/8

Substance Abuse and Mental Health Services Administration. (2019a, February 15). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf

Substance Abuse and Mental Health Services Administration. (2019b). *A practical guide to psychiatric advance directives*. https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf

Substance Abuse Mental Health Services Administration. (2023). *Advance directives for behavioral health*. https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/governance-oversight/directives-behavioral-health.

Temme, L. (2022). *Fourth amendment seizure of persons*. Find Law. https://constitution.findlaw.com/amendment4/annotation03.html

The Joint Commission. (2019). *Quick safety issue 47: De-escalation in health care*. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-47-deescalation-in-health-care/

The Joint Commission. (2023). *Quick safety 53: Improving care with psychiatric advance directives*. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-53/quick-safety-53-improving-care-with-pads/

U.S. Department of Justice. (2023). *Guardianship: Key concepts and resources*. https://www.justice.gov/elderjustice/guardianship-key-concepts-and-resources

Ulrich, R. S., Bogren, L., Gardiner, S. K., & Lundin, S. (2018). Psychiatric ward design can reduce aggressive behavior, *Journal of Environmental Psychology*, i57, 53–66. https://doi.org/10.1016/j.jenvp.2018.05.002.

Varkey, B. (2021). Principles of clinical ethics and their application to practice. *Med Princ Pract 30*(1), 17–28. https://doi.org/10.1159/000509119

Vazquez, L. D., & Santone, M. D. (2011, Winter). Psychosocial end-of-life considerations for healthcare providers. *Ochsner J*, *11*(4), 317–24.

Wilkinson, A., Wenger, N. & Shugarman, L. R. (2007). *U.S. Department of Health and Human Services literature review on advance directives*. https://aspe.hhs.gov/reports/literature-review-advance-directives-0#ethic

CHAPTER 12
Self-Determination and Advocacy

FIGURE 12.1 Understanding all of the legal and ethical issues surrounding client care is critical to ensure the nurse can support a client who is unable to make their own choices and carry out their own actions. (credit: "Legal Gavel & Open Law Book" by "howtostartablogonline.net"/Wikimedia Commons, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION When a person has autonomy, they are able to make appropriate choices in their life. They are empowered and can form meaningful relationships that provide them the self-determination required to make their own life decisions. To have autonomy and self-determination, the person may have to advocate for themselves and feel comfortable in doing so to achieve their required outcomes.

When nurses encounter clients in the mental health-care field, the clients have often experienced some type of trauma. Whatever the cause, the client may feel or live with symptoms that make them feel as though they have lost control of their emotions, actions, and/or ability to self-determine. Often the disturbance in their equilibrium results in embarrassment, anxiety, and stigma. The effort to achieve a more balanced state includes a variety of interventions that can return them to a place where they can advocate for themselves and have the ability to make autonomous decisions.

Nurses will encounter clients at various levels of functional ability. Therefore, nurses must recognize each client as an individual and meet them where they are. According to the American Nurses Association (ANA) Scope and Standards of Practice, advocacy, respect, and communication begin the process of caregiving; they also require consideration of cultural differences and absence of stigma (ANA, 2015). For each client, the mental health nurse

works to complete an assessment, establish a trusting relationship, and meet the immediate needs through collaboration with other members of the health-care team. Supporting the client's ability to self-determine, increase the level of functioning, and enhance client empowerment are roles of the mental health team.

12.1 Client Representation for Empowerment and Relationship Rebuilding

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify circumstances where client representation is required for clients with a mental health problem
- Describe the issues relating to a client who has diminished responsibility
- Outline ways to encourage the empowerment for clients with a mental health problem
- Identify situations when the empowerment approach would be used in providing care to a client with a mental health problem

Client representation entails that the mental health nurse put aside their own bias and provide culturally sensitive care to each client. Effective client representation means increasing the comfort of the client, protecting their rights, and including the client and family in the assessment and creation of a plan of care. Clients may enter mental health services through a variety of situations, including the justice system. Nurses and other mental health professionals work to create a feeling of empowerment through various avenues and protections.

Client Representation

In legal terms, **client representation** means to consult with the client regarding the client's objectives, how the client wants to proceed, and then take the action approved by the client (American Bar Association, 2024). Mental health nurses can participate in this role. Nurses are empowered by self-awareness, which can transfer to advocacy. Mental health nurses who speak as representatives for their clients are called to take every opportunity to understand the lived experience of those in their care.

When the client enters the care environment following an interruption in their equilibrium, it is important for them to be treated with respect and appropriate decisions made regarding their treatment plan. Sometimes, significant others may be available to express the concerns of a client who is unable to express their own needs and assist with establishing an acceptable plan of care. Other times, health-care facilities have recognized the need for client representatives to serve as a liaison between clients and family members and health-care workers, advocating for the rights of the client.

The Criminal Justice System

Studies indicate that 18 percent of the general U.S. population lives with mental illness and that approximately 37 percent to 44 percent of those in jails or prisons have mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2022) describes an overrepresentation of individuals with mental health conditions in the criminal justice system. In an effort to divert these clients, Mental Health America (MHA) has suggested that timely and accurate screening and evaluation can successfully result in the placement of individuals with mental health concerns in the appropriate care setting, avoiding falling into the criminal justice system (MHA, 2023). Another suggestion includes allowing access to a mental health professional for those who do find themselves in the criminal justice system, leading to appropriate assessment and treatment for adults and adolescents.

LINK TO LEARNING

Watch this video *The Portrayal of Mental Illness in the Media* (https://openstax.org/r/77mentlillmedia) while thinking about the various views of mental illness portrayed in media.

The Americans with Disabilities Act

It is important for nurses to understand that mental health issues can be considered disabilities under federal law. The Americans with Disabilities Act (ADA) is the civil rights law ensuring that persons with disabilities receive protections from discrimination with respect to employment, public services and accommodations, transportation, and other aspects of daily living. Physical and mental diagnoses that limit participation in activities of daily living

(ADL) are considered to be disabilities under this law. Such disabilities include impairments or limitations in basic activities like eating, sleeping, physical movement, thinking, concentrating, communicating, and emotional or thought regulation, especially as these impact public social and workplace interactions (ADA National Network, 2018; Spriggle, 2017). It is also important to note that mental health challenges can exacerbate physical disabilities that individuals may have.

Diminished Responsibility

Reduced liability for a criminal act on the part of a defendant who has been proven to have certain alterations in thought processes is called **diminished responsibility** (Johnston, 2024). It provides a mitigating defense when the mental health disease is not severe enough to excuse criminal responsibility completely. In certain circumstances, the diminished responsibility defense replaces, and is a lesser version, of an insanity plea; the individual often will receive a sentence for a lesser crime, for example, manslaughter instead of murder.

Nurses' Response to Clients with Diminished Responsibility

A court conviction for a lesser charge by reason of diminished responsibility is brought due to finding of the defendant's inability to comprehend the legal aspects of the situation. Examples of mental health conditions that may support a finding of diminished responsibility include:

- neurodevelopment disorders
- psychotic disorders
- bipolar disorders
- depressive disorders
- trauma and stress-related disorders
- neurocognitive disorders (Missouri State Public Defender, 2016)

Nursing care for clients with these diagnoses requires interventions to address alterations in thought processes and sensory perception, such as presenting reality, safely confronting delusions, and monitoring mood and risk for harmful behaviors. Medications and collaborative care will be essential for these clients. In addition, communication and coping skills will be included in client and family education.

Nonjudgmental care is a professional standard even when a client has been accused or convicted of a crime. Hammarström et al. (2019) found that nurses' identity as caring professionals was challenged in these situations. Nurses reported feeling frustrated, while also wanting to be open to the client's experience and condition. These researchers suggest that nurses utilize strategies of reflection and basic self-care, look at their roles realistically, and strive for ethical practice (Hammarström et al., 2019).

Lehrer (2021) addressed the problem from a trauma-informed care perspective and acknowledged that a compassionate connection is necessary in the therapeutic relationship. Lehrer calls for nursing competence in communication, assessment, and a commitment to the human right of unbiased health care.

Empowerment

Empowered individuals are able to mobilize existing resources to accomplish goals. The World Health Organization (WHO, 2024) calls for the **empowerment** of communities, which means assisting people to take action toward improving their own health. This action requires development of personal skills for members of these communities through health promotion education (WHO, 2024).

Individuals can learn to take control of their lives and make decisions that affect their well-being. In other words, nurses can help clients to become more empowered. Assisting mental health clients to gain self-confidence, self-esteem, and self-awareness can result in clients experiencing empowerment in different areas of life, such as career, finances, health, and relationships. With empowerment, clients enhance communication, build trust, and maintain boundaries, which can improve relationships.

Empowerment in Mental Health Care

According to the Directorate-General for Health & Consumers (2010) of the World Health Organization, "Empowerment is not a destination, but a journey" (p. 1). Empowerment involves people learning to adopt self-reliance, participating in decisions, possessing dignity and respect for others, feeling a sense of belonging, and

contributing to a wider community. Self-determination and autonomy are included in this process.

LINK TO LEARNING

Review this document from the World Health Organization titled *User Empowerment in Mental Health* (https://openstax.org/r/77caregvrempwr) to better understand worldwide efforts to empower the caregivers in mental health as well as the recipients of mental health care. This document addresses perspectives and taking action at societal, service, education, and individual levels.

Differentiating Between Empowerment and Enablement

It is important to recognize the difference between empowerment and enablement in efforts to assist clients. Empowering someone helps them change their behavior on their own. Nurses can empower clients by guiding them to resources and teaching them life skills. Empowerment will give them the power to make and live with their own choices (BRC Healthcare, 2021). When a person attempts to make life easier for an individual that leads to negative consequences, it is called **enablement**. Enabling someone reinforces negative behaviors. Some examples of enabling are ignoring or tolerating negative behaviors, providing excessive monetary assistance, covering or making excuses, doing work for them, denying there is a problem, and failing to follow through with established consequences. When nurses empower in place of enable, they give mental health clients the ability to confidently assess their options, make choices that align with their values, and live by their choices.

LINK TO LEARNING

Read the article *Are you empowering or enabling?* (https://openstax.org/r/77enabling) to understand the differences between empowering and enabling and to more effectively help mental health clients.

The Empowerment Approach in Mental Health Care

The overall process of empowering clients in mental health care entails the following: helping to restore hope and respect, enabling clients to reclaim their life, helping them to feel connected, recognizing and helping them recognize their rights, following client preferences for learning skills, moving from secrecy to transparency, and assisting with self-initiated growth and change.

Dimensions of Empowerment

Empowerment is the process of taking control and responsibility for one's own actions. Four dimensions identified in this process include:

- self-reliance
- participation in decisions
- dignity and respect
- belonging and contributing to a wider community (Directorate-General for Health & Consumers, 2010)

Many clients experience powerlessness; the process of empowerment can assist them in gaining control of their life, resulting in increased self-esteem (Directorate-General for Health & Consumers, 2010). Learning to trust in one's ability to take care of self and collaborating with supportive others creates an environment wherein clients' well-being is protected and enhanced.

Empowerment and Relationships

Nursing practice is relationship-based. The nurse-client relationship is based upon shared decision-making, empathy, and effective communication. Molina-Mula and Gallo-Estrada (2020) state that nurses should strive to preserve the client's values in health care and respect the client's experience. This is the meaning of person-centered care, which promotes client autonomy (Molina-Mula and Gallo-Estrada, 2020). Empowerment helps clients experience strong, healthy relationships in their personal lives. With empowerment, individuals have more confidence and are more able to build trusting relationships. Empowerment promotes stability in relationships and enhances problem-solving skills due to the individual's comfort in representing their own interests.

PSYCHOSOCIAL CONSIDERATIONS

Empowerment-Based Practice with Children with Autism

Edmunds, in a post in *Psychology Today*, discusses the importance of recognizing that children with autism need to be supported with respect and dignity. Researchers noted the importance of seeing the person with autism as a valued member of society. In order to advocate for children with autism, health-care workers should not make assumptions of ability based upon outward expressions or behaviors alone; they should validate persons on the autism spectrum, and they should avoid correcting the person with autism because it interferes with equitable treatment.

(Edmunds, 2013)

12.2 Autonomy and Independence

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the elements of autonomy
- Describe why restrictions might be placed on the autonomy of a person with a mental health diagnosis or symptoms
- Discuss power sharing in the therapeutic relationship

The concepts of autonomy (ability to make decisions) and **independence** (ability to function without assistance) are often discussed together. While autonomy is related to the right to make one's own decisions with minimal interference from others, independence encompasses the client's ability to do things on their own, without any assistance from others (Toledano-Gonzalez et al., 2019). For instance, a client may need assistance with ADLs, but continue to have the ability to make informed decisions in a meaningful way.

In mental health care, clients may need assistance in making decisions, due to the severity of mental health symptoms, so it might compromise autonomy. If thought processes are impaired and clients are unable to interpret reality, or if clients are at risk for behaviors dangerous to self or others, it may call for restriction of autonomy and independence therapeutically or legally. Personal power can be restored as mental health is restored and the nurse-client relationship is instrumental in this process.

Defining Autonomy for Mental Health Clients

One of the fundamental ethical principles in health care, and often at the heart of nursing care, is freedom for clients to make decisions for themselves (ANA, 2015). In mental health care, individuals may be unable to make decisions for themselves perhaps until they have received treatment, which can become complicated when an individual is unable to make the decision to receive the treatment. Clients may enter the mental health system demonstrating an inability for self-care due to the exacerbation of their diagnosis. For example, a client with bipolar disorder in their euphoric state may demonstrate the lack of ability to make appropriate decisions related to spending money.

Freedom is a component of autonomy and when individuals are restricted for their safety, for example, court-ordered into treatment, it limits autonomy. One argument in favor of such limitation is that the disease process itself has already altered the person's autonomy; therefore, protections are indicated (SAMHSA, 2019).

PSYCHOSOCIAL CONSIDERATIONS

Substitute Decision-Making: Alexandra's Story

Involuntary hospitalization was necessary for Alexandra due to her diagnosis in childhood. Now, as an adult, she feels that the loss of control and inability to participate in her care damaged her self-esteem and complicated her condition, leaving her without confidence.

Though substitute decision-making may be deemed necessary for those who lack capacity, the experience of the

person cannot be discounted. The subsequent fear and mistrust resulting from restrictive methods of behavior management leave lasting impressions and interfere later in life with health-seeking.

Alexandra relates her work with a therapist who empowered her to regain her sense of self.

See the World Health Organization article *Autonomy in health decision-making—a key to recovery in mental health care* (https://openstax.org/r/77autonomy) for her personal insight into the role of autonomy recovery for a mental health client.

The Influence of Autonomy on Behavior

The ability to exercise autonomy allows the client to demonstrate responsibility, integrity, dignity, individuality, and self-knowledge (Liu et al., 2022). Mental health clients can lose this ability with an exacerbation of their disease, creating the need for someone to be responsible for making decisions for them.

Agency

The term **agency**, according to Wheeler (2020), means feeling control over one's decisions and well-being. It is the component of autonomy that involves individuals being in control of what happens to them. In mental health recovery, agency plays a large role as the client begins to regain an ability to be in charge of their lives and become the owner of their thoughts, feelings, and actions.

Restrictions on Autonomy and Independence

There are certain circumstances under which restrictions on a client's autonomy are justified legally, medically, and ethically. Nurses should be aware of these instances, should understand the appropriate ways to limit autonomy in the least restrictive means necessary, and should work with clients to implement interventions that will help them to regain autonomy as quickly as possible. When a client is in an impaired state—for example, in pain, emotionally traumatized, or unable for any reason to make an informed decision—the client's autonomy may be restricted.

Nurses are bound by their ethical duty to keep clients' confidentiality, respect clients' right to refuse treatment, and ensure that clients receive emergency and continuous care. All this within the condition that if harm would ensue to the client or to others, the nurse may be in a position to modify some of these aspects of care. Careful documentation and consultation are essential for such restrictive nursing action in relation to restrictions on autonomy and independence for the client.

Independence

Independence represents an individual's ability to perform activities of daily living without assistance. Included are things like bathing, dressing, eating, ambulating, housework, and managing medication. With independence comes the ability to live alone. Often the mental health client temporarily loses the ability to live independently until they are returned to their pre-exacerbation level of functioning. For some individuals, however, they may come to a point where loss of independence is permanent and long-term arrangements must be made.

Rationality

According to Pugh (2020), autonomous decision-making is based on a person's concept of what options they have. Therefore, if an irrational thought process drives a chosen action, the action may be inappropriate, illegal, or harmful. In that situation, the autonomous decision may actually have been involuntary (Pugh, 2020). Another name for guidance of reason is **rationality**. This is in contrast to rationalization, which is a defense mechanism used in attempts to explain experiences that prompt unacceptable feelings. As a short-term defense against anxiety, rationalization can be a coping mechanism. However, when used frequently or if preventing emotional resolution, it can be unhealthy. With mental illnesses, it can prevent the client from accepting truth and delay a return to their previous level of functioning.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Client-Centered Care: Autonomy

The QSEN competencies provide a framework for nursing education and practice, emphasizing the importance of

client-centered care, safety, quality improvement, teamwork, and evidence-based practice. Advocacy in psychiatric-mental health nursing aligns closely with several QSEN competencies:

Client-centered care: Advocacy in psychiatric nursing involves prioritizing the needs, preferences, and rights of clients. Nurses advocate for client-centered care by ensuring that treatment plans are individualized, respecting clients' autonomy and self-determination, and actively involving clients in decision-making processes regarding their care and treatment options.

Safety: Advocacy in psychiatric-mental health nursing also encompasses ensuring the safety and well-being of clients. Nurses advocate for safety by assessing and managing risks, such as suicidal ideation or aggression, and implementing appropriate interventions to prevent harm while promoting client autonomy. This may involve collaborating with interdisciplinary teams, implementing de-escalation techniques, and advocating for the use of least restrictive interventions.

Teamwork and collaboration: Effective advocacy in psychiatric-mental health nursing often requires collaboration with interdisciplinary teams, including psychiatrists, psychologists, social workers, and other health-care professionals. Nurses advocate for clients by collaborating with team members to develop comprehensive care plans, ensuring that clients' needs are addressed holistically and that their voices are heard in the care process.

Evidence-based practice (EBP): Advocacy in psychiatric-mental health nursing is informed by EBP, which involves integrating the best available evidence with clinical expertise and client preferences. Nurses advocate for evidence-based interventions and practices that promote client autonomy, recovery, and well-being. This may include advocating for the implementation of psychoeducation, cognitive behavioral therapy, and other evidence-based therapeutic modalities.

Quality improvement: Advocacy in psychiatric-mental health nursing also involves participating in quality improvement initiatives aimed at enhancing client outcomes and safety. Nurses advocate for quality improvement by identifying areas for improvement in the delivery of psychiatric care, such as reducing stigma, improving access to mental health services, and promoting client empowerment and self-advocacy. By participating in quality improvement efforts, nurses contribute to the enhancement of psychiatric nursing practice and the delivery of high-quality, client-centered care.

Informatics: Technologies such as electronic medical records (EMRs) and medication distribution systems help to promote client safety, preventing harm and promoting client autonomy.

By incorporating advocacy into psychiatric-mental health nursing practice in alignment with QSEN competencies, nurses can effectively promote the rights, well-being, and recovery of individuals experiencing mental illness while contributing to the delivery of safe, high-quality care in psychiatric-mental health settings.

The client-centered care competencies (https://openstax.org/r/77clientcare) of knowledge, skills, and attitudes (KSAs) are expected of the student nurse as they transition to practice as a licensed nurse. The table serves as a resource to guide curricular development in formal academic nursing programs.

Power Sharing in the Therapeutic Relationship

The power to change and recover belongs to the client, and nurses share in the client's success. The therapeutic relationship is a helping relationship wherein a space is created for nursing interventions and client response. Goals of treatment are developed with the client and adjusted as care progresses; therefore, power is shared from the beginning. Allande-Cussó et al. (2022) assert that the nurse-client relationship is the foundation of nursing care, nursing skill, and nursing intervention simultaneously.

Nurse-client relationships function with respect and mutual decision-making, which promote independence and self-care for the client (Akpotor & Johnson, 2018). Nurse appreciation of the client experience enhances client participation. In focus group research, Beyene et al. (2018) found that clients may need differing levels of support to participate in care planning, even relying on nursing to make decisions. Nurses must respect this process of balancing responsibility with power, as this balance is essential in order to provide safe and optimal care (Beyene et al., 2018).

Challenges in Power Sharing

Nurses may view clients as incapable of participating in their own care due to their illness. Nurses may consider clients lacking in sufficient knowledge, motivation, or energy to resolve their own problems, especially if clients enter the health-care system frequently. Unfortunately, nurses may blame clients for their health-care needs.

Nurses may approach client care from a rescue perspective, believing that the nurse is the one to heal the client. If nurses approach client interactions with these concepts in mind, there could be an implied message of the nurse's greater power in the relationship. As mentioned, clients may present as dependent and be mindful of the imbalance in power between the client and the nurse. In these cases, nurses' attitudes may be reinforced and a cycle of imbalanced power results.

Application of Power-Sharing Techniques

Nurses must look honestly at their own beliefs before power-sharing skills can be acquired.

The practice of trauma-informed care (TIC) means that nurses realize the far-reaching effects of trauma in people's lives and refine nursing care accordingly in a manner that helps to share the power in the relationship through recognizing the needs of the client. The strategies in Table 12.1 utilize concepts of TIC from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2023).

Concept	Technique/Example
Safety	Manage the physical environment and provide information Example: The nurse ensures lighting and comfort for the interaction and explains what the conversation or procedure will be about.
Trust	Use open communication, transparency, and advanced notice Example: The nurse introduces self and invites the client to share. The nurse informs the client of scheduled activities.
Supportive others	Include family members and peers Example: The nurse acknowledges the client's supportive others.
Partnering	Level power differences between staff and client Example: The nurse speaks of staff members as collaborating to assist the client.
Empowerment	Build upon client's strengths and experience Example: The nurse assists the client with strengths identification. The nurse acknowledges the client's experience.
Cultural and gender issues	Move beyond stereotypes and bias Example: The nurse examines own values, is nonjudgmental of client's beliefs, and considers the client's perspective and incorporates it into mutual decision-making.

TABLE 12.1 Trauma-Informed Care

12.3 Self-Advocacy

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the components of self-advocacy
- Outline the strategies that a nurse can use to help promote self-advocacy for clients

Mental health clients enter treatment for various reasons, and it is important to remember that treatment is done with or alongside a client, not to a client. The goal is to work with the client in a collaborative fashion to achieve what they want and what they need, considering the client's values and beliefs. Mental health recovery belongs to the client, not the nurse. The objective is to accompany the client on their journey.

Defining Self-Advocacy in Mental Health

In a mental health context, **self-advocacy** means the ability to speak for oneself, have full autonomy, and complete agency. Self-advocacy means expressing personal beliefs, and making needs known, toward meeting personal goals. Ways to enhance and encourage self-advocacy in clients include asking the client to identify what they want and what they need and collaborating with them and their family to achieve the goals the client sets. Self-advocacy according to Davis (2021) includes the following:

- speaking up for yourself
- making your own decisions
- identifying support
- knowing and owning your rights
- using problem-solving skills
- learning about self-determination
- fighting for your independence
- owning your actions and words
- deciding what is suitable for you and going to get it

Self-advocacy can empower the individual, just as support and advocacy from others can promote empowerment. Empowerment is the ability to take the necessary action. For example, clients should feel empowered to ask questions if they feel unsure of something concerning decisions and treatment.

LINK TO LEARNING

Visit this website for a wealth of resources for mental health advocacy (https://openstax.org/r/77mtlhltresorcs) presented by the National Alliance on Mental Illness (NAMI).

Knowing oneself is a fundamental part of self-advocacy (Disability Resource Center, 2019). The support and encouragement of nurses and family members can hasten the client's ability to know who they are and begin the process of achieving self-advocacy. The ability to define their illnesses, strengths, and weaknesses is another important part of knowing their needs. The client is the best resource for their needs and accommodations they may require. As they evaluate previous experiences, they can identify what has worked and what has not. Knowing their individual needs can be an asset when conferring with nurses and other mental health-care professionals. Through identifying and putting into words the accommodations they may require, they are more likely to receive what they truly need.

National Alliance on Mental Illness (NAMI) advocate Tracie Noelle writes that mental health-care laws, government regulations, existing research, and standards compose a complex system for users to navigate (2016). Noelle endorses the following strategies for self-advocacy:

- Participate in the wider community and speak up for mental health resources.
- Strive for a balance between work and personal life.
- Work with professional organizations and personal support systems.
- Vote for political candidates who advocate for mental health needs and contact your representatives.

The Role of the Nurse in Promoting Self-Advocacy in Clients

Mental illness and other medical conditions share characteristics, such as chronicity, loss of control, and numerous treatment methodologies. Client advocacy is part of every nurse's role. When nurses keep clients safe, find answers to clients' questions, and bring clients' concerns to those able to address the concerns, this is client advocacy. When nurses teach and role model these actions, this is the promotion of client self-advocacy. The role of the psychiatric-mental health nurse in promoting self-advocacy in clients is critical because clients are socially and legally vulnerable (Faleti, 2020).

CLINICAL JUDGMENT MEASUREMENT MODEL

Applying the CJMM to Client Advocacy

Kimberly is a psychiatric nurse working in an inpatient psychiatric unit. She is assigned to care for Janet, a twenty-five-year-old female admitted voluntarily for treatment of severe depression and suicidal ideation. Janet has a history of trauma and has been struggling with feelings of hopelessness and worthlessness. Kimberly is responsible for providing therapeutic interventions and ensuring Janet's safety during her hospitalization.

Kimberly uses the Clinical Judgment Measurement Model to advocate for Janet.

CJMM Step	CJMM Data
Recognize Cues	Kimberly recognizes the cues indicating Janet's distress, including her withdrawn demeanor, tearfulness, and expressions of hopelessness. She assesses Janet's mental status and identifies potential risks to her safety, including the presence of suicidal ideation.
Analyze Cues	Kimberly analyzes Janet's behavior in the context of her psychiatric history and current symptoms. She considers the underlying factors contributing to Janet's depression, such as past trauma, and recognizes the importance of providing a safe and supportive environment for her recovery.
Prioritize Hypotheses	Kimberly prioritizes the need to address Janet's suicidal ideation and provide emotional support and therapeutic interventions. She considers the potential consequences of untreated depression and suicidal thoughts, including the risk of self-harm or suicide.
Generate Solutions	Kimberly develops a plan of care focused on suicide prevention and emotional support. She engages Janet in therapeutic communication, providing empathy, validation, and active listening. Kimberly collaborates with the treatment team to implement evidence-based interventions, such as cognitive behavioral therapy and medication management, tailored to Janet's individual needs.
Take Action	Kimberly takes proactive measures to ensure Janet's safety and well-being. She conducts frequent suicide risk assessments, implements safety precautions, and maintains close observation of Janet's behavior. Kimberly advocates for additional resources and support services to address Janet's complex needs effectively.
Evaluate Outcome	Kimberly evaluates the effectiveness of interventions by assessing Janet's response to treatment, including changes in her mood, thoughts, and behaviors. She monitors for signs of improvement or worsening of symptoms and adjusts the plan of care accordingly. Kimberly communicates regularly with Janet and the treatment team to ensure ongoing collaboration and support.

TABLE 12.2 CJMM Model for Advocacy for Janet

Kimberly demonstrates effective client advocacy in psychiatric-mental health nursing by applying the Clinical Judgment Measurement Model. Through recognition of cues, analysis, prioritization, generation of solutions, action, and evaluation, Kimberly advocates for Janet's safety, well-being, and recovery. By empowering, educating, supporting, collaborating with, and ensuring the safety of her client, Kimberly promotes compassionate and client-centered care in a psychiatric-mental health nursing situation.

Nurse as Educator

Client teaching may occur in formal or informal settings and may include instructions for significant life changes or simple tips for immediate change. The nurse's first step is to determine what the client already knows about the subject, then what, and how they would like to learn.

When teaching self-advocacy, the nurse may suggest the client keep a list of their questions to ask the provider on rounds or the social worker in a team treatment meeting. The nurse can pose questions to the client such as, "What is most important to you about _____?" or "How do you think we could best help you with this?" Then, the nurse develops strategies with the client to have their needs met, such as, practicing with the client how they will present their questions or how they will access resources.

Nurse as Role Model

When nurses are observed by peers and coworkers encouraging clients to participate in their care, this has influence. Other caregivers may witness how the nurse encourages and assists the client to advocate for self and realize the positive impact this can have on outcomes of care.

During interactions with other professionals, the nurse may prompt the client, "Was there more you wanted to discuss today?" or "Did you have another question about your medication?" This provides an invitation for the client to speak for self and feel successful in having their own needs met.

12.4 Client Advocacy

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the concepts involved in advocating for clients with a mental health problem
- Outline opportunities where nurses can advocate for clients
- Suggest ways that nurses can overcome any barriers to client advocacy

The ANA Code of Ethics defines one of the roles of a nurse as client advocate. In general terms, **advocacy** is supporting a cause or proposal; in nursing, advocacy for individual clients can include giving clients a voice; opening access to information and education on their condition; protecting and informing clients of their rights; ensuring accuracy, updates, and access to client records; and locating the resources the client needs. Some results of advocacy in nursing are improvement in quality of care, increases in client empowerment, enhancements to client safety, and improved access to health care (Hawai'i Pacific University, 2023).

Advocating for Clients

Client advocacy is an integral part of the nurse-client relationship, beginning with admission and gathering data concerning the client, their health, their medications, and their living conditions. True advocacy requires trust between the nurse and the client. Through the process of spending time listening to the client, the nurse and client establish a trusting relationship, which enables the client to share information. This kind of information is instrumental in nurses advocating for their clients, protecting clients' rights, and avoiding disparities in health care.

More broadly, some of the principles involved in client advocacy include protecting and advocating for the client's safety, rights, and health; providing optimal care and promoting clients' health; upholding clients' rights across the continuum of care; and incorporating social justice principles in health policies (ANA, 2015).

The American Psychiatric Nurses Association (APNA) notes that "As trusted healthcare professionals psychiatric-mental health nurses are positioned to be a voice for persons living with mental illness and those who care for them" (para 1). They provide a range of tools and links that can be used by psychiatric-mental health nurses to advocate for clients in the wider sense, for example with government representatives, newspaper editors, health-care organizations, and so forth (APNA, n.d.).

REAL RN STORIES

Nurse: Jordan
Years in Practice: Nine
Clinical Setting: Mental health inpatient facility
Geographic Location: Arizona

In the critical unit in a psychiatric hospital, Jordan, a registered nurse, encountered a challenging situation with a client named Harrison, a forty-year-old male admitted for treatment of severe bipolar disorder. Harrison had a

history of recurrent manic episodes and had been involuntarily admitted due to concerns for his safety and the safety of others. Despite his psychiatric diagnosis, Harrison was highly articulate and expressed a strong desire for autonomy in his treatment.

Upon admission, Harrison adamantly refused to take any psychotropic medications prescribed by the psychiatric team. He argued that the medications interfered with his creativity and autonomy, and he believed he could manage his symptoms through alternative therapies, such as meditation and exercise. Despite the medical team's concerns about the potential risks of untreated bipolar disorder, Harrison insisted on his right to refuse treatment.

Jordan recognized the importance of upholding Harrison's right to self-determination while also ensuring his safety and well-being. She engaged in therapeutic communication with Harrison, taking the time to listen to his concerns, validate his feelings, and understand his perspective. Jordan acknowledged Harrison's autonomy and his right to participate in decisions about his treatment plan.

Using her clinical judgment and advocacy skills, Jordan collaborated with the treatment team to explore alternative approaches to address Harrison's symptoms and promote his recovery. She advocated for the incorporation of nonpharmacological interventions, such as cognitive behavioral therapy, mindfulness techniques, and lifestyle modifications, into Harrison's treatment plan.

Jordan also facilitated open communication between Harrison and the psychiatric team, ensuring that his treatment preferences and goals were respected and considered in the decision-making process. She encouraged Harrison to actively participate in therapy sessions, psychoeducation groups, and self-management strategies to empower him in managing his condition.

Throughout Harrison's hospitalization, Jordan maintained a therapeutic relationship built on trust, empathy, and mutual respect. She monitored his mental status and safety closely, collaborating with the treatment team to develop contingency plans in case of symptom exacerbation or crisis situations. Jordan remained committed to supporting Harrison in his journey toward recovery while honoring his right to self-determination.

Despite the complexities of managing Harrison's bipolar disorder without medication, Jordan's client-centered approach and advocacy efforts resulted in positive outcomes. Harrison gradually engaged in therapy and adopted self-care practices to manage his symptoms effectively. With Jordan's support and encouragement, Harrison developed a sense of empowerment and self-efficacy in managing his mental health, paving the way for a more collaborative and autonomous approach to his treatment.

Opportunities for Nurses to Advocate for Clients

Nurses encounter the opportunity to advocate for clients throughout their day. Some areas include double-checking for errors in medication dosages, being proactive in communicating with the client's health-care team to avoid errors in treatment, ensuring family members understand the client's diagnosis and treatment plan, protecting the client's privacy rights by asking permission prior to discussing care while others are present, and teaching clients how to advocate for themselves (Hawai'i Pacific University, 2023).

LINK TO LEARNING

According to this article about the role of the nurse in client advocacy (https://openstax.org/r/77advocacy) from Hawai'i Pacific University, nurses spend a great deal of time with their clients, and fulfilling their obligation under the nursing code of ethics to advocate for their clients can make a significant difference in client outcomes.

In relation to how to conduct advocacy, Abbasinia et al. (2020) conducted a concept analysis of client advocacy and identified the following attributes: apprising, mediating, safeguarding, valuing, and championing social justice.

Apprising Clients

The definition of **apprising** is communicating something that is important to someone and updating when new information is available. With clients, this involves updating them concerning lab results, new orders, and responding to questions. Apprising is one way that a nurse advocates for an individual client. After all, an informed

client has more autonomy and is able to self-advocate more effectively, so this is one way of boosting client self-determination.

Mediating for Clients

There are situations when the nurse may be asked to speak for a client, to settle a dispute, or create agreement, which is called **mediating**. In such situations, a nurse is a liaison for the client with family members, other medical professionals, or the criminal justice system. This can involve informing other health-care professionals concerning the cultural values and preferences of the client. Dos and don'ts for mediation are listed in Table 12.3.

Do	Don't
Set realistic goals	Lose your temper
Listen/speak with respect	Be uncompromising
Be open-minded	Disparage the other party
Focus on the instant issue (not past grievances)	Lose perspective
Remember you all must live in the same community afterward	Forget this is a chance for the client to control the outcome

TABLE 12.3 Dos and Don'ts for Mediation (Texas Dispute Resolution, 2021)

Safeguarding Clients

Through attention to details, asking questions, checking in regularly with clients, and reviewing treatment plans, medications, and new orders, the nurse can protect, or **safeguard**, the client from mistakes, incompetence, or emotional or physical abuse. Reviewing the medical record for accuracy and protecting the confidentiality of client information are other essential actions. At the organizational level, nurses can participate in care conferences and ethics committees. Safeguarding is another subtle form of client advocacy.

Valuing Clients

Another way nurses can advocate for clients is by showing them that they have **value**, or respect for the person regardless of social factors, through meeting clients' physical, safety, belonging, self-esteem, and self-fulfillment needs. By demonstrating true caring through each of these needs, nurses show clients that they have value. Referrals to the appropriate outside resources also demonstrate that they have value (Sage et al., 2021).

Championing Social Justice in Health Care

Nurses also have a broader societal role to advocate for social justice in health care. Championing **social justice** in health care includes facilitating clients' access to health resources, addressing inequalities in health-care delivery, and identifying and confronting rules or policies in a health-care system that are inappropriate.

Nurses can champion social justice through the following strategies (Harris, 2023):

- creating a safe and inclusive space
- educating themselves and others
- providing resources and support
- taking breaks and prioritizing self-care
- seeking outside support

Barriers to Nursing Advocacy in Mental Health Care

Barriers to nursing advocacy exist in health-care settings and in mental health care. A major barrier is the overall lack of cooperation from clients, health-care providers, and health-care organizations. Other barriers include health-care organizations' bureaucracy, lack of support from doctors or limited supplies/medical equipment, inadequate communication among staff, lack of support from legal teams of the health-care organization and from families of clients, client lack of financial resources, fear of repercussions for advocating for clients, and limited knowledge

about client advocacy. Advocacy issues are often specific to the health-care setting in question, so solutions call for individualized approaches.

LIFE-STAGE CONTEXT

Self-Determination and Client Advocacy

In psychiatric-mental health nursing, client self-determination is a fundamental principle that applies regardless of age. Self-determination refers to the right of individuals to make decisions about their own treatment and care, based on their preferences, values, and goals, even in the context of mental illness. This principle is grounded in ethical principles such as autonomy and respect for persons. While self-determination is applicable to individuals of all ages, the capacity for decision-making may vary depending on developmental stage, cognitive abilities, and mental health status. Psychiatric-mental health nurses must assess each client's decision-making capacity on an individual basis, and advocate for them based on considering factors such as cognitive functioning, insight into illness, and ability to understand and appreciate treatment options.

In pediatric psychiatric nursing, nurses may encounter challenges related to assessing the self-determination of children and adolescents with mental health disorders. While younger clients may have limited decision-making capacity due to their developmental stage, nurses still strive to involve them in treatment decisions to the extent possible, advocating for their needs considering their evolving capacity for autonomy and involvement in care planning.

Cultural beliefs, values, and preferences may influence clients' attitudes toward self-determination and mental health treatment. Psychiatric-mental health nurses must consider cultural factors when engaging clients in discussions about treatment options and respecting their autonomy within cultural contexts.

Client self-determination in psychiatric-mental health nursing transcends age and requires a holistic approach that considers individual needs, capacities, and cultural backgrounds and these are used as a basis for advocating for the needs of the client.

Resources and Support

The lack of support from doctors or legal teams of the health-care organization, lack of client financial resources, and limited supplies were found to have interfered with nurse advocacy.

Possible solutions include the following:

- creating and disseminating guidelines for bringing advocacy issues forward
- developing policies protecting advocates from negative consequences
- promoting an overall culture of advocacy with necessary reporting and oversight
- involving nurse leaders and front-line nurses in resources planning

Knowledge and Communication

Limited knowledge about client advocacy; nurses' concerns surrounding clients' culture, religious beliefs, and literacy; and health-care organizations' bureaucracy hindered advocacy efforts. Inadequate communication among staff was also an obstacle. Possible solutions include the following:

- Organizational leadership should make information available throughout the institution and work to streamline processes connected with advocacy.
- Nurses should allow for cultural variation and let clients know they have choices, for example, asking, "How can we work within your values to provide your care?" or inviting the spiritual advisor to a care conference.
- Organizational leadership should provide nurse training on the implementation of clients' rights, which may include refusal of care, so that advocacy can be appropriately applied.
- Organizational leadership should include therapeutic communication and interpersonal skills training in all nursing educational offerings.

Fear

Nurses may be afraid of repercussions from advocating for clients. Nurses may not be assertive at heart, similar to

members of other service professions where giving is the intended action and the dissenting voice is not natural. Hierarchal relationships may prevent communication flow.

Possible solutions include the following:

- Nursing leaders should apply clinical supervision to promote client advocacy.
- Nursing leaders should acknowledge awareness of barriers to nursing advocacy and open problem-solving among nursing staff.
- Physicians' viewpoints should be requested on nursing advocacy.
- Health-care organizations must embrace client advocacy as an inclusive effort to promote safety and quality in the care setting.

Summary

12.1 Client Representation for Empowerment and Relationship Rebuilding

Nurses play a role in client advocacy, particularly in circumstances where clients are unable to adequately represent themselves, or have the legal designation of diminished responsibility. Nurses should be aware of the civil rights of those with mental illness diagnoses. Empowerment leads to self-reliance, participation in decisions, dignity and respect for us and others, and the knowledge of belonging and contribution to a wider community.

12.2 Autonomy and Independence

Autonomy and independence are not the same. Autonomy is the ability to make decisions for self. Independence is the ability for self-care. Mental health issues can impair clients from making appropriate decisions and taking care of themselves. Restrictions on autonomy are justified by ethics, law, and welfare in situations where clients are unable, because of impairments, to self-determine or act independently in their best interests. The nursing skill of power sharing can enhance nurse-client relationships and is flexible if there are levels in the client's self-care ability.

12.3 Self-Advocacy

Self-advocacy evolves through empowering and assisting clients to speak for themselves to express needs, concerns, and questions about their condition and their treatment. Self-advocacy is a skill to be acquired and nurses have a significant role in this learning through direct instruction as well as through role modeling.

12.4 Client Advocacy

Client advocacy comes into play as nurses care for clients daily, despite barriers that do exist. Included in advocacy is keeping clients informed of the plan of treatment, mediating for clients with others, being diligent to safeguard clients through assessment for possible abuse, and ensuring clients know the value placed on them through the care, compassion, and support. Nurses place importance on championing the role of social justice in ensuring all clients receive the same level of care. Barriers to client advocacy include nursing fear, lack of organizational cooperation and materials, bureaucracy, and limited client financial resources.

Key Terms

advocacy supporting a cause or proposal
agency feeling of being in charge of one's life
apprising informing someone
client representation consulting with the client regarding the client's objectives, how the client wants to proceed, and then take the action approved by the client
diminished responsibility reduces liability for a criminal act on the part of a defendant who has experienced certain alterations in thought processes
empowerment assist individual to take action toward improving their own health
enablement attempt to make life easier for an individual with negative consequences
independence ability to do things on one's own
mediating speak for a client, settle a dispute, or create agreement
rationality apparent logical decisions given for unconscious impulses
safeguard protect
self-advocacy ability to speak for oneself, have full autonomy, and complete agency
social justice fair distribution of resources and opportunities
value respect for the person regardless of social factors

Assessments

Review Questions

1. With empowerment, clients can experience strong, healthy relationships. What are two components of empowerment? Select two that apply.

    a. self-reliance

b. client representation
c. relinquishing control
d. community contribution

2. The Americans with Disabilities Act (ADA) is the civil rights law ensuring that persons with disabilities receive protections from discrimination with respect to what?
a. representation in court
b. financial assistance
c. health insurance coverage
d. employment and public services

3. Certain diagnoses may be legally accepted for the defense of diminished responsibility. What would nursing education for families of these clients likely include?
a. providing testimony in court
b. arrangements for long-term care
c. communication and coping skills
d. locating a mental health attorney

4. How can empowerment for clients be described?
a. destabilizing
b. unattainable
c. a journey
d. a destination

5. A client with bipolar disorder in their euphoric state may demonstrate the lack of ability to make appropriate decisions related to spending money. What would be an appropriate restriction for this client?
a. agency
b. rationality
c. autonomy
d. legal rights

6. What term describes a client's ability to perform ADLs without assistance?
a. autonomy
b. use of reason
c. independence
d. use of defense mechanisms

7. What remark could a nurse make to a colleague that shows that they have been challenged to accept power sharing in client relationships?
a. "There is a phone number in the client's record for a peer counselor."
b. "Family members have been visiting each evening."
c. "The client attends to hygiene independently."
d. "The client is readmitted again! I will have to make a better discharge plan for him this time."

8. When does power sharing with a client begin?
a. when the treatment with the client has been successful
b. immediately when the nurse meets the client
c. after the client agrees to take their medication
d. when the nurse is instructed to do so by the care team

9. What is self-advocacy?
a. the ability to speak for yourself
b. learning how to complete your admission paperwork

c. allowing others to speak for you
d. doing whatever you are told

10. What could be suggested as a strategy to promote self-advocacy? Select all that apply.

a. Participate in the wider community.
b. Place more importance on work than personal life.
c. Vote for politicians who promote mental health needs.
d. Speak up for mental health services.

11. What would the nurse suggest to a client when helping them to develop their self-advocacy? Select all that apply.

a. Get others to speak up for you.
b. Identify your support systems.
c. Know your rights.
d. Fight for your independence.

12. Why do clients share information with nurses?

a. legal issues
b. financial concerns
c. trust in the nurse
d. mediation

13. What helps to promote nurse advocacy with clients?

a. the client's poor financial support
b. the lack of support from the health-care organization
c. limited supplies
d. involvement of nurse leaders in resource planning

14. What is a result of advocacy with clients in nursing?

a. Client safety improves.
b. Quality of care levels off.
c. Issues with accessing health care occur.
d. Clients feel disempowered.

Check Your Understanding Questions

1. Identify the difference in empowerment and enablement and give examples of both.

2. What is a fundamental part of self-advocacy?

3. Identify how the role of the nurse in self-advocacy can achieve results for the client.

4. Identify barriers to nursing advocacy in mental health care.

Reflection Questions

1. The WHO definition of empowerment is a multidimensional social process through which all people can gain a better understanding and control of their lives and their statements. What additional processes are included in the process of empowerment?

2. In mental health recovery, agency plays a large role as the client begins to return the ability to be in charge of their lives and become the owner of their thoughts, feelings, actions. Describe how people can lose agency in their lives and how it can affect their mental health.

3. What can be the result when mental health problems interfere with decision-making?

4. How could a new nurse include clients' self-advocacy in their own nursing practice?

5. Explain the role of a nurse as a client advocate in mental health. What are some ethical principles related to client advocacy, and how do they contribute to improved quality of care, client empowerment, and safety?
6. Nurses can champion social justice for all clients, especially mental health clients, by facilitating clients' access to health resources, addressing inequalities in health-care delivery, and identifying and confronting rules or policies in a health-care system that are inappropriate. Identify other ways that nurses can advocate for social justice in the health-care system.

What Should the Nurse Do?

Max, a forty-five-year-old male, has presented himself at the community health clinic due to recent changes in his mental health. Upon further exploration, it is revealed that Max's medical history is quite complex. Diagnosed with bipolar disorder several years ago, he has been actively engaged in his treatment plan, which includes a combination of mood stabilizers and regular therapy sessions. Over the years, Max has demonstrated resilience in managing his mental health. However, the recent alterations in his emotional well-being have prompted his visit today. He reports feeling overwhelmed and anxious, accompanied by persistent feelings of sadness, which he describes as more intense than his usual mood swings associated with bipolar disorder. This shift in his emotional state raises concerns about the efficacy of his current treatment plan and the need for a comprehensive reassessment. Vital signs assessment reveals an elevated heart rate and increased blood pressure, indicating a physiological response to his heightened emotional distress. Understanding the physiological impact of his mental health challenges is integral in devising a holistic care plan that addresses both the psychological and physical aspects of his well-being.

1. In Max's case, where could client representation be essential, considering his recent changes in mental health? How might effective representation positively impact Max's overall care and treatment?
2. Given Max's diagnosis of bipolar disorder, how might diminished responsibility manifest in his case? Discuss potential legal and ethical considerations for the mental health nurse when dealing with Max's diminished responsibility.
3. Considering Max's recent emotional distress, discuss how the empowerment process could benefit him in regaining control of his life. How might empowerment contribute to Max's ability to navigate the complexities of his mental health?
4. Identify specific situations in Max's case where the empowerment approach would be crucial. How can nurses differentiate between empowering and enabling behaviors in supporting Max?

Monica, a thirty-two-year-old female, seeks assistance at the psychiatric clinic due to significant alterations in her mental health. Monica reports a progressive escalation in anxiety levels, characterized by frequent panic attacks and their subsequent interference with her daily life over the past month. Delving into her comprehensive medical history reveals a diagnosis of generalized anxiety disorder (GAD), a condition that has prompted a multifaceted treatment approach. Monica has actively engaged in cognitive behavioral therapy sessions and adhered to pharmacological interventions aimed at managing her symptoms. Unfortunately, despite her diligent efforts and ongoing treatment, Monica's condition has taken a downturn, manifested by a noticeable surge in heart rate and blood pressure observed during her clinic visit.

5. Explain how Monica's autonomy might be compromised due to her mental health symptoms.
6. Discuss the concept of agency and its role in mental health recovery, particularly in Monica's situation.
7. Under what circumstances might restrictions on a client's autonomy be justified, and how does this apply to Monica's situation?

Ebony, a fifty-five-year-old female, arrives at the local community health clinic seeking assistance with her complex health concerns. Her health history is intricate, encompassing both physical and mental health challenges. Diagnosed with rheumatoid arthritis a decade ago, Ebony has encountered persistent joint pain, stiffness, and swelling. Her arthritis management plan involves a combination of disease-modifying antirheumatic drugs (DMARDs) and nonsteroidal anti-inflammatory drugs (NSAIDs). Beyond her physical health issues, Ebony has faced significant psychological challenges. A detailed mental health history reveals a past diagnosis of generalized anxiety disorder (GAD), which has manifested as heightened anxiety and stress. She reports recurrent panic attacks and experiences constant worry about her health, further exacerbating the impact of her arthritis symptoms on her daily life. These mental health struggles have led to feelings of frustration, helplessness, and a sense of being overwhelmed. Ebony's history includes episodes of difficulty in adhering to her treatment plan. She acknowledges

periods of noncompliance with medications due to concerns about side effects and fears of dependency.

8. Define the components of self-advocacy and explain how Ebony can exercise self-advocacy in her mental health journey.
9. Outline strategies that a nurse can employ to promote self-advocacy for Ebony, considering her complex health history and mental health challenges.

Pilar, a fifty-eight-year-old female, visits a community health clinic, offering a glimpse into the intricacies of her mental health challenges. Beyond the evident emotional symptoms of persistent sadness, social withdrawal, and difficulty concentrating, Pilar unfolds a comprehensive health history that enriches the understanding of her current situation. In the realm of psychiatric history, she reveals a long-standing journey with depression and anxiety, punctuated by interactions with mental health professionals and intermittent use of antidepressant medications. This context provides valuable insights into the recurrent nature of her symptoms and underscores the need for a nuanced approach to her care. On the health front, Pilar manages hypertension with antihypertensive medications, introducing a chronic condition that adds a crucial layer to her overall well-being. Furthermore, sporadic palpitations and shortness of breath hint at a potential interplay between her mental health challenges and cardiovascular symptoms, emphasizing the importance of a holistic care strategy. During the clinic visit, vital signs are recorded, indicating an elevated blood pressure that underscores the ongoing challenge of hypertension management and a heart rate within the normal range but reflective of increased sympathetic activity, possibly linked to the emotional distress Pilar is experiencing.

10. How does the information revealed in Pilar's case study highlight the role of a nurse as a client advocate in mental health? Provide examples from her case that align with the ANA Code of Ethics and principles of client advocacy.
11. Based on Pilar's case, discuss specific opportunities where nurses can advocate for mental health clients, considering her psychiatric history, struggles with adherence, and the interplay between mental health and physical health.
12. Identify and discuss potential barriers to advocating for mental health clients, as illustrated in Pilar's case. How can nurses overcome these barriers to ensure effective advocacy?

Competency-Based Assessments

1. Describe the circumstances in which mental health nurses might need to act as client advocates, do some research, and provide some examples.
2. How can mental health nurses encourage empowerment in clients with mental health challenges, considering dimensions like self-reliance, participation in decisions, dignity and respect, and autonomy?
3. In what scenarios would a nurse employ an empowerment approach in mental health care? Discuss how empowerment contributes to building healthy relationships and problem-solving skills.
4. Describe a situation wherein autonomy would be connected to freedom for a mental health client to make personal decisions.
5. Outline how QSEN concepts can be applied when restrictions on a client's autonomy are justified in mental health care.
6. Name the key components of self-advocacy, and explain how each relates to a client's ability to speak for oneself, autonomy, and agency.
7. List and explain strategies that a nurse can employ to promote self-advocacy in mental health clients. How does the therapeutic nurse-client relationship contribute to the development of self-advocacy?
8. There are various areas where nurses can advocate for clients with a mental health disorder. Review and share three areas indicated in the discussion.
9. Identify various opportunities nurses encounter to advocate for mental health clients. How does advocacy manifest in day-to-day nursing activities, such as medication management, communication with the health-care team, and involving family members?
10. Discuss common barriers to nursing advocacy in mental health care. How can nurses overcome these

barriers, especially in situations involving lack of cooperation, bureaucratic challenges, and concerns about repercussions or cultural differences?

References

Abbasinia, M., Ahmadi, F., & Kazemnejad, A. (2020). Patient advocacy in nursing: A concept analysis. *Nursing Ethics, 27*(1), 141–151. https://journals.sagepub.com/doi/10.1177/0969733019832950

ADA National Network. (2018). *Mental health conditions in the workplace and ADA.* ADA National Network. Retrieved September 7, 2023, from https://adainfo.us/ADAMentalhealth

Akpotor, M. E., & Johnson, E. A. (2018). Client empowerment: A concept analysis. *International Journal of Caring Sciences, 11*(2), 743. https://www.internationaljournalofcaringsciences.org/docs/14._akpotor_original_10_2.pdf

Allande-Cussó, R., Fernández-García, E., & Porcel-Gálvez, A. M. (2022, March). Defining and characterising the nurse-patient relationship: A concept analysis. *Nursing Ethics, 29*(2), 462–484. https://www.doi.org/10.1177/09697330211046651

Alsbrook, K. E., Donovan, H. S., Wesmiller, W. S., & Thomas, T. H. (2022). Oncology nurses' role in promoting patient self-advocacy. *Clinical Journal of Oncology Nursing, 26*(3), 239–243. https://www.ons.org/cjon/26/3/oncology-nurses-role-promoting-patient-self-advocacy

American Bar Association. (2024). *Rule 1.2: Scope of representation & allocation of authority between client & lawyer*. https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_2_scope_of_representation_allocation_of_authority_between_client_lawyer/

American Nurses Association. (2015). *Nursing: Scope and standards of practice* (3rd ed.). ANA.

American Psychiatric Nurses Association. (n.d.). *Advocacy tools*. https://www.apna.org/resources/advocacy-tools/

Beyene, L. S., Severinsson, E., Hansen, B. S, & Rørtveit, K. (2018, January). Shared decision-making-balancing between power and responsibility as mental health-care professionals in a therapeutic milieu. *SAGE Open Nursing, 11*(4), 2377960817752159. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7774362

BRC Healthcare. (2021, July 27). *Enabling vs empowering*. https://www.brcrecovery.com/blog/enabling-vs-empowering/

Davis, S. (2021, September 13). *Self-advocacy: The basis of self-care*. https://cptsdfoundation.org/2021/09/13/self-advocacy-the-basis-of-self-care/

Directorate-General for Health & Consumers. (2010). *User empowerment in mental health*. WHO Regional Office for Europe. https://consaludmental.org/publicaciones/Userempowermentinmentalhealth.pdf

Disability Resource Center. (2019). *What is self-advocacy?* https://thearc.org/get-involved/self-advocacy/

Edmunds, D. L. (2013). *Autistic empowerment*. https://www.psychologytoday.com/intl/blog/extreme-states-mind/201306/autistic-empowerment

Faleti, D. (2020, September 7). *Advocacy in mental health nursing*. https://mhdinitiative.org/2020/09/07/advocacy-in-mental-health-nursing/

Fowler, D. M. (2015). *Guide to the code of ethics for nurses with interpretive statements* (2nd ed.). American Nurses Association.

Hammarström, L., Häggström, M., Devik, S. A., & Hellzen, O. (2019, December). Controlling emotions-nurses' lived experiences caring for patients in forensic psychiatry. *Int J Qual Stud Health Well-being, 14*(1),1682911. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6818121/

Harris, J. (2023, January 6). *The impact of social justice issues on mental health*. Natural Appraise on Mental Illness (NAMI). https://nami-dac.org/the-impact-of-social-justice-issues-on-mental-health/

Hawai'i Pacific University. (2023). *Nursing advocacy: The role of nurses advocating for patients*.

https://online.hpu.edu/blog/nursing-advocacy

Hearth, S. (2022, April 28). *How do you empower someone with mental health?* https://wellbeingport.com/how-do-you-empower-someone-with-mental-health-issues/

Johnston, E. L. (2024). Imperfect insanity and diminished responsibility. Florida Law Review, Forthcoming, Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4696928

Lehrer, D. (2021, June). Compassion in corrections: The struggle between security and health care. *J Correct Health Care, 27*(2), 81–84. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9041396/

Liu, L., Daum, C., Cruz, A. M., Neubauer, N., Perez, H., & Rincon, A. R. (2022). Ageing, technology, and health: Advancing the concepts of autonomy and independence. *Healthcare Management Forum,* 35(5), 296–300. https://www.doi.org/10.1177/08404704221110734

Mental Health America. (2023). *Mental health and criminal justice issues*. http://mhanational.org/newsroom/chimng-in

Missouri State Public Defender. (2016). *Health guide to mental health evaluations for competence to proceed and responsibility for the charged offence*. https://publicdefender.mo.gov/wp-content/uploads/2021/05/MSPD-Guide-to-Mental-Health-Evaluations-2016.pdf

Molina-Mula, J., & Gallo-Estrada, J. (2020, January 29). Impact of nurse-patient relationship on quality of care and patient autonomy in decision-making. *Int J Environ Res Public Health, 17*(3), 835. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7036952/

Noelle, T. (2016). *Do you know the layers of self-advocacy?* National Alliance on Mental Illness (NAMI). https://www.nami.org/Blogs/NAMI-Blog/October-2016/Do-You-Know-the-Layers-of-Self-Advocacy

Nsiah, C., Siakwa, M., & Ninnoni, J. P. K. (2019, December 19). Barriers to practicing patient advocacy in healthcare setting. *Nurs Open, 7*(2), 650–659. https://www.doi.org/10.1002/nop2.436. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7024610/

Pecorino, P. (2002). *Medical ethics: An online textbook*. https://www.qcc.cuny.edu/socialSciences/ppecorino/MEDICAL_ETHICS_TEXT/default.htm

Pugh, J. (2020). Autonomy, Rationality, and Contemporary Bioethics [Internet]. Oxford University Press. Available from: https://www.ncbi.nlm.nih.gov/books/NBK556865/

Sage, J., Witkowski, M., & Opelka, F. (2021). *Expressing value in health care*. https://bulletin.facs.org/2021/07/expressing-value-in-health-care/

Spriggle, T. (2017, February 9). *Does the ADA cover psychiatric disabilities?* The Spriggle Law Firm. https://spigglelaw.com/does-the-ada-cover-psychiatric-disabilities/

Substance Abuse and Mental Health Services Administration. (2019). *Civil commitment and the mental health care continuum*. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf

Substance Abuse and Mental Health Services Administration. (2022). *About criminal and juvenile justice.* https://www.samhsa.gov/criminal-juvenile-justice/about

Substance Abuse and Mental Health Services Administration. (2023). *Practical guide for implementing a trauma-informed approach*. https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf

Texas Dispute Resolution System. (2021, November 7). *Mediation and mental health best practices handbook*. https://www.ncsc.org/__data/assets/pdf_file/0024/72843/SJI-Texas.pdf

Toledano-Gonzalez, A., Labajos-Manzanares, T., & Romero-Ayuso, D. (2019). Well-being, self-efficacy and independence in older adults: A randomized trial of occupational therapy. *Archives of Gerontology and Geriatrics,* 83, 277–284.

Wheeler, B. (2020, May 26). *Loss of agency: How domestic violence impacts mental health*. https://www.wadvocates.org/2020/05/26/loss-of-agency-how-domestic-violence-impacts-mental-health/

World Health Organization. (2024). *Health promotion action means*. https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference/actions

CHAPTER 13
Clinical Guidelines and Practice

FIGURE 13.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION The American Psychiatric Nurses Association (2023) describes the practice of psychiatric-mental health (PMH) nursing as the provision of relationship-based care, holistic in scope, and oriented toward recovery and wellness. This practice encompasses work with individuals, families, and communities and in collaboration with an interprofessional team. PMH nurses incorporate cultural considerations, social determinants of health, and ethical/legal guidelines into their practice.

In the United States, individual state boards of nursing set the regulatory practice standards for each state. Additional guidelines and standards also exist at both federal and institutional levels for nurses to follow. Care planning is performed in conjunction with an interdisciplinary care team—psychiatrists, psychiatric-mental health nurse practitioners, clinical psychologists, licensed professional counselors, social workers, therapists, and other disciplines—with guidance by the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (*DSM-5-TR*) (2022) published by the American Psychiatric Association. The *DSM-5-TR* is the standard reference in clinical practice for the diagnosis of mental health disorders. These diagnoses form the basis for understanding the signs, symptoms, and recommended evidence-based approaches to treatment and care for the wide range of

disorders that clients with PMH disorders may present.

13.1 Clinical Guidelines and Standards

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the governing entities of nursing that have the authority to set nursing standards
- Describe the role of state boards of nursing
- Provide examples of how standards are set at the federal and local levels

A range of governing entities oversees nurses, as health-care professionals, in order to ensure that they are complying with the required standards of practice; these standards may be federal, state, local, or institutional. The understanding of nursing standards and regulations begins during nursing education and is continued through the licensure process, and for the length of the nurse's career. To ensure that nurses maintain and uphold these standards, the regulations developed for nursing practice are set, and compliance is monitored, by professional bodies, federal and state governmental bodies, and the health-care organizations themselves.

Standards of Nursing Practice

The **standards of nursing practice** are developed to ensure best practices and expectations in nursing care. These standards can be utilized to compare the nurse's performance with the current standard of nursing care and are used to maintain safety and competent nursing practice. Specifically, standards of nursing practice help to guide the provision of care to clients by nurses, give organizations rules by which to evaluate nursing care, and allow for accountability for clinical decisions and actions. Several organizations develop professional standards of practice, such as the American Nurses Association (ANA) and the **American Psychiatric Nurses Association (APNA)**. Standards of practice are established for the generalist nurse as well as specialty nursing areas, including psychiatric-mental health nursing.

LINK TO LEARNING

The American Nurses Association (ANA) describes the Standards of Practice (competence in use of the nursing process) and the Standards of Professional Performance (competence in role behavior) in the publication *Nursing: Scope and Standards of Practice*, Fourth Edition (2021). Read this sample chapter (https://openstax.org/r/77ANAStdPrac) to get a glimpse into the full document.

The American Nurses Association

The **American Nurses Association (ANA)** is a professional organization that advances and protects the nursing profession. The nurse will find many valuable tools on the ANA website that can be applied to their practice and improve the care of clients. Founded in 1896, the ANA intends to: "foster high standards of nursing practice; promoting a safe and ethical work environment; bolstering the health and wellness of nurses; and advocating on health care issues that affect nurses and the public" (ANA, n.d.-a, para 3). The ANA partners with the Standards for Excellence Institute to provide resources for best practice (ANA, 2015). Professional standards published by the ANA are meant to provide direction to nurses across the nation, influence legislation, and implement a framework to evaluate nursing excellence (ANA, 2015).

The ANA standards include the Code of Ethics for Nurses, which guide nursing responsibilities and ethical obligations. The ANA Nursing Standards also include the scope and standards of practice describing the art and science of nursing, as well as Standards of Professional Performance. The nursing process is a critical thinking model, which includes six components as reflected in the first six standards (Figure 13.2):

- Standard 1. Assessment: The registered nurse collects pertinent data and information relative to the health-care consumer's health or the situation.
- Standard 2. Diagnosis: The registered nurse analyzes the assessment data to determine actual or potential diagnoses, problems, and issues.
- Standard 3. Outcomes Identification: The registered nurse identifies expected outcomes for a plan individualized to the health-care consumer or the situation.

- Standard 4. Planning: The registered nurse develops a plan that prescribes strategies to attain expected, measurable outcomes.
- Standard 5. Implementation: The registered nurse implements the identified plan.
  - Standard 5A. Coordination of Care: The registered nurse coordinates care delivery.
  - Standard 5B. Health Teaching and Health Promotion: The registered nurse employs strategies to promote health and a safe environment.
- Standard 6. Evaluation: The registered nurse evaluates progress toward attainment of goals and outcomes.

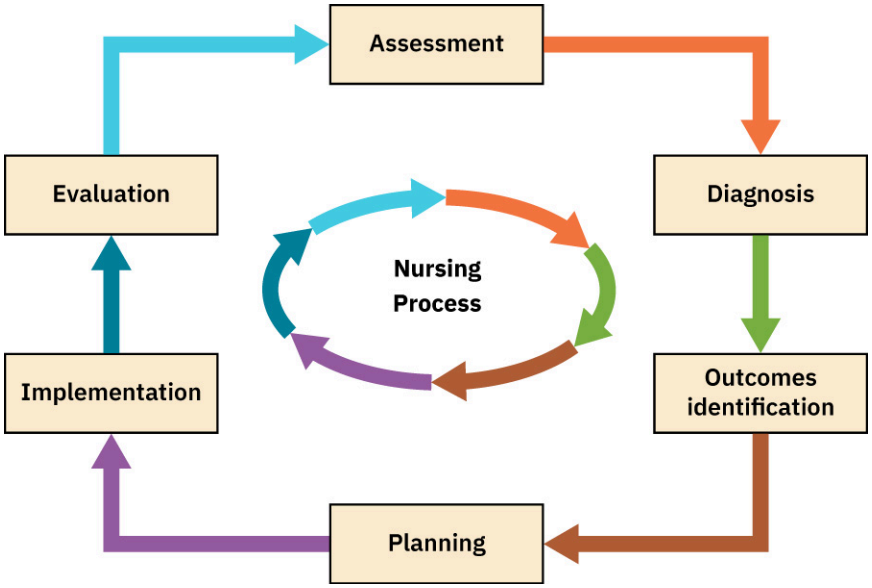


FIGURE 13.2 The nursing process is a critical thinking model based on a systematic approach to client-centered care. (modification of work from *Clinical Nursing Skills*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The ANA Position Statements describe the stance of the ANA on various topics that may arise. These topics include artificial intelligence in nursing practice, racism in nursing, risk and responsibility in providing nursing care, nursing role and workforce issues, and technology in health care. The ANA Principles for Nursing Practice describe the more day-to-day guidelines as "aimed at giving you practical information for your professional practice" (ANA, n.d.-b, para 10). Areas addressed include documentation processes, delegation, and staffing. They also address nursing pay and offer solutions of changing insurance reimbursement to health-care organizations through a pay for quality process.

Councils for State Boards of Nursing (NCSBN)

The National Council of State Boards of Nursing (NCSBN) is composed of the state nursing regulatory bodies (NRB) whose mission is to protect the public by ensuring licensed nurses provide safe and competent care (NCSBN, 2023). The NCSBN, which is the body that affiliates all of the NRB, guides the NRB on topics like risk analysis, monitoring of nursing education programs for curriculum content, pass rates, and employment rates. The nursing regulatory bodies are the state boards of nursing in all 50 states, the District of Columbia, and four U.S. territories. The NRB's role is to "monitor licensees' compliance to jurisdictional law and take action against the licenses of those nurses who have exhibited unsafe nursing practice" (NCSBN, n.d., para 2). Each state board of nursing enforces the Nurse Practice Act of each jurisdiction. Each act contains qualifications for licensure, including what titles may be used; defines the nurses' scope of practice; and outlines the outcomes if the nurse does not follow the law. The guiding principle of the NRB is to "develop policy, design regulation, administer and enforce regulatory law and rules to accomplish their mandates of protecting the safety of the public" (NCSBN, 2022, para 2). Moreover, the NRB develops regulations based upon the NCSBN Model Act (2021) whose purpose is to protect the health, safety, and welfare of the public. The **NCSBN Model Act** defines the scope of practice for all levels of nursing, from licensed practical/vocational nurses and registered nurses to advanced practice registered nurses, and each is different. The NCSBN also defines the makeup of the membership of each individual board of nursing to include members from each licensure field as well as a member from the public. One specific role of state boards of nursing is to assure the public of nursing competency. Nurse licensure ultimately serves to protect the public, as defined by law. Therefore, non-nurse members of the public serve on state boards (NCSBN, 2021).

The NCSBN also developed the Clinical Judgment Measurement Model (CJMM) to guide decision-making on the nurse licensure exam Table 13.1. The ANA Standards apply to clinical reasoning nurses must utilize in practice. Terminology may differ, as indicated in the following table, but the concepts are synonymous. Both the CJMM and the ANA Standards outline a cyclical process strategy to ensure a competent level of nursing care and to evaluate that process—whether by testing or in actual practice. The overall term nursing process is the nurse's thinking that drives nursing action.

ANA Standards	NCSBN CJMM	Meaning in Nursing Process
Assessment	Recognizing cues	Collecting data and noticing which are relevant to care
Diagnosis	Analyzing cues	Determining what could be contributing to the relevance of the data
Outcomes identification	Prioritizing hypotheses	Deciding which to address first and what are the goals or desired results
Planning	Generating solutions	Formulating what to do
Implementation	Taking actions	Doing what has been planned
Evaluation	Evaluating outcomes	Summarizing success of the plan; revising if necessary

TABLE 13.1 Comparison of Terminology—ANA Standards, CJMM and Nursing Process

The American Psychiatric Nurses Association

The American Psychiatric Nurses Association (APNA) is a professional organization that provides leadership in issues related to all nurses working in the mental health field in all practice settings. The APNA publishes the *Psychiatric-Mental Health Nursing, Scope and Standards of Practice*, Third Edition. These standards were developed in collaboration with the ANA and the International Society of Psychiatric-Mental Health Nurses (ISPN). The standards are authoritative statements that describe the responsibilities for which its practitioners are held accountable (APNA-ISPN Scope and Standards Revision Joint Task Force, 2022) for psychiatric mental-health nurses. There are seventeen standards published and each standard has associated competencies. These standards outline the nursing process and coordination of care, health teaching and literacy, as well as pharmacological and biological, complementary/integrative therapies, and milieu therapy. They discuss the importance of therapeutic relationships, counseling and psychotherapy, and evaluation. The standards also cover professional performance, including ethics, cultural humility, communication, professional collaboration, leadership and education, evidence-based practice, and research as well as quality, professional practice evaluation, resource utilization, recovery-oriented care, and environmental health.

PSYCHOSOCIAL CONSIDERATIONS

American Psychiatric Nurses Association Standard Regarding Cultural Humility

The APNA's Scope and Standards of Practice (2022) indicate that a Psychiatric-Mental Health Registered Nurse (PMH-RN) must practice from a perspective of cultural humility.

Awareness, through self-reflection, is important so that nurses can open their thinking to consider inclusivity; one good place to start is through collaborating with colleagues of different cultures. Nurses can also accomplish this by reading professional publications, such as *Minority Nurse, Journal of the National Black Nurses Association,* and *The Journal of Transcultural Nursing*, or scholarly articles, such as "Health Inequities in LGBT People and Nursing Interventions to Reduce Them: A Systematic Review" by J. Medina-Martínez et al., published in the *International*

Journal of Environmental Research and Public Health (2021).

Exposure to this information may enable the nurse to recognize personal views that may have been obstacles to cultural humility. Next, the nurse should seek opportunities to attend culturally diverse presentations and events. A good starting place is the recorded presentations (https://openstax.org/r/77USDeptHlthHumn) available from the U.S. Department of Health and Human Services.

National League for Nursing (NLN)

The National League for Nursing (NLN) was the first nursing organization in the United States, started in 1893. The NLN's mission and focus is on nursing education, specifically to promote "excellence in nursing to build a strong and diverse nursing workforce to advance the health of our national and the global community" (NLN, n.d., para 1). The NLN reports its core values as caring, integrity, diversity and inclusion, and excellence. Its commitment includes enhancing the NLN both at a national and international level as a leader in nursing education. The NLN reports a commitment to, and seeks to be the voice of, nurse educators in all specialties, including performing and publishing research and evidence regarding nursing education and teaching. For nurse faculty, the NLN offers professional development opportunities, access to data and grants, and certification as a Certified Nurse Educator (CNE). Students benefit from the NLN's efforts to contain costs and facilitate access to nursing education, diversify the nursing workforce, and ease transition to higher degree programs (NLN, 2011).

Quality and Safety Education for Nurses (QSEN)

The Quality and Safety Education for Nurses (QSEN) initiative addresses the knowledge, skills, and attitudes (KSA) required to improve the quality and safety of the health-care system. Its website provides information on the QSEN (https://openstax.org/r/77QSENinfo) competencies, KSAs, teaching strategies, and faculty development to support safety and quality in health care.

In 2000, the Institute of Medicine published reports calling for systems redesign in health care to address safety and quality. In 2005, the Robert Wood Johnson Foundation provided funding for nursing leaders to develop quality and safety competencies for nursing. These competencies were included in nursing education curricula, and now are incorporated into the ANA's Nursing Alliance (https://openstax.org/r/77competencyANA) for Quality Care.

QSEN utilizes the Institute of Medicine competencies, QSEN faculty, and a national advisory panel to define quality and safety competencies for nursing both at the graduate and undergraduate levels. QSEN focuses on KSAs in the areas of client-centered care, teamwork and collaboration, evidenced-based practice, quality improvement, safety, and informatics.

QSEN competencies are integrated into nursing education programs to ensure that students are adequately prepared to meet the challenges of providing safe, high-quality care in a rapidly evolving health-care landscape. The QSEN initiative emphasizes the importance of interprofessional education and collaboration, recognizing that safe and effective care requires a team-based approach. The aim of incorporating QSEN principles is to provide client-centered care, work effectively in teams, utilize evidence-based practice, contribute to quality improvement efforts, prioritize client safety, and leverage informatics to support decision making.

LINK TO LEARNING

Review the QSEN competencies (https://openstax.org/r/77QSENComptency) set by the QSEN Institute.

Boards of Nursing

The Boards of Nursing are the regulatory bodies that oversee the practice of nursing within a certain jurisdiction, such as a state or territory. In the United States, each state, including the District of Columbia, American Samoa, Guam, the Northern Mariana Island, and the Virgin Islands, has an individual board of nursing that, together, make up the NCSBN. Puerto Rico is an associate member of the NCSBN and has its own Board of Nurse Examiners.

The function of state boards is to evaluate licensure applicants, issue licenses when appropriate, renew licensures, ensure each participant is in good standing, and take disciplinary action when needed. State boards of nursing are governed by the laws in each individual state's Nurse Practice Act. Each individual state board of nursing has the

ability to enforce the law; nurses must understand the law and how it can affect their practice.

Licensing and Accreditation of Nursing Programs

Registered nurses receive their education through either an accredited bachelor's degree program in nursing (BSN), which typically takes four years; an associate's degree program in nursing (ADN), which takes two to three years; or a diploma in nursing, typically for licensed vocational nurses, which is not as common. Nursing education programs are required to provide the knowledge, skills, and abilities (KSAs) set forth by the NLN. The **American Association of Colleges of Nursing (AACN)** establishes quality standards for nursing education. The AACN utilizes a national consensus–based process to develop "essential documents that outline competency expectations for graduates of baccalaureate, master's, and Doctor of Nursing Practice programs" (AACN, n.d., para 4). Utilizing these essential documents, the AACN ensures consistently high standards of nursing education programs. The AACN publishes *The Essentials: Core Competencies for Professional Nursing Education*, which outlines different domains and competencies that must be included and taught in nursing curricula. Nursing education programs must adhere to these standards and undergo an accreditation process to maintain their approval from the AACN. The AACN also has several arms to help improve the education of nurses, including health policy advocacy, research and data services, conferences and webinars for faculty development, leadership development, programs on diversity and inclusion, and special education projects such as end-of-life nursing care. The **Commission on Collegiate Nursing Education (CCNE)** is an accrediting arm of the AACN, developed to advocate for baccalaureate, and higher, nursing degree-granting programs in the United States. The CCNE promotes self-regulation and peer review by nursing programs and the accreditation is voluntary.

Two other accrediting agencies oversee nursing programs: the Accreditation Commission for Education in Nursing (ACEN) and the National League of Nurses Commission for Nursing Education Accreditation (CNEA). Both entities help to establish standards of accreditation, peer evaluation of nursing programs, and resources to ensure quality education that meets the expectations and core competencies for future nurses.

The Nurse Practice Act

The **Nurse Practice Act (NPA)** is a set of state laws and regulations that govern the practice of nursing within a specific jurisdiction. Specific details of each NPA may vary between jurisdictions. The NPA governs licensure and certification, such as criteria for education requirements for licensure, as well as continuing education requirements. The NPA for each area defines the activities and responsibilities that fall within the scope of nursing practice, outlining what nurses are allowed and not allowed to do, or activities that may require collaboration with other health-care professionals. The NPA establishes the standards of care that nurses must adhere to and encompasses such items as client safety, confidentiality, documentation, and ethical considerations. The NPA also sets the grounds for disciplinary action against any nurse who violates the law or fails to meet professional standards. This may include misconduct, negligence, substance misuse, or other behaviors that jeopardize the safety of the client or violate the standards of practice.

REAL RN STORIES

Nurse: Brenda B., ADN, RN
Years in Practice: Four
Clinical Setting: Medical-surgical floor of a small, rural hospital
Geographic Location: Tennessee

Brenda is a nurse working in a small rural hospital on the medical-surgical floor. Brenda encountered a client with a large wound on their lower extremity that will require extensive surgery. Brenda used her phone to take a photo of the client's wound without the client's permission and posted the photo on her social media page. The client and their family were notified by other members of the community who were able to identify the client based on the social media photo. The family notified the hospital administration and obtained a lawyer to bring charges against both Brenda and the hospital due to a breach of confidentiality. Brenda was fired from her position at the hospital, the State Board of Nursing temporarily suspended her license, and she was required to face the State Board of Nursing hearing board. After six months and continuing education, the board reinstated her license. Brenda learned a valuable lesson regarding the importance of client confidentiality.

Standards Set by Institutions, Federal Regulations and Programs, and Accrediting Bodies

Nursing practice standards and legal regulations for nursing care are outlined by the Nurse Practice Act (NPA), which in turn informs professional organizations, federal regulators, and state boards of nursing. These standards and regulations include authoritative statements that describe scope of and competence in practice.

Standards Set by Employers and Agencies

Individual employers, agencies, and institutions also set standards and guidelines for nursing practice. These guidelines may reflect state laws or they can be more restrictive than the state laws, but they cannot be more lenient than the standards and laws set by state boards of nursing. Guidelines set by individual institutions to guide nursing care are normally developed to help nurses practice within the scope of their licensure. These guidelines may be posted as institutional policies, practices, protocols, or procedures to follow.

Federal Regulations

Nurses must also be aware of the federal influence on the practice of nursing. There are several federal agencies and programs, along with their guiding laws and regulations, that intimately affect nursing care. For example, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, Healthy People 2030, and the Occupational Safety and Health Administration play a role in most health-care institutions. They help to establish criteria for reimbursement and quality measures for care of clients.

Department of Health and Human Services

The Department of Health and Human Services (HHS) is a department of the United States government that is responsible for the health of all residents of the United States. The HHS works with various federal, state, and local agencies, as well as private organizations, that influence public health, health care, social services, and medical research. The HHS administers various health-care programs, including Medicare and Medicaid, which provide health coverage to older adults, low-income individuals, and those with disabilities. HHS addresses public health emergencies; helps to prevent and control the spread of diseases by research, policymaking, and making information available for health-care providers; conducts research on diseases; and promotes healthy behaviors.

Centers for Medicare and Medicaid Services

It is important for nurses to understand federal insurance coverage, run by the Centers for Medicare and Medicaid Services (CMS), that may impact their clients. CMS is under the direction of the Department of Health and Human Services. It is dedicated to advancing health equity, expanding coverage, and improving health outcomes. CMS offers insurance coverage for three groups of individuals: people aged sixty-five or older, individuals under age sixty-five with certain disabilities, and people of all ages with end-stage renal disease. Medicare part A covers care in hospitals and skilled nursing facilities as well as hospice care and some home health care. Medicare part B helps to cover doctor's office fees and community care, as well as some medical supplies; it requires a monthly fee. Medicare part D is a prescription drug coverage service available for those who qualify for Medicare and want to purchase a plan. CMS also offers insurance coverage to low-income adults, children, pregnant women, older adults, and people with disabilities through the Medicaid program. This program is jointly funded by individual states and the federal government.

Healthy People 2030

Nurses must have a vested interest in the problems affecting the health of the nation. The **Healthy People 2030** initiative is a program in the United States that sets objectives and goals to improve the nation's health over a specified period. The Healthy People 2030 initiative is sponsored by the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. It sets health-care priorities based on leading health indicators, as well as overall health and well-being measures. Priority areas for 2030 include the elimination of health disparities and equality for people to live healthy lives. This includes health equity but also an increase in health literacy and addressing the social determinants of health across the nation. Healthy People 2030 also publishes evidence-based resources to help those working in health care identify sources to improve health. For the mental health nurse, Healthy People 2030 provides links to pertinent information on mental health, such as screening for anxiety in children and adults, and an evidence-based practices resource center.

LINK TO LEARNING

Grouped into five domains, social determinants of health (https://openstax.org/r/77healthdetermn) are aspects of the person's environment affecting health and well-being.

OSHA

The **Occupational Safety and Health Administration (OSHA)** is a regulatory agency in the United States that operates under the Department of Labor. OSHA's main purpose is to ensure safe and healthy working conditions for employees in various industries. OSHA develops and enforces workplace safety and health regulations. These standards cover a wide range of industries, including hospitals and other medical facilities. OSHA addresses specific hazards and risks to protect workers' safety and well-being. An example for nursing includes the use of safety needles to avoid unnecessary needlesticks. OSHA may regulate hazardous materials in the workplace and have specific guidelines for using and disposing of such materials.

OSHA conducts inspections of workplaces to ensure compliance with safety and health regulations. These may be routine inspections or may be in response to a reported incident. OSHA provides training programs and educational materials as well as resources to employers and workers to raise awareness about workplace hazards, prevention strategies, and workers' rights.

The Joint Commission on Accreditation of Healthcare Organizations

Many public service and health-related entities, such as hospitals, schools, and universities, have accreditation programs. The **Joint Commission for Accreditation of Healthcare Organizations (JCAHO)**, or the Joint Commission, an independent, nonprofit organization, accredits and certifies health-care organizations and programs in the United States. It focuses on quality improvement and client safety. The Joint Commission surveys hospitals for compliance with its set of standards in health care. These standards may change each survey year and are related to areas, such as safety. Surveys may include such items as policy and procedure review, protocols in place for medical diagnoses, such as myocardial infarctions or deep vein thrombosis, and equipment examination.

National Patient Safety Goals

The **National Patient Safety Goals (NPSGs)** are one set of standards the Joint Commission establishes for ensuring safety for client care. The NPSGs, revised regularly, focus on promoting surgical safety and prevention of infections, preventing medication errors, and addressing suicide risk and specific clinical harm. Client safety and prevention of adverse events in the health-care setting are a priority for nursing. The NPSGs are designed to promote client safety and prevent adverse events in health-care settings. These goals serve as a framework for health-care organizations to improve the quality and safety of client care.

The Joint Commission established the NPSGs in an effort to promote client health and safety in inpatient and outpatient settings. Some common goals for NPSGs include identifying clients correctly through the use of two identifiers, such as name and date of birth. NPSGs focus on improved communication between health-care providers, including the use of effective handoff communication during transitions of care. Medication safety is a top priority for NPSGs and includes ensuring the safe use of high-alert medications. Evidence-based practice is also a priority and includes such items as handwashing, proper use of personal protective equipment to prevent infections, and adherence to infection prevention guidelines. Other areas of focus include prevention of falls, by assessing risks for each client and implementing interventions; prevention of surgical errors, by implementing safety measures; and improving clinical alarm safety, by addressing things like alarm fatigue.

LINK TO LEARNING

Expectations are set for health-care organizations annually by the Joint Commission. The 2024 Hospital National Patient Safety Goals (https://openstax.org/r/77PatientSafety) publication is an easy-to-read one-page summary of the goals.

13.2 *DSM-5* Criteria and Use

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the history of development of the *DSM-5-TR*
- Summarize how the *DSM-5* is used in the diagnosis of mental disorders
- Outline the disadvantages of using the *DSM-5* system of categorization of mental disorders

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) provides a **taxonomy**, or system of classification, and diagnoses of mental disorders. According to the American Psychiatric Association (APA, 2022), the *DSM-5* encompasses the "best available description of how mental disorders are expressed and can be recognized by trained clinicians" (xxiii). Therefore, it is the frame of reference used in health care to describe the various forms of mental disorders. The evidence-based approaches to treatment are formulated around the classifications of and diagnostic criteria for the conditions.

History of the Development of the *DSM*

The *Diagnostical and Statistical Manual of Mental Disorders* (*DSM*) was originally published in 1952 by the American Psychiatric Association to provide the standard criteria for the diagnosis and classification of mental disorders. The *DSM* has undergone several revisions and updates since its initial publication (Figure 13.3).

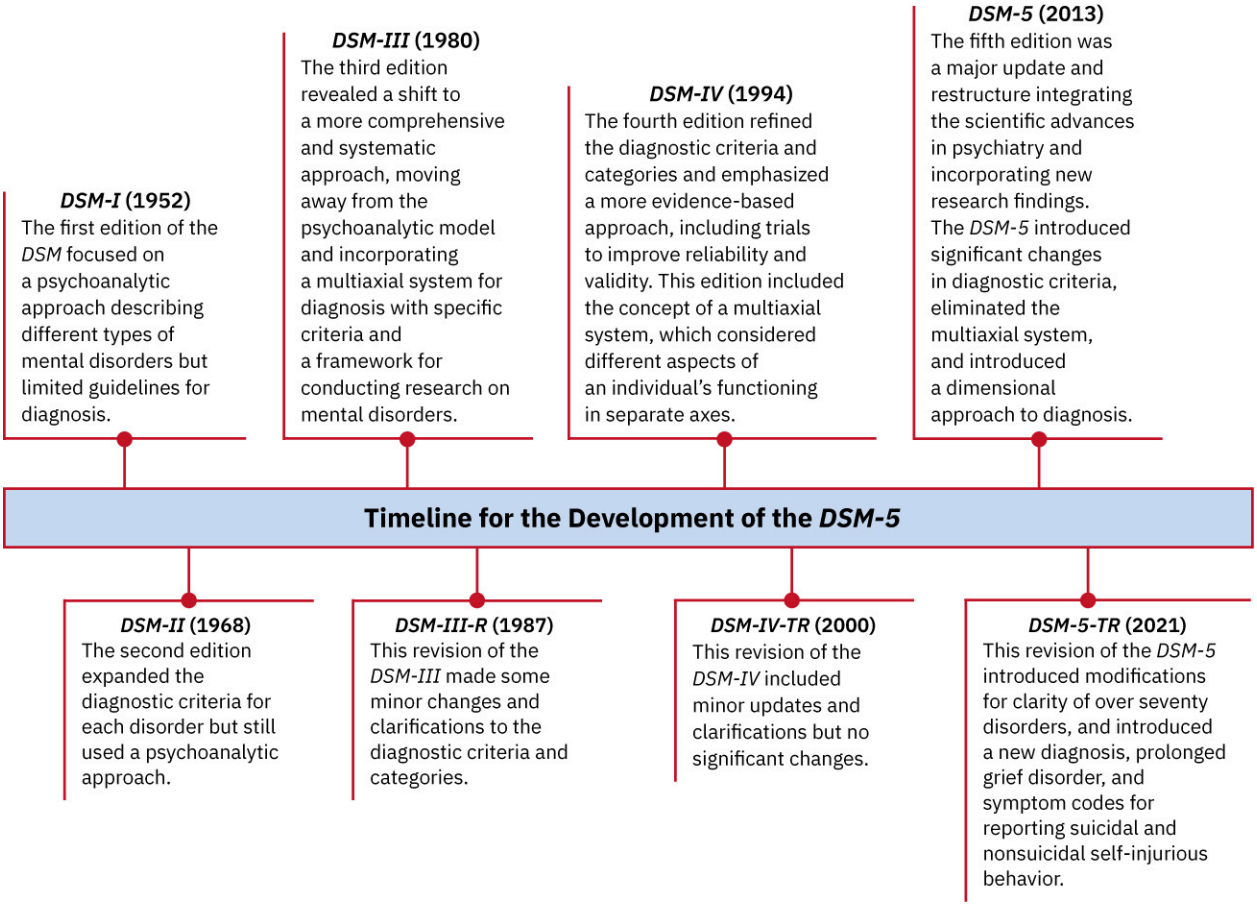


FIGURE 13.3 The *DSM-5* was first published in 1952 and has been revised and updated numerous times in the last seventy years. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Structure and Organization of *DSM-5-TR*

The ***DSM-5-TR*** (Text Revision) was designed as a reference guide to clinical practice and is utilized as a common language for clinicians and researchers from many different backgrounds. The *DSM-5-TR* is also considered a tool for collecting and communicating accurate public health statistics on mental disorder frequency, morbidity, and mortality rates (APA, 2022). It is a tool for concise and explicit criteria for mental health disorders and is intended to facilitate objective assessment of symptom presentations.

The manual begins with an introduction that provides an overview of the purpose, goals, and intent of the *DSM-5-TR*, including its development process and updates from previous editions. The diagnostic criteria section outlines specific diagnostic criteria for various mental disorders. Each disorder is described in detail and is organized into chapters with related disorders. The *DSM-5-TR* includes an addition that describes various assessment measures and models that can be used in conjunction with diagnostic criteria. The *DSM-5-TR* recognizes the importance of cultural factors in understanding and diagnosing mental disorders. The appendices section includes information and resources, including a glossary of terms, codes for billing and reporting, a list of cultural concepts of distress, an alternative *DSM-5* model for personality disorders, and conditions for further study.

PSYCHOSOCIAL CONSIDERATIONS

The Types of Mental Disorders Covered in *DSM-5*

The *DSM-5-TR* covers a broad range of mental disorders from different categories. Here are the major types of mental disorders covered in the *DSM-5-TR*:

1. Neurodevelopmental disorders: These disorders usually begin in early childhood and include such conditions as intellectual disability, autism spectrum disorder, attention-deficit hyperactivity disorder, and specific learning disorders.
2. Schizophrenia spectrum and other psychotic disorders: These disorders include disorders characterized by psychosis, such as schizophrenia, schizoaffective disorder, and delusional disorder.
3. Bipolar and related disorders: These disorders include mood disorders, such as manic and depressive episodes. Bipolar I, bipolar II, and cyclothymic disorders fall under this category.
4. Depressive disorders: These disorders include various forms of depression, such as major depressive disorder, persistent depressive disorder (dysthymia), and premenstrual dysphoric disorder.
5. Anxiety disorders: These disorders involve excessive and persistent worry or fear, including generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias.
6. Obsessive-compulsive and related disorders: These disorders include disorders characterized by intrusive thoughts (obsessions) and repetitive behaviors (compulsions).
7. Trauma and stress-related disorders: These disorders are related to exposure to a traumatic or stressful event.
8. Dissociative disorder: These disorders involve disruptions in consciousness, memory, identity, or perception, such as dissociative identity disorder and dissociative amnesia.
9. Somatic symptom and related disorders: These are disorders in which physical symptoms are the primary focus, often without a clear medical explanation.
10. Personality disorders: These disorders include patterns of behavior and inner experience that significantly deviate from cultural expectations, such as borderline personality disorder and antisocial personality disorder.

LINK TO LEARNING

In this video, the American Psychiatric Association explains why prolonged grief disorder (https://openstax.org/r/77griefdisorder) was added to the *DSM-5-TR*.

Relationship of the *DSM-5* to the International Classification of Diseases

The **International Classification of Diseases (ICD)** is a standardized system used globally for classifying and coding diseases, disorders, injuries, and other health-related conditions. It is maintained by the World Health Organization (WHO) and provides a common language for health professionals, researchers, and policymakers to communicate and exchange health information. The ICD is currently in its tenth revision, known as ICD-10, published by the WHO in 1992. The *DSM-5-TR* criteria define disorders identified by the ICD diagnostic names and code numbers. In *DSM-5-TR*, both ICD-10-CM (Clinical Modification) and ICD-10-PCS (Procedure Coding System) codes are attached to the relevant disorders in the classification. The codes allow for medical insurance billing and reimbursement, as well as collection of health-care statistics. The *DSM-5-TR* structure corresponds with the organizational arrangement of disorders planned for the upcoming ICD-11 scheduled for release in the United States in the future.

LINK TO LEARNING

The APA published a supplement containing updated codes for neurocognitive disorders (https://openstax.org/r/77neurocogcodes) that also describes the corresponding changes to the ICD-10-CM codes.

Clinical Usage of the *DSM-5-TR*

In clinical practice, the *DSM-5-TR* provides a standardized framework for the classification and diagnosis of mental disorders. The *DSM* provides a comprehensive list of diagnostic criteria for various mental disorders, defines mental health conditions, and gives examples of identifying signs and symptoms. Mental health conditions are also categorized into groups. Clinicians use these criteria to assess and diagnose individuals presenting with mental health symptoms.

Nurses can use the *DSM* to help assess clients and build their care plan based on the criteria, presentations, and risks outlined in the *DSM*. The *DSM* also helps those doing research to have a common language and communication for collaboration.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Teamwork: The Use of *DSM-5* in Promoting Teamwork in the Care of Clients with a Psychiatric Disorder

The QSEN definition of teamwork and collaboration is to "function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality" (QSEN, n.d., table 2). During treatment team meetings, health-care professionals (psychiatrists, nurses, psychiatric nurse practitioners, clinical psychologists, social workers, and licensed professional counselors) may use the *DSM-5* as a resource to collaborate with clients for the plan of care. The *DSM* information is shared to communicate the criteria for the medical diagnosis as well as risk factors for the disorder that relate to the client's current clinical status and needs for care. It allows for interprofessional collaboration among all team members.

Conceptualizing Client Problems

The *DSM* aids nurses and health-care providers to conceptualize client issues. When conceptualizing the client problem, it is important to start by gathering important information about the client and their current presenting problem. For those with mental health disorders, this may take the form of a mental status exam, along with collecting any other relevant data. The nurse must identify any observable signs or symptoms indicating a problem and then define the problem statement with priority problem identification. The PMH nurse utilizes the *DSM-5-TR* medical diagnosis for reference to the pathology and helps to identify the client's response to the health problem. The *DSM-5-TR* is helpful in providing a framework for helping individuals with specific diagnoses in ways that are evidence-based and culturally considerate.

LIFE-STAGE CONTEXT

Diagnoses and Older Adults

Many older adults suffer from mental health disorders, but can have very different symptoms and need specific individualized interventions due to the changes with the aging process. Noted in the *DSM-5-TR* are several disorders that apply specifically to this age group. This includes major neurocognitive disorder when cognitive decline is noted. Many mental health disorders can be exacerbated by the experience of loss by the older adult. This can include death of a spouse or significant other, loss of mobility, and loss of inability to operate a motor vehicle, further isolating and leading to worsening mental health disorders. Depressive disorders may present differently than in younger individuals and may include sadness, loss of interest, changes in appetite or sleep, fatigue, and thoughts of death or suicide. Symptoms may present as irritability in young persons, rather than sadness. Anxiety disorders are also experienced by older adults. Substance-related disorders may occur in the older adult and may include alcohol,

prescription medications, or illicit drugs, which may have serious implications for their physical and mental health.

Formulating Treatment Plans

The *DSM* helps nurses and care providers to assess and create treatment plans for mental health clients. Formulating a treatment plan begins with assessment of clinical findings. A physical and mental health exam, including a mental status exam, will help to guide the diagnosis. An evaluation of any test results may reveal a physical reason for their symptoms, such as thyroid abnormalities. It is important to rule out a physical and medical cause first. After assessment and diagnosis, the team creates a treatment plan. The treatment plan may include medications to treat symptoms as well as psychotherapy and other complementary therapies, such as deep breathing, mindfulness, and exercise.

CLINICAL JUDGMENT MEASUREMENT MODEL

Nursing Priority Problem Identification: How Does It Relate to Medical Diagnosis?

Clinical judgment is a critical component of nursing practice, including the process of priority problem identification. Clinical judgment refers to application of the nursing process to an individual, family, or community's response to actual or potential health problems or life processes. The nurse then prioritizes the identified problems and formulates nursing interventions. Once carried out, the nurse will evaluate the outcome of the interventions and make any revisions identified. Medical diagnosis focuses strictly on the classification of a specific disease or condition, based on signs and symptoms as well as diagnostic tests. Nursing problem identification differs in that it is a clinical judgment made by a registered nurse in response to a health problem and in partnership with the client. Nursing problem identification focuses on the client's physical, psychological, sociocultural, and spiritual responses to an illness or disease and then determines the priority order of the problems.

Billing for Treatment

The *DSM* makes billing for treatment more efficient and, in many cases, possible. Billing for treatment of mental health disorders is completed by health-care providers, such as licensed social workers, physicians, and advanced practice nurses utilizing the *DSM-5-TR* as well as the ICD-10 diagnostic codes. Billing involves assigning a procedure code to the services provided to the client. This code is known as the **Current Procedural Terminology (CPT)** and is a standardized system of medical codes used to describe specific procedures or services. They are maintained and published by the American Medical Association.

Criticisms of the *DSM-5*

The *DSM-5* has received both praise and criticism. A strength is that it is a widely used diagnostic tool in the field of mental health that identifies disorders, criteria, and risks. Criticisms include lack of scientific validity and subjectivity of symptoms and dependence on the practitioner's clinical judgment. Critics have stated that the expansion of diagnostic criteria has led to overdiagnosis and labeling those with mild or temporary symptoms with a mental disorder that may stay with them for life. Other critics note that the *DSM-5* relies on categories and mental disorders as distinct entities with clear boundaries, though many may exist on a continuum instead of within such boundaries. Some critics identify the undue influence of the pharmaceutical industry, and argue that expansion of criteria may lead to overmedication. Critics also point out a lack of cultural sensitivity in the *DSM-5*; the *DSM-5-TR* has attempted to address the experiences and expressions of mental distress in diverse cultural contexts.

13.3 Nursing Assessment and Care Plans

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the importance of the nursing assessment and care planning in mental health
- Outline the nursing assessment process in mental health
- Explain problem identification and other issues involved in PMH nursing care planning
- Describe implementation of a nursing care plan in a mental health setting
- Outline the issues involved in evaluating a nursing care plan for a client with a mental health problem

The nursing process is a systematic framework used by nurses to deliver client-centered care. It consists of six essential steps: recognize cues from assessment data, analyze cues to identify problems, hypothesize priority problems, generate solutions, take action, and evaluate client care outcomes. This is commonly described as ADPIE: Assessment, Diagnosis, Planning, Intervention, and Evaluation.

The Nursing Process in Mental Health

The nurse collects comprehensive data about the client's mental health status. This involves conducting interviews, observing, and utilizing assessment tools to gather information about the client's mental health history, current symptoms, cognitive abilities, emotional state, and social functioning.

A nursing care plan in mental health begins the same as all care plans, with the assessment process. The nurse gathers comprehensive information, and in mental health, the mental status exam, to evaluate the client's needs. Problem identification is based on the assessment findings, prioritizing which needs or problems require immediate attention.

Assessment and Data Collection

The nurse utilizes the skills of observation and a structured interview to obtain information regarding the client's mental health status. There are several tools available, based on the client's symptoms, the nurse may employ. Examples include the Patient Health Questionnaire (PHQ-9), which evaluates symptoms of depression. The General Anxiety Disorder (GAD-7) looks at symptoms of anxiety. There are many tools to choose from based on the judgment of the nurse and the needs of the client.

Mental Status Exam

The mental status exam (MSE) is an assessment tool used by mental health professionals to analyze an individual's cognitive, emotional, and behavioral functioning. It provides an overview of a person's mental state at a specific point in time and helps clinicians form a treatment plan. The MSE evaluates appearance and behavior, mood (as stated by the client) as well as affect, or emotional expressions observed by the nurse. The MSE also looks at speech and language, including rate and volume, and observes any abnormalities, such as pressured or rapid speech. It also includes observation of thought process, including logic and how thoughts are organized through the client's expression. The examiner assesses thought content for delusions, hallucinations, or suicidal/homicidal thoughts. Orientation and cognition assessment determines cognitive functions, such as attention or memory. Insight and judgment assessment determines a client's ability to understand their own condition and make appropriate decisions.

Risk Assessments

Nurses must assess the level of risk clients have for self-harm or harm to others due to their mental health condition. This is an essential part of mental health care, especially when dealing with individuals who may be at risk of self-harm, suicide, or violent behavior. Nurses can utilize the nursing process to gather information, including the client's mental health history, current symptoms, any social support, and any previous incidents of self-harm or violence, as well as any protective factors in their life such as family support. Nurses can perform an evaluation of the individual's current thoughts, feelings, and intentions utilizing validated assessment tools, such as the Columbia-Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2010). In order to determine if the client has access to lethal weapons or means to end their life, the nurse may want to ask specific and important assessment questions such as: Are there guns in the home? Are there any medications that may be life-threatening if taken in excess? Utilizing a collaborative approach, involve the individual in the risk assessment process, fostering open communication, and ensure their participation in safety planning. Include other health-care providers, family members, and caregivers in the plan to promote safety.

LINK TO LEARNING

Review this helpful resource for how to ask about suicide (https://openstax.org/r/77suicidequestn) from the National Alliance on Mental Illness (NAMI).

Cultural Considerations

It is important for nurses to approach each client with an open mind, respect, and sensitivity to cultural differences. Culture plays a significant role in shaping a person's beliefs, values, attitudes, and behaviors, including their understanding and experience of mental health. Cultural competence involves acquiring knowledge about different cultures, understanding their beliefs and practices, and being sensitive to the impact of culture on mental health. Moreover, language barriers can hinder effective communication and accurate assessment of the client. Nurses must be aware of cultural communication styles and nonverbal cues. Different cultures have varying beliefs and explanations for mental health issues and the nurse must acknowledge these beliefs, including the stigma that many cultures hold regarding mental illness.

The *DSM-5-TR* and Nursing Care Planning

While the *DSM* provides classification of mental health disorders, client-care problems are identified based on the assessment findings noted by the nurse. The nurse identifies actual or potential problems related to the client's mental health condition and helps the client to identify their priority problems as well. Problem identification in mental health nursing may include such stressors or situations as impaired social interaction for those with social anxiety, or risk for self-harm/suicide for those expressing suicidal thoughts. The nurse collaborates with the client, their family, and other health professionals to establish accurate problem identification and prioritization.

PSYCHOSOCIAL CONSIDERATIONS

Mental Health Assessment

Thomas et al. (2020) found that consideration of psychosocial factors in client assessment and planning of care contributed positively to health outcomes, especially involving lifestyle changes.

High-risk health behaviors, such as smoking, high alcohol consumption, inactivity, and poor diet, were shown to exist in multiple in certain individuals in the study. While economic factors were recognized, also identified were psychosocial factors such as depression, hostility, and ineffective coping. Of note is that healthy psychosocial factors (such as positive outlook, hope, and trust) could be protective and contribute to the ability to change risky lifestyles.

Nurses should sharpen their focus on client empowerment for those who live with the burden of chronic disease, with less emphasis on clients' personal responsibility for behavior change and more direction toward building coping ability.

(Thomas et al., 2020)

Nursing Problem Identification in Mental Health Care

The steps in the Clinical Judgment Measurement Model allow the nurse to assess subjective and objective data and synthesize the data to determine which of the problems or symptoms could be contributing to the client's presentation or expressed need. The PMH nurse collects this data through observation, interviewing the client and or support persons, and obtaining information from medical records, tests, and other outside sources.

Once the PMH nurse has analyzed the information or assessment data, and connected it to the client's presenting problem, the nurse then prioritizes which of the problems to address first, hypothesizing which of the problems would be contributing most to the presenting problem. Then, the PMH nurse determines what steps, actions, or interventions would improve or prevent the priority problems, and identifies solutions that focus on improving the outcome for the client. Finally, the PMH nurse must evaluate, reassess, and link the information to the presenting problem and the client's presentation to determine if the plan of care was effective. These steps allow the nurse to identify the client's needs and develop appropriate interventions.

Some common client problems that may present in a psychiatric-mental health nursing assessment process are ineffective coping, impaired social interaction, or disturbed thought process. Here are three examples:

1. Client reports impending eviction from housing and lack of employment.
    - Recognize cues from collected data: Nurse notes psychological distress and impaired functioning.

- Analyze cues/determine the meaning: Cues supporting client's experience—client is exposed to multiple stressors.
- Prioritize hypotheses/what to address first: What is the most likely explanation? Ineffective coping.
- Generate solutions/formulate what to do: Teach stress reduction, stress management, connect to resources, teach goal-setting, assist to identify personal strengths.

2. Social history in the health record details repeat admissions.
   - Recognize cues from collected data: Client difficulties in establishing or maintaining stable relationships with others.
   - Analyze cues/determine the meaning: Of concern: client in conflict with roommate, which may sabotage discharge plans.
   - Prioritize hypotheses/what to address first: What is the most likely explanation? Impairment in social interactions.
   - Generate solutions/formulate what to do: Teach conflict resolution, discuss client's feelings and perceptions, role-play interaction skills.
3. Client's speech contains fearful remarks.
   - Recognize cues from collected data: Client preoccupied during interview as if attending to internal stimuli (hallucinating).
   - Analyze cues/determine the meaning: Conditions consistent with cues—delusions and hallucinations.
   - Prioritize hypotheses/what to address first: What is the most likely explanation? Disturbed thought process.
   - Generate solutions/formulate what to do: Nursing management of medications, present reality, provide safety.

Identification of Priority Problems in Mental Health

Nurses must prioritize the issues identified by their evaluation of the client. Safety is a priority for all clients and especially those with mental health disorders at risk for self-harm or harm to others. The nurse is responsible for not only prioritizing, but also individualizing a client's plan of care. The nurse uses all steps in the nursing process and collaborates with the client to individualize their care.

Generating Solutions and Defining Interventions

In collaboration with the client and considering their individual needs and preferences, the nurse should establish goals and expected outcomes. Outcomes are derived from potential solutions, which are based on hypotheses and interventions. This is a crucial step in the nursing process, involving communication and collaboration among medical providers, nurses, social workers, counselors, and therapists in order to provide safe and effective care for the client.

The American Psychiatric Nurses Association (APNA) Scope and Standards of Practice (2022) reports that outcomes are based on the client's goals and are individualized per each client's circumstances. Outcomes should consider age and culture, risks and benefits, as well as costs to the client. The outcomes should provide direction for care and these outcomes should be in language developed by or understandable to the client. The APNA identifies the importance of incorporating clinical guidelines linked to positive clinical outcomes.

The APNA encourages development of a client-centered plan that prescribes strategies and alternatives to attain expected outcomes. Specific to the psychiatric-mental health registered nurse (PMH RN), the APNA identifies assessment and diagnostic strategies and therapeutic interventions that reflect current evidence. These plans aim to minimize complications, promote individualized recovery, and optimize the client's quality of life through various treatment modalities, including psychodynamic, cognitive behavioral therapy, supportive interpersonal therapies, and psychopharmacology. The APNA stresses the importance of client education on self-regulation skills to promote resilience as well.

Taking Action in Mental Health Care

Competencies for the PMH RN in the implementation of the nursing process include partnering with the client, family, support system, and other health-care providers to provide safe, realistic care (APNA, 2022). This includes utilizing evidence-based care, the principles of recovery and trauma-sensitive care, and cultural humility. Incorporating community resources may further enhance the care needed by the client as might supervision of

ancillary staff in the implementation of the plan of care.

Nursing Interventions

Nursing interventions may include strategies to prevent illness, injury, or disease; provide immediate safety and stabilization; or promote recovery. The nurse will prioritize the interventions based on safety needs of each client and the level of risk for harm to themselves or others. Defining nursing interventions includes recognition of actions to be avoided, such as making personal judgments about clients' preferences or confronting a client about a lifestyle change before the client is stable. Additional data collection is another form of intervention, as are requests for consults and making referrals.

Complex and Challenging Situations

The PMH RN may encounter many challenges in the mental health-care arena. This may include the status of the client. Particularly difficult challenges may include delirium or delusions that make it difficult to maintain orientation. For the client who may be suicidal, safety is of primary importance. This may mean closely monitoring the client in the safest yet least restrictive environment possible. For the client who is angry and aggressive, the importance lies in not only client safety, but also in safety of the health-care team.

Documenting Interventions

The PMH RN must document client progress toward the goals previously developed and any changes made in the plan of care. Documentation is an important step in the nursing process and allows the PMH RN to share information with the health-care team. Documentation should be objective, free of interpretation and judgment, and assist in the communication of the client's assessment and plan of care to the members of the interdisciplinary team. Documentation should include the progress the client is making toward their goals.

Evaluation of Expected Outcomes in Mental Health Care

An evaluation of the outcomes and goals previously agreed upon and response to interventions should be ongoing. Observed outcomes should be compared with expected outcomes to determine the client's status as result of the interventions. The APNA (2022) identifies the importance of evaluating intervention outcomes to include optimizing wellness and quality of life as well as minimizing unwarranted or unwanted treatment. Further, the nurse should consider what alternative interventions may have been effective. Continual reassessment and evaluation of the plan of care helps to determine if the nurse should continue or change the plan of care.

13.4 Promoting Recovery in Psychiatric Nursing

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the recovery model in psychiatric nursing
- Outline the history of recovery in psychiatric nursing
- Explain the role of the psychiatric nurse in promoting recovery

Recovery is the emergence from a stressful state, incorporating self-care ability, and attempting to reach one's full potential. As a model of care, recovery has been applied to mental health and addictions treatment, wherein the client defines wellness, and a supportive team fosters resilience. Recovery encompasses social change and utilizes person-centered mental health care.

Defining Recovery and the Recovery Model in Psychiatric Nursing

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery from mental illness and substance use disorders as change that improves health and wellness, empowers a self-directed life, and enhances full potential of the individual. Health is defined by SAMHSA as "overcoming or managing one's disease(s) or symptoms" and "for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing" (SAMHSA, 2012, para 4) Nurses should take note that the SAMHSA definition does not limit the meaning of health to cure, but extends it to the ability to function and make choices in life.

The Recovery Model—Mental Health

In mental health care, a recovery focus views the person beyond the limitations of the disease process. Elimination of the disease is not the specific goal—rather, the goal might be the person's potential for resilience, even if

symptoms continue. Incorporating hope and optimism and the willingness to take responsibility for self, the **recovery model** emphasizes ability and personal control of one's health and well-being, functioning at higher levels, and achieving a meaningful life even without complete cure.

The Recovery Model—Addictions

In addictions treatment, various methods support recovery. The recovering person assumes ownership in the process. Some will achieve sobriety, stability, or freedom from dependency through abstinence, while others may utilize behavioral change or harm reduction strategies. Peer counselors and twelve-step sponsors, along with professional therapists, collaborate with the recovering person. Communities, such as Alcoholics Anonymous or Recovering Couples Anonymous, provide mutual support and fellowship within the social network.

Historical Overview of Recovery in Psychiatric Nursing

The recovery model was officially defined by experts working in mental health and substance use. These experts set out to define a working definition of recovery and to clarify the concepts of recovery.

Some believe that the recovery model started in the 1960s with the deinstitutionalization of psychiatric clients from state institutions. There was a belief that those living with mental illness would improve in a community setting as compared with an institution. In 1993, Dr. William Anthony published a paper discussing recovery from mental illness and described recovery as a "process of changing one's attitudes, values, feelings, goals, and skills in order to live a satisfying life within the limitations caused by an illness" (p. 11). In February 2001, President George W. Bush announced his New Freedom Initiative, which ensured that people with disabilities had access to educational and employment opportunities (President's New Freedom Commission on Mental Health, 2001). The commission recommended transforming mental health to focus on recovery-oriented approaches utilizing evidence-based practices. The commission focused on reducing the stigma against mental health.

Since that time, organizations including SAMHSA and the National Alliance on Mental Illness (NAMI) have endorsed the recovery model as an effective strategy to help clients become partners in their care. SAMHSA reports the foundation of recovery as being built on persons' strengths, talents, coping abilities, resources, and inherent values. They also report recovery should be holistic, address the whole person as well as their community, and be supported by peers, friends, and family members.

Asylums and Mental Illness

According to the National Institute of Health, early Americans cared for mentally ill family members at home, but in severe cases they would be detained in "almshouses or jails." As the population grew, community institutions arose to house those who were mentally ill. In 1752, the Quakers in Pennsylvania opened Pennsylvania Hospital, which had rooms in the basement to house mentally ill clients. In the nineteenth century, new ideas for treatment of the mentally ill brought the advent of the **asylum**, which is an institution offering shelter. The focus of treatment was on recovery and cure. The asylums were meant to provide a quiet, peaceful environment for promotion of health and recovery. The Friends Asylum, built in 1814, was the first asylum built to promote a program of moral treatment and was meant for those who could afford to pay for the care provided. In the 1930s, the economic crisis in America cut funding for any state appropriations to the asylums.

Peer Support and Health-Care Consumers

The concept of peer support, ironically the sharing of experiences and personal stories among survivors of harsh treatments for psychiatric disorders, likely began in France in the eighteenth century. Public awareness emerged over the next 200 years as more individuals and families made their experiences known. This awareness promoted the concept of an individual or family as a **consumer** of health care, meaning those who purchase a service, and peer support as beneficial in mental health care (Colorado Mental Wellness Network, 2023).

LINK TO LEARNING

The National Alliance on Mental Illness has created a free, eight-session educational program called NAMI Peer-to-Peer (https://openstax.org/r/77NAMEPeer2Peer) intended to help adults with a mental health diagnosis to help themselves in their recovery.

The Civil Rights Movement and Deinstitutionalization

The civil rights movement of the 1960s focused on human rights and equality among social groups. At the time, much mental health care entailed simple confinement and using harsh measures to manage extreme behaviors. Political and social pressure came from the public wanting change, along with financial demands to reduce the cost of incarceration-type mental health care.

Dr. Richard Lamb published in 1998 on the subject of **deinstitutionalization**, which was the policy, process, and movement that released thousands of mentally ill persons from state institutions back into the communities. Lamb and Bachrach (2001) discussed the lack of support within individual communities, which resulted in many persons released from psychiatric institutions being simply displaced. Many years later, lessons revealed the need for services planning and continuity of care, as these were lacking in the beginning (Lamb & Bachrach, 2001).

Consumer Movement and Current Trends

Consumer rights were formalized in 1962. The term consumer was developed to create a positive term for people who were utilizing mental health care and resources. Consumer activists began to collaborate with mental health-care policymakers about improving mental health treatment. As the philosophies of consumer rights and the shared stories of peer supporters came together, a recovery orientation in mental health care emerged (Moran, 2018).

The Role of the Psychiatric Nurse in Promoting Recovery

Because recovery in mental health care includes the person's self-care ability, nurses are essential as coaches, educators, and advocates. Nurses must distinguish between simple remedy to empowerment of the person, which becomes power sharing within the domain of recovery. The client's definition of success is the guiding principle.

APNA Recovery Components

The American Psychiatric Nurses Association Recovery Council envisions PMH nursing practice as incorporating a recovery orientation. The therapeutic relationship as basis of care places the PMH nurse in position to foster wellness through the shared belief in recovery as a possibility. The use of **person-first language**, which means speaking of the person without focus on the diagnosis, is one of the components. Role modeling this way of expression can be a powerful motivator for others. Some phrases in our language can reinforce harmful stereotypes. Try substituting these words to promote a recovery orientation. For example:

Instead of: "Robin is crazy."
Say: "Robin lives with a mental health challenge."
Instead of: "He's schizophrenic."
Say: "He's living with schizophrenia."
Instead of: "She's manic-depressive."
Say: "She lives with bipolar disorder."
Instead of: "Their father committed suicide."
Say: "Their father died by suicide/was lost to suicide."
Instead of: "Denny's an old junkie."
Say: "Denny has been in recovery for ten years."
Instead of: "Mari is an ex-addict."
Say: "Mari is in recovery."

Practicing with a recovery orientation means the nurse speaks and acts with a focus on the client's strengths and abilities and the possibility of self-care. Reflection is essential for the nurse, as is peer feedback, in order to increase personal awareness.

Nurses may inadvertently discourage those in their care by emphasizing limitations. Nurses should strive to strengthen their own communication skills by asking clients what may be helpful to learn before developing a teaching plan, or acknowledging the client's frustration before offering a solution. As in all therapeutic communication, the nurse's nonverbal expressions must be congruent with the verbal message. For instance, if the nurse is physically preparing to leave the interaction and chooses that moment to ask the client if they have any more questions, the message is unclear.

LINK TO LEARNING

Watch this video to learn about the national observance of recovery (https://openstax.org/r/77recoveryday) that began in 1989 to raise national consciousness regarding mental health and addictions recovery.

National Initiatives

Originally an initiative by SAMHSA to increase public awareness about mental health and substance use, President Biden issued a proclamation (https://openstax.org/r/77proclamation) endorsing the recognition of National Recovery Month in September 2023. This reinforces the government's dedication to prevention, support, and recovery for those living with mental health or substance use challenges. The document further calls for health insurance coverage parity for these conditions.

13.5 Special Considerations for PMH Practice

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss special considerations within the nursing scope of practice in mental health nursing
- Discuss the challenges that nurses face in adhering to the scope of practice

As a specialty practice area, psychiatric-mental health nursing requires a skill set specific to client needs. The American Nurses Association sets standards for all nursing practice, which address safety, ethical practice, health-care advocacy, public health, and the well-being of nurses. The American Psychiatric Nurses Association sets standards for the specialty of psychiatric-mental health (PMH) nursing through the lifespan, including addictions care. These standards employ the nursing process, specifically including the therapeutic relationship, multiple therapies and treatment modalities, and treatment settings. The PMH standards separately address professional performance to include ethical behaviors, evidence-based practice, leadership, interprofessional collaboration, and recovery-oriented care.

Special Considerations within PMH Nursing Scope of Practice

One of the first hurdles in nursing care of individuals with mental health or addiction challenges is to accept the nature of these conditions as physiological and not behavioral. Nurses must expand their own awareness to eliminate the blame that can exist when persons are expected to "behave better."

Review the imagination exercise in Table 13.2 and think about the impact of treating physical illness like one might treat mental illness.

Imagine someone saying:	To a person who is:
"I don't see that you're even trying to get better!"	Having coffee-ground emesis
"Well, staying in bed all the time is not helping, is there something else you could do?"	In traction for pelvic fracture
"Aren't you afraid that medicine is changing the real you?"	Injecting their insulin
"I understand that you have this infection, but could you just do a little more to help yourself?"	Hospitalized for severe sepsis with fever
"Look, just don't give in to this problem!"	Diagnosed with inoperable brain cancer

TABLE 13.2 Imagination Exercise

Based on limited specialized clinical education in nursing programs, the next concern may be that nurses new to the specialty of PMH may wonder what there is to do for the clients. Talking with the client may happen when the work

is done in medical settings, but in the mental health setting, talking with the client*is* the work. Some nurses may feel at a loss without their own props of stethoscope, alcohol wipes, hemostat clamps, marking pens, or IV start kits. It can be a transition for the nurse to conceptualize self as the instrument.

Psychopharmacology may pose another learning curve for the nurse new to mental health care. Medications are one of the essential components of treatment, and it is critical for the PMH nurse to become familiar with medication indications and potential side effects.

The Professional Nurse as Milieu Manager

The milieu is the treatment area, a safe place created to promote coping, relationships, and recovery. The psychiatric-mental health nurse is the **milieu manager**, meaning they are in charge of the therapeutic value of the environment. This may be as literal as the placement of furniture or the volume of the television, or as conceptual as the attitudes of the staff. The professional nurse must be physically present in the treatment area, rounding, interacting, teaching, observing, and role modeling.

LINK TO LEARNING

View the ANA's Principles for Delegation (https://openstax.org/r/77delegation) for nurses, which includes a decision tree for delegation decisions.

Delegation and supervision are components of the professional nurse role in most all settings. In mental health treatment, nursing staff may be composed of the RN, LPN/LVN, and mental health worker or unlicensed assistive personnel, as well as clerical workers. Delegation guidelines apply for the professional nurse as outlined in state Nurse Practice Acts and by the American Nurses Association (ANA), which acknowledges that evolving health-care expectations require professional vigilance.

LINK TO LEARNING

The NCSBN and ANA's National Guidelines for Nursing Delegation (https://openstax.org/r/77nursedelegatn) detail the licensed nurse's responsibilities as well as responsibilities of the delegate (the one to whom duties are assigned).

Professional Boundaries

Professional boundaries are the guidelines that frame the therapeutic relationship, and they are particularly important considerations in PMH nursing. Nurses recognize the significance of this as distinct from a social relationship. Professional boundaries set the limits of the relationship so that it remains focused on the client's needs. Self-disclosure from the nurse is used at a minimum to show the nurse's familiarity with the client's concerns, such as in acknowledging frustration with decision-making, though this is redirected back to the client, for example, "I did struggle with school. What's it been like for you?" Nurses should seek peer feedback and mentoring to enhance skills and awareness in setting and maintaining professional boundaries.

LINK TO LEARNING

Review A Nurse's Guide to Professional Boundaries (https://openstax.org/r/77nurseboundary) published by the National Council of State Boards of Nursing for important information on maintaining professional boundaries.

Challenges in Scope of Practice

In all care settings, nurses must provide holistic care. The person in care for a medical illness has psychosocial needs and the person in care for mental health has physiological needs. A phenomenon of clinical bias called **diagnostic overshadowing** may occur in mental health treatment when symptoms are attributed to the psychiatric diagnosis and medical comorbidities are missed, increasing mortality for these clients (Hallyburton, 2022).

Nurses may struggle to keep a focus on the physiological stability of the client in mental health care, such as hydration, nutrition, sleep, and activity. Ongoing medical conditions, such as diabetes, cancer, or heart disease require the nurse's surveillance. A person in mental health crisis may lose the ability to self-monitor for medical conditions.

Research by Joubert and Bhagwan (2018) found other challenges in mental health nursing to be denial of diagnosis by clients, clients' refusal of medications, and clients' unpredictable behaviors. Nurses experienced frustration with clients' aggression and expressed need for ongoing skills support. Leaders in nursing education are called to incorporate curriculum revisions to capture these challenges before and as they arise (Joubert & Bhagwan, 2018).

Treatments provided through measures that prevent client control and autonomy, **coercive measures**, were worrisome to PMH nurses, according to research by Manderius et al. (2023). Coercive measures may begin with involuntary hospitalization within legal guidelines. Nurses identify difficulty with upholding the ethical principles of dignity and autonomy in client care, as well as the concept of **do no harm**, wherein interventions may be withheld if harm ensues. For instance, nurses may use seclusion (involuntary confinement to a secured area), though considered a restrictive intervention. The most restrictive intervention, restraint, entails applying devices to restrict the person's physical movement; nurses can use restraints when the client is self-injuring or a threat to others. Seclusion and restraint are to be utilized for the minimal time with a provider's order and should be combined with medication administration and supportive nursing interaction. Table 13.3 lists nursing strategies to address identified ethical concerns (Manderius et al., 2023).

Ethical Concerns	Nursing Strategies
Imbalance of power, client vulnerability	Guard physical exposure, manage environment, select staff members to participate.
Client autonomy	Promote advance directives on admission. Prior to the need, discuss preferences for calming, and inquire as to measures that have been effective in the past for stress or during a crisis.
Seclusion and restraint	Monitor client status, use preventative interventions, such as comfort measures, oral medications, and exercise. If client is able, allow client to select site for injection and who may administer. Stay with or near client for support. Ensure opportunity for client to express feelings after the restrictive intervention. Offer praise for client's ability to regain control.
Nurses' feelings of isolation in ethical decision-making	Departmental and organizational awareness of nurses' ethical concerns. Leaders to inquire during staff meetings and employee evaluations. Leaders to routinely solicit nurses' suggestions for effective interventions. Leaders to institute ethics rounds or ethics in-service opportunities and support group activities for nurses.

TABLE 13.3 **Nursing Strategies in Response to Ethical Concerns** (Manderius et al., 2023)

Delegation and Supervision Issues

The RN (registered nurse) to LPN/LVN (licensed practical/vocational nurse) relationship functions well in most PMH settings. Medication administration is such an important aspect of mental health care and the LPN/LVN is frequently assigned in this role. The role of nursing assistants in mental health care, however, was found by Roche et al. (2021) to lack standardization and differ across settings. Noted is the impact on RN workload for supervision and the need for identification of outcomes of care delivered by nursing assistant staff in mental health settings.

Similarly, Wilson et al. (2023) conducted a scoping review of delegation practice and found a knowledge gap in client outcomes. This research cited a professional implication of delegation decisions made at the service level, which was, in effect, reassignment of nursing duties and not true delegation.

In hospital, care center, and treatment facility settings, the nursing workforce hierarchy defines roles and relationships. This is generally intended to support decision-making for collaboration between team members, meaning that expertise at every level is appropriately and effectively applied. The workplace culture should be one of collaboration toward safe client care with staff members at all levels encouraged to contribute to safety and quality.

A hierarchy that feels more oriented toward power, with rigid, disrespectful, or dismissive interactions between levels of staff, can negatively impact communication. This may have the effects of increasing risk and compromising safety, decision-making, and staff engagement overall.

According to the Joint Statement of the NCSBN and the ANA (2019), delegation is an essential skill. Registered nurses in leadership roles may delegate to other RNs. LPN/LVNs are under the direction and delegation of the RN. LPN/LVN staff may provide direction and supervision to UAP (unlicensed assistive personnel, who may be titled mental health workers or psychiatric technicians, or be certified nursing assistants). UAP do not have delegation authority.

Delegation is appropriate when the direction fits the scope of practice. For example, the UAP may be directed to provide basic hygiene for a stable client or monitor clients on routine safety rounds. The LPN/LVN may be assigned blood glucose monitoring and ordered insulin administration with report to the RN. RNs may perform all client care, though they are best able to manage unstable clients, admissions, discharges and transfers, and collaborate with medical providers if a functional team of nursing staff is in place. Delegation is inappropriate when UAP are assigned to determine treatment decisions, for example, moving clients to restrictive care, or when LPN/LVN are asked to independently revise the client's plan of care.

Professional Burnout, Incivility, and Stress

Kanitha and Naik (2021) surveyed fifty nurses and found almost all had experienced **incivility** (disrespectful or offensive behaviors) on the job. Moreover, Dall'Ora et al. (2020) noted that job stressors of work intensity and workload, extended work shifts, inadequate staffing, and nurses' inability to influence these issues resulted in **burnout**, which is a psychological phenomenon characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment related to one's work. The ANA acknowledges workplace stressors and calls for system-level mental health promotion for nurses. Melnyk et al. (2021) specifically endorse:

- creation of more positive work environments
- creation of more positive learning environments
- reduction of administrative burden for working nurses
- provision of technology solutions and support
- investment in nursing research

Summary

13.1 Clinical Guidelines and Standards

Nurses must be aware of the many organizations and agencies that affect their role in the health-care field. These organizations operate on local, state, and federal levels. It is imperative that nurses know the rules and regulations that govern the care they provide, how to maintain their license, and the consequences for not following the regulations. The scope of nursing practice is outlined by the Nurse Practice Act in each nurse's state. There are also institutional policies of which nurses must be cognizant in order to demonstrate competence and commit to best practices.

Federal agencies and accrediting agencies also affect nursing practice. Nurses should be familiar with federal insurance providers, like Medicare and Medicaid, safety protocols promulgated by OSHA, and programs like Healthy People 2030 and National Patient Safety Goals to help them focus on national priorities and maintain the safest work and client environments.

13.2 *DSM-5* Criteria and Use

The *DSM-5-TR* provides a widely used diagnostic tool in the field of clinical psychology, PMH nursing, and psychiatry. It provides a standardized framework for the classification and diagnosis of mental disorders. The *DSM* has been updated many times to adapt to current evidence, research, and the evolving practice of mental health care. Practitioners use it to conceptualize client problems, formulate treatment plans, and bill for services rendered.

13.3 Nursing Assessment and Care Plans

It is important for the PMH RN to utilize the nursing process in helping the mental health client improve and recover. The APNA, in task force with the International Society of Psychiatric-Mental Health Nurses (ISPN), developed the Scope and Standards of Practice, Third Edition (2022) to guide the PMH RN in the nursing process. The nursing process includes assessment to recognize and analyze cues to problems, prioritizing hypotheses, generating solutions, taking action, and evaluating outcomes.

13.4 Promoting Recovery in Psychiatric Nursing

This section has defined the recovery model and orientation in PMH nursing and provided a historical outline of its development. PMH nurses play an essential role in the recovery process through the therapeutic relationship. Nurses support persons toward mental health and addictions recovery through education, advocacy, and promotion of national initiatives like National Recovery Month.

13.5 Special Considerations for PMH Practice

There are a number of challenges and special considerations specific to PMH nursing. First and foremost, nurses must reflect on their own perceptions of, and stigma toward, mental health issues to ensure that they acknowledge the physiological basis of these mental health disorders. These clients cannot just be told to "behave better." Nurses must also become accustomed to the idea of self as the instrument of intervention, talk therapy, for instance, being the care provided. Other challenges include diagnostic overshadowing, ethical concerns over restrictive treatments like seclusions and restraints, denial of diagnosis by clients, clients' refusal of medications, and clients' unpredictable behaviors. Nurses also experience frustration with clients' aggression and lack of ongoing skills support, and they struggle with stress, incivility in the workplace, and burnout.

Key Terms

American Association of Colleges of Nursing (AACN) professional organization that establishes quality standards for nursing education.

American Nurses Association (ANA) professional organization that advances and protects the nursing profession

American Psychiatric Nurses Association (APNA) professional organization that provides leadership in issues related to all nurses working in the mental health field in all practice settings

asylum institution offering shelter

burnout psychological phenomenon characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment related to one's work

coercive measures treatments provided through external control
Commission on Collegiate Nursing Education (CCNE) voluntary accrediting arm of the AACN
consumer those who purchase a service
Current Procedural Terminology (CPT) standardized system of medical codes to describe procedures or services
deinstitutionalization policy, process, and movement that released thousands of mentally ill persons from state institutions back into the communities
diagnostic overshadowing phenomenon of clinical bias that may occur in mental health treatment when symptoms are attributed to the psychiatric diagnosis and medical comorbidities are missed, increasing mortality for these clients
do no harm premise wherein interventions may be withheld if harm ensues
DSM-5-TR standard reference in clinical practice for the diagnosis of mental health disorders
Healthy People 2030 objectives and goals to improve the health of the nation
incivility disrespectful or offensive behaviors
International Classification of Diseases (ICD) clinical diagnostic tool maintained by the World Health Organization
Joint Commission for Accreditation of Healthcare Organizations (JCAHO) independent, nonprofit organization that accredits and certifies health-care organizations and programs in the United States. It focuses on quality improvement and client safety
milieu manager person in charge of the therapeutic value of the environment
National Patient Safety Goals (NPSGs) set by JCAHO to ensure safety in client care
NCSBN Model Act defines the scope of practice for all levels of nursing
Nurse Practice Act set of state laws and regulations that govern the practice of nursing within a specific jurisdiction
Occupational Safety and Health Administration (OSHA) federal agency that ensures the safety and health of working conditions required to improve the quality and safety of the health-care system
person-first language speaking of the person without focus on the diagnosis
recovery model emphasizes ability and personal control of one's health and well-being, functioning at higher levels, and achieving a meaningful life even without complete cure
Standards of Nursing Practice describes competent levels of nursing care
taxonomy system of classification

Assessments

Review Questions

1. What is the purpose of developing nursing standards of practice?
    a. to evaluate the skill level of the nursing assistants
    b. to describe the competency of nursing care
    c. to compare the nursing care from one state to another
    d. to define nursing organizations in the United States

2. Who develops standards of nursing practice?
    a. professional nursing organizations
    b. the State Board of Nursing
    c. the American Psychiatric Association
    d. health-care facilities

3. Why was the Code of Ethics for Nurses with Interpretive Statements (The Code) developed?
    a. to be a guide for carrying out ethical responsibilities for nurses
    b. to help guide nurses with employer contracts
    c. to direct the nurse as they advocate for their profession
    d. to guide the nurse when discussing salary obligations

4. What was the purpose of the American Nurses Association when it was founded in 1896?

a. to foster high standards of nursing practice
b. to promote higher salary requirements for nurses
c. to advocate for health-care issues that affect nurses only
d. to promote a safe and ethical home environment for nurses

5. What group of people does the American Psychiatric Nurses Association serve?
a. all nurses working in the mental health field in a mental health facility
b. mental health nurses in hospital settings
c. all nurses working in the mental health field in all practice settings
d. all health-care professionals working in the mental health field

6. What is the American Psychiatric Nurses Association's Psychiatric-Mental Health Nursing Scope and Standards of Practice?
a. a nonauthoritarian document that can help to guide nursing care
b. a document describing the laws governing nursing care of all clients
c. a document assisting with the rules and regulations in caring for inpatient mental health clients only
d. an authoritative statement that describes the responsibilities for which its practitioners are held accountable

7. What is the mission of the National League for Nursing?
a. to promote excellence in nursing, to build a strong and diverse nursing workforce, and to advance the health of our national and global community
b. to protect the public's health and welfare by ensuring that safe and competent nursing care is provided by licensed nurses
c. to describe the responsibilities for which all mental health professionals are held accountable
d. to guide nurses in ethical obligations

8. What does the Quality and Safety Education for Nurses (QSEN) project address?
a. the education, licensure, and attitude to improve the quality of the health-care system
b. the knowledge, skills, and attitudes required to improve the safety of the health-care system
c. the skills, procedures, and attitudes needed to improve the safety of the health-care system
d. student development to support safety in health care

9. Why did the American Association of Colleges of Nursing (AACN) develop *The Essentials: Core Competencies for Professional Nursing Education* document?
a. to outline competency expectations for baccalaureate nursing programs
b. to outline guidelines for nursing education
c. to outline competency expectations for baccalaureate, master's and Doctor of Nursing Practice programs
d. to outline clinical guidelines required for licensure for all levels of nursing practice

10. What is the purpose of the Nurse Practice Acts?
a. to establish nursing guidelines for care of those with mental health disorders
b. to establish sets of laws that govern the practice of nursing within a specific jurisdiction
c. to improve the education of nurses by providing conferences and webinars
d. to emphasize the importance of collaboration and evidence-based practice

11. Who publishes the *DSM*?
a. the American Nurses Association
b. the American Medical Association
c. the QSEN project
d. the American Psychiatric Association

12. What is a purpose of the *DSM*?
   a. collecting and communicating accurate public health statistics on mental health disorders
   b. defining a medical procedure or process
   c. making a nursing diagnosis
   d. part of the ICD-10 classification

13. What disorders or groups of disorders are covered in the *DSM*? Select all that apply.
   a. neurodevelopmental disorders
   b. psychotic disorders
   c. diabetes mellitus
   d. depressive disorders

14. What new diagnosis is included in the update to the *DSM-5* in the *DSM-5-TR*?
   a. anxiety disorders
   b. depressive disorders
   c. prolonged grief disorder
   d. social anxiety disorders

15. What disorders in the *DSM* are diagnosed as obsessive-compulsive and related disorders?
   a. disorders characterized by intrusive thoughts
   b. disorders characterized by disruptions in memory
   c. acute amnesia disorder
   d. disorders with physical symptoms as the primary focus

16. What is the first step in formulating a treatment plan?
   a. psychotherapy
   b. administering medications
   c. ordering lab work
   d. assessment of clinical findings

17. What is a nursing problem identification?
   a. the medical diagnosis
   b. clinical judgment about an individual, family, or community's response to an actual or potential health problem or life process
   c. the result of medical signs and symptoms after diagnostic testing is done
   d. a nonclinical judgment

18. What skill does assessment of the mental health client involve?
   a. observation
   b. goal setting
   c. documentation
   d. evaluation

19. What assessment technique do health-care providers utilize to determine the client's current mental status?
   a. physical assessment
   b. evaluation of family support
   c. expression of current goals
   d. mental status exam

20. What does the mental status exam evaluate?
   a. cognitive, emotional, and long-term goals
   b. behavioral, cognitive, and emotional functioning

c. current behavioral function only
d. emotional support available

21. What does an assessment of the client's affect include?
a. how the client describes their mood in the past
b. how the client describes their current mood
c. the emotional expressions observed by the nurse
d. what the client reports they are thinking

22. What is a tool that evaluates suicide risk?
a. the Client Health Questionnaire-9
b. the General Anxiety Disorder-7
c. the Columbia-Suicide Severity Rating Scale
d. the Mania Reporting Scale

23. How does the PMH RN prioritize a client's health problem?
a. using the nurse's beliefs
b. focusing first on safety
c. only considering what the client wants it to be
d. following the ICD-10 system

24. According to the APNA Standards and Scope of Practice, what are outcomes based on?
a. family goals
b. the nurse's goal
c. the health-care provider goals
d. goals individualized to each client's circumstances

25. What is an ongoing step in the nursing process in which subjective and objective data is obtained about the client?
a. assessment
b. intervention
c. implementation
d. evaluation

26. Documentation in the nursing process allows the nurse to share the client's progress with whom?
a. the client
b. the family
c. the health-care team
d. the primary care provider

27. In the nineteenth century, new ideas for treatment of the mentally ill brought the advent of asylums, which were defined in what way?
a. free of charge to the public
b. institutions offering shelter
c. institutions offering vocational training
d. focused on religious conversion

28. What does the term consumer mean?
a. a peer counselor
b. those with mental illness who are hospitalized
c. those who work in the safety industries
d. those who purchase goods or services

29. What is true about deinstitutionalization?
   a. It took place in the 1940s.
   b. It was well supported by local communities.
   c. It released thousands of mentally ill persons from state institutions.
   d. It provided a seamless transfer for mental health clients to private hospitals.

30. What does using person-first language mean?
   a. sharing beliefs in recovery
   b. speaking of the person before the diagnosis
   c. using only verbal communication
   d. addressing the client by the name they prefer

31. In the recovery model of care, wellness is defined by the client, and how is resilience achieved?
   a. It is fostered by a supportive team.
   b. It is not possible due to the client's limitations.
   c. It is addressed utilizing nonverbal communication.
   d. It is only available through insurance reimbursement.

32. Who sets the standards for psychiatric-mental health (PMH) nursing?
   a. the ANA only
   b. the APNA and the ANA
   c. health-care organizations
   d. the Joint Commission

33. What is the responsibility of the professional nurse as milieu manager?
   a. They are in charge of the therapeutic environment.
   b. They delegate only to LVN/LPNs.
   c. They administer all medications.
   d. They remain in the nurses' station.

34. What regulations or organizations address delegation practice?
   a. ANA only
   b. NCSBN only
   c. ANA, NCSBN, and Nurse Practice Acts
   d. State Nurse Practice Acts only

35. When should a nurse use self-disclosure while maintaining professional boundaries in the therapeutic relationship?
   a. not at all
   b. liberally throughout the conversation
   c. minimally
   d. with the client's permission

36. Diagnostic overshadowing is a form of what concept?
   a. clinical bias
   b. client support
   c. focus on a medical illness
   d. client's lack of self-care

37. What aspect of seclusion and restraint may cause nurses to experience ethical concerns?
   a. They require lengthy time frames.
   b. They are coercive measures.
   c. They are indicated only for aggression.

d. They do not include medication administration.

38. When is it important to address a client's preferences in order to preserve client autonomy?
    a. at the beginning of a crisis
    b. at discharge
    c. only during ethics rounds
    d. prior to the need

39. Why may nurses struggle with delegation to assistive personnel on PMH units?
    a. confusion with LVN/LPN role
    b. no impact of unit culture
    c. same guidelines across settings
    d. lack of role standardization

Check Your Understanding Questions

1. How would you describe the goals of the QSEN project initiative?
2. What are the goals of the Healthy People 2030 project and how are they determined?
3. What were the National Patient Safety Goals designed to address?
4. What is the purpose of the *DSM-5*?
5. What are the components of the mental status examination?
6. What are the steps of the nursing process?
7. What factor is prioritized when defining nursing interventions with the client?
8. How can language feed stereotypes?
9. What is the psychiatric nurse's role in promoting recovery?
10. What would the nurse find in the APNA Standards that is specific to PMH nursing?

Reflection Questions

1. As a psychiatric-mental health nurse, how will you use the American Psychiatric Nurses Association to help guide your practice?
2. As a nurse considering a higher nursing degree, how will you determine the quality and accreditation of various programs?
3. How does your health-care organization decide the guidelines for nursing practice?
4. What criticisms of the *DSM* do you feel are valid?
5. How can you utilize the *DSM* in your practice?
6. What are some important factors in nursing documentation concerning the plan of care?
7. Explain problem identification in PMH nursing care planning. How do nurses identify and prioritize actual or potential problems related to a client's mental health condition?
8. Describe how a recovery-oriented approach influences the nurse's therapeutic relationship, communication, and empowerment of individuals in mental health care.
9. An adult client experiencing an acute psychotic episode continually disrobes and walks out into the populated areas of the mental health unit. The client cannot follow verbal direction or accept oral medication. The nurses select seclusion as the intervention. What is the nurses' rationale and what other action will the nurses take? How might the nurses feel about this intervention and what will they do about their concerns?
10. Discuss the challenges that nurses face in adhering to the scope of practice in mental health nursing. How do

challenges like diagnostic overshadowing, coercion, and ethical concerns impact the nurse's ability to provide effective care?

What Should the Nurse Do?

Jeff, a forty-two-year-old male, married with two children, has presented to the community health clinic with a recent onset of concerning symptoms. He works as a software engineer and mentions that his job has been particularly stressful lately due to increased project demands and tight deadlines. Jeff reports persistent fatigue, difficulty concentrating, and changes in sleep patterns over the past month. He describes frequent episodes of insomnia, often waking up in the middle of the night with racing thoughts about work-related tasks. In terms of his medical history, Jeff has been managing hypertension for the past five years. He takes a daily regimen of antihypertensive medications prescribed by his primary care physician. His last routine blood pressure check revealed slightly elevated readings, prompting his visit to the community health clinic. In addition to his hypertension, Jeff has a psychiatric history that includes a previous episode of depression, which occurred two years ago. During that time, he underwent therapy, which he found beneficial in managing his emotional well-being. During the current assessment, Jeff's vital signs indicate an elevated blood pressure of 150/90 mmHg, which is higher than his baseline. He appears visibly distressed, displaying signs of restlessness, and frequently rubbing his temples during the conversation. His affect is flat, and he struggles to maintain eye contact. When questioned about his mood, Jeff admits to feeling overwhelmed and stressed, particularly due to the increased workload and responsibilities at his job.

1. How might the bodies of nursing standards, such as the American Nurses Association (ANA), be relevant to Jeff's case, considering his recent onset of symptoms?
2. How might the State Board of Nursing contribute to Jeff's care plan, considering his current distress and the need for a multidimensional approach?
3. How might federal entities, such as the Centers for Medicare and Medicaid Services, influence the provision of care for a client like Jeff?

Ji-Yeon, a twenty-eight-year-old female, has presented to the mental health clinic seeking assistance for recent distressing symptoms. She reports a persistent low mood, loss of interest in activities she once enjoyed, and disrupted sleep patterns, experiencing difficulty falling asleep and staying asleep. Ji-Yeon's medical history indicates no known physical health issues, and she is not currently taking any medications. She discloses a family history of depression, with her mother and maternal aunt both diagnosed with the condition. During the assessment, Ji-Yeon describes feeling overwhelmed by her emotions, often on the verge of tears for no apparent reason. She reports a noticeable decrease in energy, leading to difficulties in completing daily tasks and maintaining focus at work. Vital signs, including blood pressure, heart rate, and respiratory rate, fall within normal ranges.

4. How has the history of the *DSM*, from its initial publication in 1952 to the current *DSM-5-TR*, influenced the understanding and diagnosis of mental disorders, particularly in Ji-Yeon's case?
5. Discuss how the *DSM-5-TR* criteria can guide clinicians in Ji-Yeon's assessment and diagnosis.
6. In light of the advantages and disadvantages of using the *DSM-5* system for categorizing mental disorders, how might these factors impact Ji-Yeon's experience with the diagnostic process?

Lin, a thirty-five-year-old male, has sought help at the psychiatric clinic, expressing apprehensions about his mental well-being. In his detailed self-report, Lin describes a persistent and overwhelming sense of sadness that has lingered for the past six months. He discloses a profound loss of interest in activities that once brought him joy, such as spending time with friends and engaging in hobbies. Additionally, he notes a noticeable decline in concentration at work, impacting his overall performance and contributing to heightened stress levels. Exploring Lin's medical history reveals a noteworthy diagnosis of hypertension, established in the preceding year. Currently managed with antihypertensive medications, this condition adds a layer of complexity to his overall health. The psychiatric evaluation, however, uncovers that Lin has no documented history of mental health diagnoses or prior therapeutic interventions. During the assessment, Lin's physical appearance is marked by signs of fatigue, with noticeable dark circles under his eyes. Despite this, his vital signs, including blood pressure and heart rate, fall within the normal range. As the nursing team delves into Lin's history, they inquire about lifestyle factors, sleep patterns, and any recent life changes that may contribute to his emotional distress.

7. How does a comprehensive assessment contribute to client-centered care, especially considering Lin's case?
8. How can tools like the mental status exam (MSE) and assessment instruments (e.g., PHQ-9, GAD-7) aid in

gathering relevant information for Lin's care plan?

9. How might the nurse prioritize problems for Lin, considering his symptoms and coexisting conditions like hypertension?
10. How does the nurse collaborate with the client and the health-care team to individualize the care plan, considering Lin's unique circumstances?
11. How can the nurse effectively implement interventions for Lin, balancing safety, individualized care, and cultural competence?
12. How can ongoing evaluation contribute to optimizing Lin's wellness and quality of life?

Mei, a twenty-eight-year-old female, has presented to the psychiatric outpatient clinic seeking support for her mental health. Mei reports experiencing symptoms of persistent anxiety, accompanied by intrusive thoughts and difficulty sleeping. Her medical history includes a past diagnosis of asthma, which is currently managed with inhalers. Psychiatrically, Mei discloses a history of recurrent depressive episodes that have been episodically managed with medication and therapy. During the assessment, Mei exhibits signs of restlessness, frequently tapping her foot, and appears tense. Her vital signs, including blood pressure, heart rate, and respiratory rate, fall within normal ranges. Mei communicates a desire for a more active role in her treatment and expresses interest in exploring approaches that go beyond symptom management.

13. Define the recovery model in psychiatric nursing and how it relates to Mei's case. How does the recovery model differ from traditional approaches to mental health care, and what aspects of Mei's experience align with the principles of recovery-oriented care?
14. Explain the role of the psychiatric nurse in promoting recovery, specifically in Mei's case. How can the nurse foster a recovery-oriented approach, considering Mei's expressed desire for an active role?

Donny, a forty-five-year-old male, has presented to the mental health clinic with symptoms of severe anxiety and emotional distress. He reports a recent loss of employment due to ongoing panic attacks, and his medical history reveals a diagnosis of hypertension managed with antihypertensive medications. Psychiatrically, Donny has a history of generalized anxiety disorder, for which he has been prescribed anxiolytic medication in the past. During the assessment, Donny exhibits signs of restlessness, increased heart rate, and difficulty maintaining eye contact. His vital signs, including blood pressure and respiratory rate, show an elevation from his baseline. Donny expresses concerns about the impact of his mental health on his daily functioning and relationships.

15. Discuss special considerations within the nursing scope of practice in mental health nursing, considering Donny's case. How might the unique aspects of mental health care, such as the therapeutic milieu and psychopharmacology, influence the nursing scope of practice in this scenario?
16. How do challenges in mental health nursing, such as diagnostic overshadowing, relate to the importance of professional boundaries and ethical considerations? How can nurses address these challenges while maintaining a therapeutic relationship with clients like Donny?

Competency-Based Assessments

1. How do these bodies of nursing contribute to maintaining the required standards of nursing practice?
2. Describe the role of Boards of Nursing in regulating nursing practice. How do they contribute to the evaluation, renewal, and disciplinary actions related to nursing licenses?
3. Give examples of how nursing standards are set at both the federal and state levels. How do organizations like the ANA and government entities impact nursing practice standards?
4. How has the *DSM* evolved since its initial publication in 1952?
5. How does the *DSM-5* guide clinicians in assessing and diagnosing individuals with mental health symptoms?
6. What methods and tools do nurses use to gather comprehensive data about a client's mental health status?
7. How do nurses develop individualized care plans that address the unique needs and preferences of clients with mental health disorders?
8. How does ongoing evaluation contribute to optimizing wellness and minimizing unwarranted treatment in mental health care?

9. How does the recovery model focus on wellness, resilience, and self-directed living in mental health and addictions treatment?
10. How did the recovery model evolve, and what historical events and movements influenced its development?
11. How do challenges such as diagnostic overshadowing, psychopharmacology learning curves, and ethical dilemmas impact nurses?

References

American Association of Colleges of Nursing. (n.d.). *About AACN*. https://www.aacnnursing.org/about-aacn

American Nurses Association & National Council of State Boards of Nursing. (2019). *Joint statement on delegation*. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/joint-statement-on-delegation-by-ANA-and-NCSBN

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. *Nursing World*, 1–14. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). ANA.

American Nurses Association. (n.d.-a). *About ANA*. https://www.nursingworld.org/ana/about-ana/

American Nurses Association. (n.d.-b). *ANA standards for excellence*. https://www.nursingworld.org/ana/about-ana/standards/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed.) Text Revision. American Psychiatric Association.

American Psychiatric Association. (n.d.). *Patient health questionnaire (PHQ-9)*. https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

American Psychiatric Nurses Association. (2022). *Psychiatric-mental health nursing: Scope & standards of practice* (3rd ed.). APNA.

American Psychiatric Nurses Association. (2023). *Recovery council*. https://www.apna.org/about-apna/councils/join-a-council/recovery-council/

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11–23. https://do.org.10.1037/h0095655

Anxiety and Depression Association of America. (n.d.). *GAD-7 anxiety*. https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

APNA-ISPN Scope and Standards Revision Joint Task Force. (2022). *Psychiatric-mental health nursing: Scope & standards of practice* (3rd ed.). https://www.apna.org/publications/scope-standards-2/

Center for Substance Abuse Treatment (US). (2014). *Trauma-informed care in behavioral health services*. Substance Abuse and Mental Health Services Administration (US). (Treatment Improvement Protocol (TIP) Series, No. 57.). https://www.ncbi.nlm.nih.gov/books/NBK207188/

Colorado Mental Wellness Network. (2023). *The early peer support movement*. https://cmwn.org/the-history-of-peer-support/the-early-peer-support-movement/

Dall'Ora, C., Ball, J., Reinius, M., & Griffiths, P. (2020). Burnout in nursing: A theoretical review. *Human Resources for Health, 18*, 41. https://doi.org/10.1186/s12960-020-00469-9

Exstrom, S. M. (2001). The state board of nursing and its role in continued competency. *The Journal of Continuing Education in Nursing, 32*(3), 118–25.

Hallyburton, A. (2022, December). Diagnostic overshadowing: An evolutionary concept analysis on the misattribution of physical symptoms to pre-existing psychological illnesses. *International Journal of Mental Health Nursing, 31*(6), 1360–1372. https://doi.org/10.1111/inm.13034

Institute of Medicine. (2000). *To err is human: Building a safer health system*. The National Academies Press.

Joubert, P. D., & Bhagwan, R. (2018). An empirical study of the challenging roles of psychiatric nurses at in-patient psychiatric facilities and its implications for nursing education. *International Journal of Africa Nursing Sciences, 9*, 49–56. https://doi.org/10.1016/j.ijans.2018.08.001.

Kanitha, D., & Naik, P. R. (2021). Experience of workplace incivility and its impact on stress and turnover intention among the nurses working at a hospital: Cross-Sectional survey approach. *Iranian Journal of Nurse Midwifery Research, 26*(3), 285–287.

Lamb, R. H., & Bachrach, L. L. (2001). *Some perspectives on deinstitutionalization*. Psychiatry Online. https://doi.org/10.1176/appi.ps.52.8.1039

Manderius, C., Clintståhl, K., Sjöström, K., & Örmon, K. (2023). The psychiatric mental health nurse's ethical considerations regarding the use of coercive measures – A qualitative interview study. *BMC Nursing, 22*(23). https://doi.org/10.1186/s12912-023-01186-z

Melnyk, B. M., Hsieh, A. P., Davidson, J., Carpenter, H., Choflet, A., Heath, J., & Hess, M. E. (2021). Promoting nurse mental health: An urgent call to shift from crisis intervention to long-term prevention. *American Nurse Journal, 16*(1). https://www.myamericannurse.com/promoting-nurse-mental-health/

Moran, G. S. (2018, October). The mental health consumer movement and peer providers in Israel. *Epidemiology and Psychiatric Sciences, 27*(5), 420–426. https://doi.org/10.1017/S2045796018000173.

National Counsel of State Boards of Nursing. (2019). *Clinical Judgment Measurement Model*. Next Generation NCLEX News. https://www.ncsbn.org/public-files/NGN_Winter19.pdf.

National Counsel of State Boards of Nursing. (2021). *NCBSN model act*. https://www.ncsbn.org/public-files/21_Model_Act.pdf

National Counsel of State Boards of Nursing. (2022). *Guiding philosophy*. https://www.ncsbn.org/nursing-regulation/about-nursing-regulatory-bodies/guiding-philosophy.page

National Counsel of State Boards of Nursing. (2023). *About NCBSN*. https://ncsbn.org/about.page

National Counsel of State Boards of Nursing. (n.d.). *About U.S. nursing regulatory bodies*. https://www.ncsbn.org/nursing-regulation/about-nursing-regulatory-bodies.page

National League for Nursing. (2005). *Core competencies of nurse educators with task statements*. https://www.clarksoncollege.edu/assets/files/nln-core-competencies-of-nurse-educators.pdf

National League for Nursing. (2011). *Academic progression in nursing education*. https://www.nln.org/docs/default-source/uploadedfiles/about/nlnvision_1.pdf?sfvrsn=67074931_3

National League for Nursing. (n.d.). *Mission and strategic plan*. https://www.nln.org/about/about/mission-and-strategic-plan

Norris, D. R., Clark, M. S., & Shipley, S. (2016). The mental status examination. *American Family Physician, 94*(8), 635–641. https://www.aafp.org/pubs/afp/issues/2016/1015/p635.html

Posner, K., Brent, D., Lucas, C., Gould, M. Stanley, B., Brown, G., Fisher, P., Zelazny, J., Burke, A., Oquendo, M., & Mann, J. (2010, June 23). *Columbia-Suicide Severity Rating Scale (C-SSRS)*. https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

President's New Freedom Commission on Mental Health. (2001). *Achieving the promise: Transforming mental health care in America*. https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.htm

QSEN Institute. (n.d.) *QSEN Competencies*. https://www.qsen.org/competencies-pre-licensure-ksas

Roche, M. A., Glover, S., Luo, X., Joyce, M., & Rossiter, C. (2021). Extending the role of nursing assistants in mental health inpatient settings: A multi-method study. *International Journal of Mental Health Nursing, 30*(5), 1070–1079. https://doi.org/10.1111/inm.12859

Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's working definition of recovery. 10 guiding principles of recovery. https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf

The Joint Commission. (2023). *Standards*. https://www.jointcommission.org/standards

Thomas, K., Nilsson, E., Festin, K., Henriksson, P., Lowén, M., Löf, M., & Kristenson, M. (2020, February 14). Associations of psychosocial factors with multiple health behaviors: A population-based study of middle-aged men and women. *Int J Environ Res Public Health, 17*(4), 1239. https://doi.org/10.3390/ijerph17041239

U.S. Department of Health and Human Servces. (2010). *National action plan to improve health literacy*. https://health.gov/sites/default/files/2019-09/Health_Literacy_Action_Plan.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2023). *Healthy People 2030*. https://health.gov/healthypeople.

Wilson, N. J., Pracilio, A., Morphet, J., Kersten, M., Buckley, T., Trollor, J. N., & Cashin, A. (2023). A scoping review of registered nurses' delegating care and support to unlicenced care and support workers. *Journal of Clinical Nursing, 32*, 6000–6011. https://doi.org/10.1111/jocn.16724

World Health Organization. (n.d.). *International statistical classification of diseases and related health problems*. https://www.who.int/standards/classifications/classification-of-disease

CHAPTER 14
Neurocognitive Disorders

FIGURE 14.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION This chapter highlights neurocognitive changes that occur in adults. Neurocognitive disorders affect the way the brain functions. Neurocognitive disorders include conditions such as mild neurocognitive disorder, delirium, and dementias (now known as major neurocognitive disorder in the *DSM-5*). Alzheimer disease, Parkinson disease, Huntington disease, and multiple sclerosis are well-known neurocognitive disorders. These disorders can have a genetic component and can be associated with environmental factors. They can also be caused by an underlying medical condition, such as a traumatic brain injury or stroke, metabolic conditions, and even infections. Continued research is important for discovering new treatments, medications, and preventive strategies for neurocognitive disorders.

14.1 Mild Neurocognitive Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the issues involved in diagnosing mild neurocognitive disorders
- Describe the care planning for and the role of the nurse in treating clients with mild neurocognitive disorders

A group of disorders known as **neurocognitive disorders** (NCD) affects an individual's cognition with a gradual decline in at least one of the following domains of cognition: "executive function, complex attention, language, learning, memory, perceptual-motor or social cognition" (Emmady et al., 2022, para 1). For information on neurodevelopmental disorders that occur in younger clients, see Chapter 23 Children and Adolescents. According to the Alzheimer's Society (2023b), 5 to 20 percent of people sixty-five and older are living with mild cognitive impairment. Mild cognitive impairment (MCI) happens when normal changes in brain cognition that occur with aging begin to gradually increase and negatively impact daily living. People with MCI have more problems with memory and thinking than other people their age. Because the symptoms are not as severe as in some of the major neurocognitive disorders, such as Alzheimer disease or other dementias, people with MCI generally are able to continue to care for themselves and carry out their normal daily activities. Signs and symptoms include being unable to follow a conversation or difficulty making decisions, getting lost in a known place, missing appointments, and forgetting things more often (Mayo Clinic, 2023). Many people remain in this stage for years, while others will progress to more severe cognitive decline and dementia. The *DSM-5* now uses the term mild neurocognitive disorder (MiND), which requires the presence of one or more measurable cognitive disabilities for diagnosis (Ellison, 2021).

Diagnosing Mild Neurocognitive Disorders

A **mild neurocognitive disorder (MiND)** causes a gradual decline in a person's cognition, beyond that of normal aging, negatively impacting daily living, but the individual is still able to function independently (Mount Sinai, 2023). There is no single test that a provider can do to diagnose MCI. Instead, it takes a combination of information provided by the individual and standardized mental status testing (Mayo Clinic, 2023). Providers may also do a neurological exam to test reflexes, eye movements, and walking/balance to assess the neurological deficits. Labs can determine if the individual has a physical problem related to deficiencies in vitamin B12 or thyroid hormones (Mayo Clinic, 2023). An MRI can check for strokes, bleeding, or a brain tumor. To be diagnosed, the symptoms must be connected to a medical condition, not another mental health problem (Psychology Today, 2019).

LINK TO LEARNING

A multidisciplinary advisory group of health professionals involved in dementia care have published a summary of pragmatic approaches for nurses to help address modifiable risk factors for early Alzheimer disease and mild cognitive impairment in their clients (https://openstax.org/r/77Alzheimrisks) in an article in the *British Journal of Nursing*.

Diagnosis for MiND, according to the *DSM-5*, includes the presence of one or more cognitive difficulties in the areas of complex attention, memory, executive function, expression and understanding of language in written and spoken forms, visuospatial cognition, or social cognition (Ellison, 2021). In most cases, people who do not know the individual would not notice these changes.

PSYCHOSOCIAL CONSIDERATIONS

Living with HIV and Neurocognitive Impairments

There are approximately thirty-eight million people who have HIV, and 55 percent of those people live in southern and eastern Africa (Tareke et al., 2022). Sixty-eight percent of people with HIV have a neurocognitive impairment related to the infection and the medications used to treat it. HIV-associated neurocognitive disorder (HAND) decreases quality of life and, along with the stigma of living with HIV, these individuals also face stigma related to having a neurological illness. Lack of social support in individuals with HIV can cause a 31 percent higher chance of developing anxiety and depression as compared with the general population. Further, people who feel that they have poor social support are less likely to have good outcomes or follow their treatment protocol. A recommendation based on the study by Tareke et al. was screening all individuals who get treatment at antiretroviral therapy (ART) clinics (Tareke et al., 2022).

Causes of Mild Neurocognitive Disorders

There are both nonreversible and reversible causes of neurocognitive disorders. Nonreversible causes will be discussed in 14.3 Dementia. Reversible causes include hypoxia, low oxygen level in the brain; hypercapnia, high carbon dioxide levels in the body; infections; reactions to medications; poisoning; thyroid problems; vitamin deficiencies, such as low B1, B6, or B12; subdural hematoma; and tumors (Baptist Health, 2023; Mount Sinai, 2023). As with any other mental health consideration, providers should rule out medical causes first.

Risk factors for developing a neurocognitive disorder include being over sixty-five years of age, smoking, excessive alcohol, Down syndrome, a family history, cardiovascular disease, depression, diabetes, or sleep apnea (Baptist Health, 2023). The primary risk factor is age. Women are more likely to be diagnosed with a neurocognitive disorder, but this could be because they tend to live longer than men (Psychology Today, 2019).

Symptoms of Mild Neurocognitive Disorders

All neurocognitive disorders, whether mild or major, share the following symptoms, with differences in their severity depending upon the person's diagnosis: difficulty planning and making decisions, difficulty focusing and remembering the names of objects or people, difficulty performing daily tasks, and speaking or acting in ways that are not socially correct (Psychology Today, 2019). Individuals may take longer to perform some of the activities of daily living, including grocery shopping, finding their keys, being able to drive or use a telephone, managing their medications, and handling their finances (National Institute on Aging and National Institutes of Health, 2024).

The decline usually occurs gradually over time. In cases of mild neurocognitive disorders, only close family and friends may notice the differences in an individual, where strangers do not see a decline.

Nursing Treatment of Mild Neurocognitive Disorders

There is no cure for true mild cognitive disorders, but there are treatments that can help decrease symptoms. A provider may prescribe an antidepressant or a medication specifically for memory loss (Psychology Today, 2019). Psychotherapy can be very helpful for dealing with the stress of cognitive decline. This therapy can include family members so that they have a better understanding of the disease and the amount of support needed by the individual. There are certain things that an individual can do to reduce the risk of their cognitive decline becoming more severe. Things like getting regular exercise; eating healthy food; limiting alcohol, smoking, and sugar intake; having good sleep hygiene; and staying connected to social supports all work together toward better overall health (Psychology Today, 2019).

CLINICAL JUDGMENT MEASUREMENT MODEL

Treatment and Help for MiND: Take Action

After assessing the client and gathering data, the nurse prepares a care plan that is written in easy-to-understand language. This care plan should include the specific symptoms that the client is experiencing, how the team proposes to manage those symptoms, information about any comorbid medical conditions, and caregiver support needs. The nurse then discusses the care plan with the client and their family and gives them a copy. Referrals to consult specialists must be made. While there is no cure for MiND, some daily interventions can be helpful, such as maintaining a routine, providing memory aids like calendars and clocks, eating and drinking well, and getting enough sleep.

(Alzheimer's Association, 2023a)

Planning Nursing Care for a Client with Mild Neurocognitive Disorders

Nurses need to be supportive of the person who is noticing a decline in their cognitive abilities. Person-centered care involves treating the client with empathy, respect, and looking at situations from their point of view, including their history, cultural preferences, and basic likes and dislikes. It entails assisting them to enjoy their relationships with others, despite a decline in some of their cognitive abilities (Alzheimer's Society, 2023b). One important step in the nursing assessment process is to ask the person to describe their own perceptions of problems they are encountering. It may be helpful to have the family involved while gathering the health history, because they may have a better grasp of the cognitive decline they have witnessed in their loved one (Lin et al., 2012). Because early detection is beneficial in managing MiND, nurses should routinely educate older clients and their families about the

signs and symptoms of mild neurocognitive disorders (Lin et al., 2012).

Nurses can make a difference by incorporating interventions that address modifiable risk factors (MRFs). MRFs are separated into four areas that evidence has shown may delay cognitive decline (Hope, 2020). These areas are medical, nutrition, psychosocial, and lifestyle. Examples of interventions in these areas are listed in (Table 14.1).

Category	Examples
Medical	• Checking blood pressure routinely to ensure that blood pressure remains within a healthy range. This could include the purchase of an at-home electronic blood pressure cuff for an individual who already has some cardiovascular concerns. • Checking that cholesterol and blood glucose levels are within normal ranges—hypercholesterolemia and diabetes are known to increase the risk for dementia.
Nutrition	• Teaching individuals about the importance of eating a nutritious diet to maintain a healthy weight/BMI.
Psychosocial	• Encouraging the individual to remain socially active. • Encouraging the individual to pursue treatment for depression and anxiety. • Encouraging the individual to do daily activities that will work the brain—crossword puzzles, playing cards, and learning something new.
Lifestyle	• Advising the reduction/cessation of smoking or drinking alcohol. • Encouraging the individual to remain physically active.

TABLE 14.1 Interventions That May Delay Cognitive Decline (Hope, 2020)

There are several challenges nurses may face caring for a person with MiND. First, an individual may have noticed some decline but not be fully aware of how far their deficits extend. Second, a nurse may see an individual who they suspect has a cognitive decline but has not yet been diagnosed. In this case, the nurse could perform a screening assessment such as the Mini-Cog (see 14.3 Dementia). Third, the nurse needs to be sure to include the individual's beliefs and cultural values in the conversations they have about the disease process (Lin et al., 2012) because there are different belief systems about the signs and symptoms as well as the illness itself. Additionally, some people think of cognitive declines as a normal part of aging and do not consider that these declines may be due to something else.

LIFE-STAGE CONTEXT

The Use of Standardized Screening Tools

The use of standardized screening tools to test for cognitive impairment and dementia provides information about the client's strengths and weaknesses. The psychologist must choose the tool that uses normative data that is the most appropriate for their client's age, culture, gender, language, and educational background. Brief mental status exams are frequently used to determine if a client is experiencing cognitive decline or dementia. Health-care providers must be aware that this tool is more sensitive to dementia than to MCI. There has been an increase in the number of screening tests available for clients in the older age ranges and for particular demographics, such as particular cultures. Providers must continue to educate themselves on the screening tools available for particular population groups (American Psychological Association, 2021).

Supporting Caregivers

Cognitive impairment is stressful for the individual and their family members. Talking about the responsibilities that often fall on family caregivers when cognitive impairment worsens may be the first step to take in preparing the family for the road ahead. A family meeting can help the family members learn more about MiND and what they can

do to support their loved one. Encouraging the family to think about how they might divide or design tasks allows each person to have a sense of autonomy and connection to one another. Even family members who live far away can be involved in such things as checking in regularly (via phone, e-mail, texting, or FaceTime) with the individual and the primary caregiver, taking over things that can be handled online, such as bill paying or doing research to locate in-home services should that need arise (National Institute on Aging, 2023).

Encourage family members to be honest about how much they feel they can realistically do and to share any concerns they may have about how these added responsibilities might affect their own jobs, immediate family, or personal wellness. Pay particular attention to what is referred to as the "sandwich generation" caregivers. These are the family members who are caring for their parents while also caring for their children (National Institute on Aging, 2023). These caregivers account for one in four people who are caring for an aging parent. They are at an increased risk for additional stress and fatigue due to caring for both their parents and their children.

Offering resources, such as support groups that are available in the community, will help family members connect with other people caring for older parents. Respite care services are another helpful resource for family caregivers if the individual's cognitive impairment has progressed beyond basic assistance. One such resource is the ARCH National Respite Locator Service (https://openstax.org/r/77respitecare) which has a searchable function for finding care.

LINK TO LEARNING

This article includes a case study about assisting families in finding trustworthy in-home caregivers (https://openstax.org/r/77homecare) for their loved ones who have a cognitive impairment.

14.2 Delirium

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the differences in the diagnosis of delirium and dementia
- Explain the role of the nurse in providing care for a client with delirium

Diagnosing Delirium

Psychosis caused by medical issues is often referred to as **delirium**, which is a mental state in which the client becomes temporarily confused, disoriented, and not able to think or remember clearly. It usually starts suddenly and can indicate the onset of a life-threatening medical condition. Delirium resolves upon successful treatment of the underlying condition. Each year, more than seven million Americans experience delirium (American Delirium Society, 2023).

Nurses must closely monitor the cognitive function of all clients and promptly report any changes in mental status to the health-care provider. The provider will take a medical history, perform a physical and neurological examination, perform mental status testing, and may order diagnostic tests based on the client's medical history. After determining the cause of delirium, treatment targets the cause and attempts to reverse its effects.

Incidence and Causes of Delirium

Hospitalized older adults are at increased risk for developing delirium, especially if they have been previously diagnosed with dementia. One-third of clients aged seventy years or older exhibits delirium during their hospitalization. Delirium is the most common surgical complication for older adults, occurring in 15 to 25 percent of clients after major elective surgery and up to 50 percent of clients experiencing hip-fracture repair or cardiac surgery (Marcantonio, 2017). There are many common causes of delirium, including the following (MedlinePlus, 2021; American Delirium Society, 2023):

- dehydration and electrolyte imbalances
- dementias and other neurocognitive disorders
- hospitalization, especially intensive care
- intoxication or withdrawal from alcohol or drugs

- kidney or liver failure
- medications, such as sedatives, opioids, anesthesia, antihistamines, anticholinergics, antidepressants, antipsychotics, or anticonvulsants
- metabolic disorders, such as diabetic ketoacidosis (DKA)
- serious infections, such as urinary tract infections, pneumonia, and influenza
- severe pain
- sleep deprivation

In older adults, one of the most common causes of delirium is a urinary tract infection (UTI), so it is important to get a urine sample as soon as acute confusion is noted. Older adults may not have pain as a symptom of a UTI, like a younger person would, but acute confusion, incontinence, and shivering are telltale signs. After diagnosing a UTI, antibiotics generally resolve the confusion.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care of a Client Experiencing Delirium

During the care of an older client who has delirium, it is important for the nurse to:

- Assess levels of physical and emotional comfort, which may require observing body language rather than relying on a spoken answer.
- Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs. Again, this could be based on how the client is expressing their needs (grimacing, guarding, changing body positions, or even input from family members).
- Remove barriers to having families and other designated surrogates present with the client, based on the client preferences. The nurse may need to educate the family members on behavior seen in delirium and how they can best help their loved one while visiting or caring for the individual.

(QSEN Institute, n.d.)

Symptoms of Delirium

The symptoms of delirium usually start suddenly, over a few hours or a few days, and they often come and go. The most common symptoms are as follows (MedlinePlus, 2021):

- changes in alertness (usually more alert in the morning, less at night)
- changing levels of consciousness
- confusion
- disorganized thinking or talking in a way that doesn't make sense
- disrupted sleep patterns or sleepiness
- emotional changes: anger, agitation, depression, irritability, or overexcitement
- hallucinations and delusions
- incontinence
- memory problems, especially with short-term memory
- trouble concentrating

Nursing Treatment of Delirium

The general treatment of delirium is to manage the causes and the symptoms. This might entail, for instance, discontinuing medications or treating infection or imbalances (electrolytes) in the body. There are supportive care measures provided to prevent any complications from occurring. These measures include proper diet and nutrition, treating pain, assisting with movement, taking care of incontinence issues, keeping the same caregivers as much as possible, and involving family members (Mayo Clinic, 2022). Involving family members to assist with familiarity, comfort, prevention of falls, and assistance with safety and monitoring of the client can be very helpful. Additionally, reminders, such as whiteboards with visual cues, dates and times, and names of staff members is beneficial. Promoting sleep hygiene is an important role of the nurse, and good sleep can help the client recover more expediently.

A nurse who recognizes the confusion and frustration experienced by the individual with delirium will begin to form a plan of care that will increase the individual's comfort and sense of calm. There are some easy things nurses can do to assist the client in getting reoriented and to decrease their stress levels. Nurses can often manage the symptoms of delirium with the following nursing interventions (MedlinePlus, 2021):

- making sure the room is quiet and well lit
- having clocks and calendars within view
- inviting family members to spend time in the room
- ensuring clients are wearing hearing aids and glasses
- allowing for undisrupted sleep when possible
- getting clients up and out of bed when possible
- controlling pain with pain relievers (unless the pain medication is causing the psychosis)
- administering prescribed medications to distressed clients at risk to themselves or to others, such as haloperidol (note that sedation can worsen delirium symptoms)
- avoiding the use of restraints

The confusion that a client feels can be very scary to them, so providing a supportive environment is especially important during the acute stages of delirium.

PSYCHOSOCIAL CONSIDERATIONS

Delirium and Alcohol Withdrawal

The most severe condition caused by withdrawal from alcohol is delirium tremens (DTs). This can be life-threatening and requires medical attention (Cleveland Clinic, 2023). The heavier a person drinks, the higher their risk to develop the DTs if they suddenly stop drinking. Symptoms usually occur one to three days after the last drink and include tremors (in the hands is most common), confusion, agitation, hallucinations, disorientation, diaphoresis, seizures, hyperthermia, headaches, nausea and vomiting, and tachycardia (Cleveland Clinic, 2023). Many people feel ashamed to ask for help and may not be truthful with their health-care provider about the actual amount of alcohol they regularly consume. It is the job of the nurse and the entire health-care team to care for clients going through alcohol withdrawal without any judgments and with client safety as the focus.

14.3 Dementia

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define various forms of dementia
- Describe the approaches to treatment and nursing care planning for a client with dementia

Dementia is an umbrella term that covers a host of neurocognitive disorders. The symptoms of these disorders show up as a gradual decline in a person's cognitive functioning. There are over fifty-five million people in the world living with dementia (American Psychiatric Association, 2023). The most common form of dementia is Alzheimer disease, accounting for 60 to 80 percent of cases.

Definition and Forms of Dementia

The term **dementia** is an older one that describes neurodegenerative brain disorders that cause changes in a person's cognition (American Psychiatric Association, 2023). When a person has dementia, they lose the ability to think, take care of themselves, remember things, and sometimes control their emotions. The *DSM-5* no longer uses the term dementia, because it has been primarily associated with older adults and Alzheimer disease, and now uses the term **major neurocognitive disorder** (major NCD) to reflect the group of disorders that can affect younger and older individuals' cognition with a gradual decline in at least one of the following domains of cognition: executive function, complex attention, language, learning, memory, perceptual-motor, or social cognition (Emmady et al., 2022). This text uses the terms dementia and major neurocognitive disorder interchangeably. Clinical manifestations of major NCD include forgetfulness, impaired social skills, and impaired decision-making and thinking abilities that interfere with daily living. Major NCD is gradual, progressive, and irreversible (Alzheimer's

Association, 2023b). Nonetheless, appropriate assessment and nursing care improve the safety and quality of life for those affected by dementia. There are seven stages of major neurocognitive disorder based upon symptoms and ranging from mild to very severe cognitive decline (Table 14.2).

Stage	Description
1. No cognitive decline	No memory problems.
2. Very mild cognitive decline	Complaints about losing things, such as car keys or forgetting names of things. No deficits in social or occupational settings.
3. Mild cognitive decline	Difficulty with tasks in the work setting. Memory deficits. Anxiety related to cognitive changes. Potential for a diagnosis of MiND.
4. Moderate cognitive decline	Difficulty with remembering personal history. Difficulty managing money or traveling. Lack of emotional expression. Withdrawal from situations deemed challenging.
5. Moderately severe cognitive decline	Assistance needed with things like choosing an outfit. Increased deficits in short-term memory. Not oriented to time, date, or place.
6. Severe cognitive decline	Needs assistance with ADLs. Lack of memory of recent activities. Sleep disturbances, incontinence of bladder and bowel. Hallucinations, agitation, anxiety, and obsessive behavior may occur.
7. Very severe cognitive decline	No longer able to hold a conversation or talk. No longer able to control bladder and bowel functioning. Needs assistance for all ADLs. Difficulty moving, eating, swallowing. Drastic changes to personality and behavior.

TABLE 14.2 Reisberg's Stages of Neurocognitive Disorders

The Cognitive Domains Used in Diagnosing Major NCD in the *DSM-5*

There are six main cognitive domains used in the *DSM-5* to measure cognitive decline. Complex attention is capacity to remain focused while doing multiple things at one time. Executive function includes the high-level abilities individuals need in order to control cognition, such as sequencing, planning, and organizing tasks. Learning and memory are the abilities to understand and store information and later retrieve it. Language is the way that people communicate, whether that be through speech, writing, or reading. Perceptual-motor control allows individuals to control their body movements so that they can interact with the environment. Social cognition helps people process, remember, and apply information in social situations. All six of these cognitive domains are used to assess for major NCD and subsequently diagnose them (Sheikh, 2022). However, for diagnosis, there must be evidence of decline to the level of substantial impairment in at least two cognitive domains, one of which must be memory.

Subtypes of Major NCD

Major NCD has many subtypes, each with its own *DSM-5* diagnostic criteria (American Psychiatric Association, 2022). The *DSM-5* recognizes the following subtypes: Alzheimer disease, frontotemporal degeneration, Lewy body dementia, vascular disease, traumatic brain injury, substance use, HIV infection, Prion disease (Creutzfeldt-Jakob disease), Parkinson disease, Huntington disease, another medical condition, multiple etiologies, and unknown etiology.

The most common of these disorders is **Alzheimer disease**, which affects the brain by causing atrophy in the cortex

(Figure 14.2), deposits of amyloid plaques and neurofibrillary tangles in the neurons, and degeneration of the neurons (Emmady et al., 2022). The presence of the amyloid plaques is found on autopsy. The *DSM-5* criteria for Alzheimer disease includes evidence of genetic mutation from family history or testing of all of the following: clear evidence of decline in memory and learning and at least one other cognitive domain; progressive, gradual decline in cognition, without extended plateaus; and no evidence of other causes of symptoms. Risk factors for Alzheimer disease include age, cardiovascular diseases, history of stroke, history of traumatic brain injury, and Down syndrome. Genetic testing for markers is now available to test for amyloid precursor protein (APP), presenilin 1 (PSEN1), and presenilin 3 (PSEN2). The genetic test for PSEN1 is widely available.

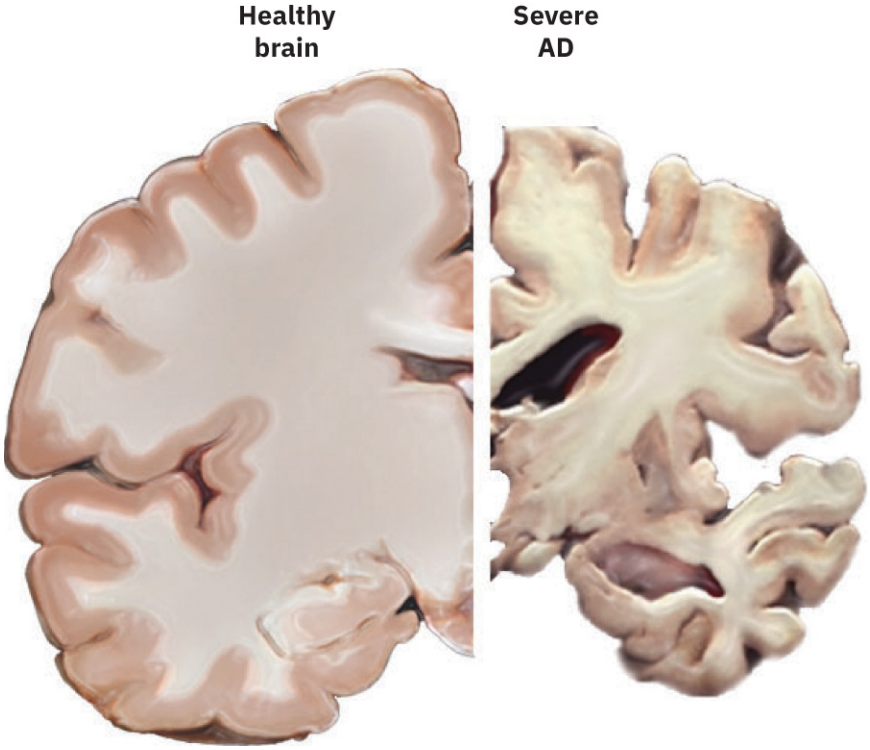


FIGURE 14.2 Alzheimer disease causes atrophy of the brain. (credit: "Healthy Brain and Severe AD Brain" by National Institute on Aging, National Institutes of Health/flickr, Public Domain)

The disorder called **frontotemporal degeneration** involves personality and behavior changes; it affects nerve cells in the frontal and temporal lobes of the brain. This is the most common dementia in younger people and usually begins between ages forty and sixty-five years (John Hopkins Medicine, 2023). Symptoms include impaired judgment; lack of empathy; behavior changes; emotional withdrawal; difficulty with language, speaking, and writing skills; and agitation. There is no known cause. There are no treatments to slow the progression; clients can benefit from some symptom management using antidepressants, sleeping pills, and antipsychotic medications.

Comedian Robin Williams developed a major NCD called Lewy body dementia, which ultimately caused him to take his own life. Since his death, the family has aimed to raise awareness for this progressive form of dementia. This disease accounts for 5 percent of dementia cases. Both **Lewy body dementia** and **Parkinson disease** involve Lewy bodies, insoluble deposits of alpha-synuclei protein that damage the brain (Emmady et al., 2022). In her article "The Terrorist Inside my Husband's Brain" (2016), Susan Williams describes her husband's history of depression and the new symptoms he began to experience: insomnia, heartburn, a poor sense of smell, constipation, and urinary difficulty. He was diagnosed with Parkinson disease. At that point, he had a hand tremor, shuffling gait, masklike expression, and weakened voice. It wasn't until after his autopsy that it was determined he actually had Lewy body dementia that had done massive amounts of damage to his brain. Lewy body dementia can be difficult to diagnose until after death when the autopsy confirms the presence of Lewy bodies in the brain. This disease is often first diagnosed as Parkinson disease because of the many shared symptoms (John Hopkins Medicine, 2024).

Injuries to the brain from ischemia, such as a stroke, that block blood flow to the brain and lead to permanent neuron death can cause **vascular dementias**. Illnesses, such as diabetes, hypertension, and hyperlipidemia, can be

risk factors because they can be precursors to having a stroke (Centers for Disease Control and Prevention [CDC], 2023). Moreover, untreated HIV infection can lead to the development of specific neurocognitive disorders caused by toxic inflammation (encephalopathy) in the brain.

Commonly mistaken for "madcow" disease, **Prion disease (Creutzfeldt-Jakob disease)** is a very rare form of dementia, affecting only one to two people per million worldwide in any year. This disease progresses rapidly and leads to death within one year. This disease is considered a transmissible form of spongiform encephalopathy (Centers for Disease Control and Prevention, 2021). This disease is believed to develop spontaneously when normal prion proteins become abnormal prion proteins. In 85 percent of people who develop this disease, there is no understandable pattern of transmission. There is a familial component with a dominant inheritance pattern in 5 to 15 percent of clients who develop this disease (Centers for Disease Control and Prevention, 2022). Symptoms of this disease include rapidly progressing dementia, and at least two of the following symptoms: myoclonus (muscle jerks), visual or cerebellar signs, pyramidal/extrapyramidal signs, and Akinetic mutism (person is in a wakeful state of profound indifference to goal-directed behavior and emotions) (CDC, 2022).

Another cause of dementia, **Huntington disease** is a genetic mutation that causes the building blocks of DNA to repeat more times than they normally do. The disease attacks the neurons in the brain, causing them to die. Symptoms include uncontrollable movements (chorea) that can cause a person to fall easily. The person develops difficulty with speech, swallowing, eating, and cognition (National Institute of Neurological Disorders and Stroke, 2023). While each of these subtypes of neurocognitive disorder affects brain cognition, they all have varying symptoms and diagnostic criteria under the *DSM-5*.

LINK TO LEARNING

This sharable PDF about dementia from the National Institute on Aging (https://openstax.org/r/77dementiatypes) is a great way to educate clients and family members about some of the different types of major NCD.

Dementia and Alzheimer Disease

Many people still refer to a person who begins to have memory problems as having Alzheimer disease. Alzheimer disease is one type of major NCD diagnosed after a complete physical exam and neurological tests. In a client with Alzheimer disease, PET scan images will reveal buildup of amyloid plaques and tau proteins (Alzheimers.gov, n.d.). There is medication available to treat some of the symptoms of Alzheimer disease, and to slow the progression (Table 14.3), but there is no cure (Alzheimer's Association, 2023c). Figure 14.2 shows the spread of Alzheimer disease through the brain.

Function	Name (Generic/ Brand)	Indicated For	Common Side Effects
Slows disease progression	Aducanumab (Aduhelm)	Alzheimer disease (MCI or mild dementia)	Headache and fall
	Lecanemab (Leqembi)	Alzheimer disease (MCI or mild dementia)	Infusion-related reactions and headache
Treats cognitive symptoms (memory and thinking)	Donepezil (Aricept)	Mild to severe dementia due to Alzheimer disease	Nausea, vomiting, loss of appetite, muscle cramps, and increased frequency of bowel movements

TABLE 14.3 Medications for Treating Symptoms of Alzheimer Disease (Alzheimer's Association, n.d.)

Function	Name (Generic/ Brand)	Indicated For	Common Side Effects
	Galantamine (Razadyne)	Mild to moderate dementia due to Alzheimer disease	Nausea, vomiting, loss of appetite, and increased frequency of bowel movements
	Rivastigmine (Exelon)	Mild to moderate dementia due to Alzheimer or Parkinson disease	Nausea, vomiting, loss of appetite, and increased frequency of bowel movements
	Memantine (Namenda)	Moderate to severe dementia due to Alzheimer disease	Headache, constipation, confusion, and dizziness
	Memantine + Donepezil (Namzaric)	Moderate to severe dementia due to Alzheimer disease	Nausea, vomiting, loss of appetite, increased frequency of bowel movements, headache, constipation, confusion, and dizziness
Treats noncognitive symptoms (behavioral and psychological)	Brexpiprazole (Rexulti)	Agitation associated with dementia due to Alzheimer disease	Weight gain, sleepiness, dizziness, common cold symptoms, and restlessness or feeling the need to move Warning for serious side effects: Increased risk of death in older adults with dementia-related psychosis. Rexulti is not approved for the treatment of people with dementia-related psychosis without agitation.
	Suvorexant (Belsomra)	For insomnia; has been shown to be effective in people with mild to moderate Alzheimer disease	Impaired alertness and motor coordination, worsening of depression or suicidal thinking, complex sleep behaviors, sleep paralysis, compromised respiratory function

TABLE 14.3 **Medications for Treating Symptoms of Alzheimer Disease** (Alzheimer's Association, n.d.)

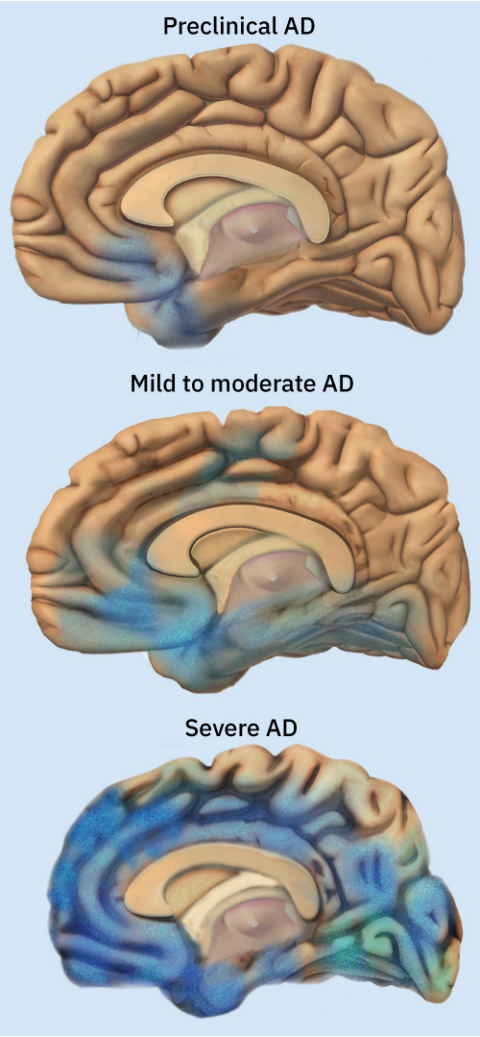


FIGURE 14.3 In preclinical Alzheimer disease (before symptoms appear), only a small portion of the brain is affected. As the disease progresses through the brain, symptoms become more severe. (credit: "Alzheimer's Disease, Spreads through the Brain" by National Institute on Aging, National Institutes of Health/flicker, Public Domain)

LINK TO LEARNING

Watch this video describing the changes that occur in the brain during Alzheimer disease (https://openstax.org/r/77Alzheimrbrain) from the National Institute on Aging.

Understanding the Symptoms

Often, providers confuse major NCD and delirium, leading to misdiagnosis. If an older person suddenly becomes confused, it is very likely the result of another medical cause, such as infection, fecal impaction, or dehydration, not dementia. According to UHealth Collective (2018), there are thousands of people misdiagnosed with dementia each year. It is important to remember that the onset of dementia has a slower progression while delirium has rapid symptom development. Because the different subtypes of major NCD can share symptoms, it can also be difficult to get an exact diagnosis. A primary care doctor may refer a client to see a neurologist in order to get the correct diagnosis (Alzheimers.gov, n.d.). (Table 14.4) compares dementia to delirium to aid in differential diagnosis.

	Dementia	Delirium
Onset	Vague, insidious onset, symptoms progress slowly	Sudden onset over hours and days with fluctuations
Symptoms	Symptoms may go unnoticed for years; may attempt to hide cognitive problems or may be unaware of them; often disoriented to time, place, and person; impaired short-term memory and information processing; confusion is often worse in the evening (referred to as "sundowning")	Often disoriented to time, place, and person; impaired short-term memory loss and information processing; confusion is often worse in the evening
Consciousness	Normal	Impaired attention/alertness
Mental state	Possibly labile mood, consistently decreased cognitive performance	Emotional lability with anxiety, fear, depression, aggression, variable cognitive performance
Delusions/ hallucinations	Common	Common
Psychomotor disturbance	Psychomotor disturbance in later stages	Psychomotor disturbance present—hyperactive, purposeless, or apathetic

TABLE 14.4 Comparison of Dementia and Delirium

LINK TO LEARNING

This short video differentiates delirium and dementia (https://openstax.org/r/77OCDCAMPS) using the mnemonic OCD CAMPS.

Planning Treatment for a Client with Major NCD

It is important that a team approach be taken to care for a person with major neurocognitive disorder. Emmady et al. (2022) recommend that the physician coordinate the plan of care with the pharmacist, social workers, nurses, and family members. The primary health-care provider does the initial assessment and may refer the client to a neurologist to confirm a diagnosis. There are screening tests performed to establish a benchmark and then repeated at follow-up visits to record further decline. One such test is the Mini-Cog, which includes the clock test. This simple test assesses the client's memory recall, brain function, and spatial abilities by asking them to recall three words and then draw the face of a clock, placing the numbers around the face of the clock and the hands at a specific time (Alzheimer's Association, 2023b).

LINK TO LEARNING

This short article about administering the clock test (https://openstax.org/r/77clocktest) provides its history and some basic instructions.

The provider also coordinates medication with the pharmacist. Social workers assist the client and their families to ensure that the living environment is safe and support is available to caregivers. Family members should be educated about the disease process and given information about community support. Nurses provide care in the

inpatient, outpatient, and community settings that is designed to provide the best possible outcomes for the client.

Planning Nursing Care for a Client with Major NCD

Because people are living longer, there are more and more individuals who need nurses who are trained to take care of people with illnesses like major neurocognitive disorder. According to the most recent report of Administration for Community Living (2021), 16 percent of the U.S. population, or 54.1 million people were over the age of sixty-five in 2019. Nurses should become educated about the symptoms, treatment, interventions, and coordination of services in the care of this population of clients (Deshaies, 2023). Nurses create a plan of care that helps develop a daily routine to assist and support clients with their daily self-care activities. Many clients with dementia believe they are living in their younger years, going to work, or caring for their families. Offering activities, such as folding towels, caring for a baby doll or stuffed animal, or giving them a job to do, such as wiping down tables, encourages the client to participate in their surroundings in a way that is comforting to them.

An assessment of the environment is important to keep the client safe. If the client lives at home, look for throw rugs that could be tripping hazards, check if the bathroom is equipped with grab bars, and determine if there is adequate lighting or stairs to navigate. Nurses should also take care to communicate with these clients by asking simple questions in a calm manner. The nurse recognizes when the client is becoming anxious, angry, or more confused. Nurses may also play a role in managing medications. They can encourage families and friends to spend time with the client. Nurses work with an interdisciplinary team to share their expertise and interactions as a way of keeping safety and autonomy goals in sight for the client.

If an older adult requires more care than family members are able to provide at home, nurses provide valuable information about available care options and make referrals to social workers and case managers. There are a wide variety of community-based resources to enhance care for older adults. Local aging and disability resource centers (ADRCs) can help facilitate referrals based on specific needs of the older adult. Examples of other resources include adult day centers, home health agencies that provide personal care and nursing assistance, community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs). If an older adult requires twenty-four-hour nursing care, placement in a nursing home (also referred to as a skilled nursing facility) may be required.

REAL RN STORIES

Nurse: Lenore, MSN, RN, PMH-BC
Years in Practice: Nineteen
Clinical Setting: Inpatient Behavioral Health Unit
Geographic Location: Texas

As a nurse who has worked with many older adult clients grappling with Alzheimer disease, one specific older client stands out. He was in his eighties and had been admitted to the inpatient behavioral health unit to give his family some respite while they tried to figure out the appropriate placement for him after hospitalization. In comparison with other older adult clients I have seen, this client did not display any of the anger or aggression sometimes revealed as clients would sundown in the early evening hours. Instead, this client got up each morning and dressed in a pair of work slacks, a long-sleeved colored shirt, and sat at a table in the community day area. After he had his breakfast, he would say he was ready for work. He had had a long career as an accountant/businessman, and each day he thought he needed to get to work. I would provide him with a legal pad, a pencil, and a phone book. He would spend the next few hours "working," writing numbers on that notepad. I would stop by his chair several times during the morning to ask if he needed anything.

One thing we are taught in nursing school is that we should reorient our clients. In the case of a person with Alzheimer disease, there is an exception to that rule. If reorienting is going to cause the person stress, it is better to just go along with their beliefs as to where they are and in what time period. I am sure if I had tried to tell this client that he was in the hospital and he was now in his eighties, it would have caused more frustration than clarity in his mind. Instead, I went along with where he was in that moment. It gave him a purpose, satisfaction that he was doing a good job, and peace.

Summary

14.1 Mild Neurocognitive Disorders

While mild cognitive impairment (MCI) and mild neurocognitive disorder (MiND) are very similar, diagnosis for MiND includes the presence of one or more cognitive difficulties in the areas of complex attention, memory, executive function, expression and understanding of language in written and spoken forms, visuospatial cognition, and social cognition (Ellison, 2021). There is no single test to diagnose this disorder. Instead, it takes a combination of information provided by the individual and standardized mental status testing (Mayo Clinic, 2023). All neurocognitive disorders, whether mild or major, share the following symptoms, with differences in their severity depending upon the person's diagnosis: difficulty planning and making decisions, difficulty focusing, cannot remember the names of objects or people, difficulty performing daily tasks, and speaking or acting in ways that are not socially correct (Psychology Today, 2019). There is no cure for MiND, but there are treatments that can help decrease symptoms.

14.2 Delirium

Each year, more than seven million Americans experience delirium (American Delirium Society, 2023). Delirium is a mental state in which the client becomes temporarily confused, disoriented, and not able to think or remember clearly. Although delirium is a medical emergency that can result in death, it is treatable if detected and treated. Delirium will resolve once the underlying medical cause is treated. Nurses can put in place a number of interventions to help manage the symptoms of delirium.

14.3 Dementia

Major neurocognitive disorders are a group of disorders that can affect younger and older individuals' cognition with a gradual decline in at least one of the following domains of cognition: executive function, complex attention, language, learning, memory, perceptual-motor, or social cognition. There are seven stages of major neurocognitive disorder (dementia) used to determine how severe the cognitive decline. Neurocognitive disorder has many subtypes, each with its own *DSM-5* diagnostic criteria (American Psychiatric Association, 2022). The *DSM-5* recognizes the following subtypes: Alzheimer disease, frontotemporal degeneration, Lewy body dementia, vascular disease, traumatic brain injury, substance use, HIV infection, Prion disease (Creutzfeldt-Jakob disease), Parkinson disease, and Huntington disease. Alzheimer disease is the most common of these disorders.

Key Terms

Alzheimer disease most common neurocognitive disorders; affects the brain by causing atrophy in the cortex and deposits of amyloid plaques and neurofibrillary tangles in the neurons, which cause degeneration of the neurons

delirium mental state in which the client becomes temporarily confused, disoriented, and not able to think or remember clearly

dementia older term to describe major neurodegenerative brain disorders that cause changes in a person's cognition

frontotemporal degeneration affects nerve cells in the frontal and temporal lobes of the brain, most common form in younger people

Huntington disease genetic mutation that causes both physical and cognitive declines; the disease attacks the neurons in the brain, causing them to die

Lewy body dementia involves Lewy bodies, insoluble deposits of alpha-synuclei protein that damage the brain

major neurocognitive disorder group of disorders that can affect younger and older individuals' cognition with a gradual decline in at least one of the following domains of cognition: executive function, complex attention, language, learning, memory, perceptual-motor, or social cognition

mild neurocognitive disorder (MiND) diminishment in an individual's cognition, attention, memory, learning, and/or social and motor skills that is greater than expected from the regular aging process but that does not cause the individual to be unable to function on their own

neurocognitive disorder brain function disorders that mark gradual or sudden diminishment in cognition, attention, memory, learning, social, and/or motor skills and often affect the ability to perform activities of daily living

Parkinson disease similar to Lewy body dementia, involving Lewy bodies, insoluble deposits of alpha-synuclei

protein that damage the brain

Prion disease (Creutzfeldt-Jakob disease) very rare dementia that progresses rapidly and leads to death within one year

vascular dementia stem from injuries to the brain caused by ischemia, such as a stroke, that block blood flow to the brain and lead to permanent neuron death

Assessments

Review Questions

1. A newly graduated RN is doing an initial assessment on a sixty-eight-year-old male who has come in with complaints of a decline in his cognitive abilities. What risk factor does she recognize as possibly contributing to the client's memory issues?
   a. no family history of dementia
   b. healthy weight and BMI
   c. history of skin cancer
   d. history of high blood pressure

2. Henry is an eighty-year-old client being followed for mild cognitive disorder. He says to Nurse Sylvia, "I don't understand why you keep telling me to do crossword puzzles." What is Nurse Sylvia's best response?
   a. "Doing crossword puzzles helps to keep the brain healthy by 'working it.'"
   b. "Doing crossword puzzles will keep you from getting bored."
   c. "Doing crossword puzzles is an inexpensive way to be entertained."
   d. "Doing crossword puzzles is what we recommend to all our older clients."

3. Nurse John visits an eighty-eight-year-old male with a history of dementia. When Nurse John arrives at the client's home, he notes that the client is more confused than normal, agitated, and has been incontinent on his couch. What important next interventions will help determine the cause of this increased confusion? Select all that apply.
   a. drawing labs
   b. taking a set of vital signs
   c. calling the physician
   d. collecting a urine specimen

4. A family member of a person with delirium asks the nurse to explain the main difference between delirium and dementia. What statement is correct?
   a. "Dementia resolves quickly once the cause is found."
   b. "Delirium resolves quickly once the cause is identified and treated."
   c. "The terms delirium and dementia are interchangeable."
   d. "Delirium will continue to worsen. There is no cure."

5. What should a nurse working on an inpatient unit for older adults recognize as an appropriate intervention for a ninety-year-old female who is worried about her baby?
   a. Re-orient her to her current age.
   b. Tell her that her baby is all grown up.
   c. Give her a baby doll to hold.
   d. Put her in front of the TV in the day room.

6. A nursing instructor is teaching students about neurocognitive disorders. Students are working in groups of four to complete a case study assignment. What statement made by one group indicates that the group needs further instruction?
   a. All older adults end up with dementia.
   b. Major neurocognitive disorder is the newer name for dementia.
   c. Alzheimer disease is the most common form of neurocognitive disorders.

d. The clock test is a standard assessment for neurocognitive disorders.

7. A nurse is planning the care of an eighty-five-year-old male with dementia. The nurse notices that the client is becoming anxious. What would be an appropriate intervention when talking to him does not decrease his anxiety?
   a. taking him to his room for a rest
   b. asking him to join other clients for an afternoon group
   c. offering a distraction or task such as folding towels
   d. calling the doctor to request an order for a tranquilizer

Check Your Understanding Questions

1. In your own words, define mild neurocognitive disorder.
2. Explain the nurse's role in caring for a client with delirium.
3. What nursing interventions can be implemented to manage delirium symptoms and create a supportive environment for the client?
4. Describe approaches to treatment used with dementia clients.

Reflection Questions

1. What information might you give to a primary caregiver of a person with mild cognitive disorder?
2. How does the nurse differentiate between delirium and dementia when assessing an older adult client? Describe specific symptoms and risk factors for each condition that the nurse should consider.
3. What information is important to collect in order to determine the type of dementia that a client might have?
4. What information would you need to determine if a person has dementia or delirium?

What Should the Nurse Do?

Tahira, a sixty-eight-year-old female, arrives at the clinic with memory lapses and challenges in daily tasks. She forgets names and misplaces items, causing increased frustration. Her daughter notes a gradual decline in cognitive abilities over the past year. Medical history includes well-controlled hypertension and type 2 diabetes. Compliant with treatment, Tahira monitors blood pressure and glucose levels at home, maintaining an active lifestyle. No significant psychiatric history is reported. During the assessment, the nurse observes mild confusion and a struggle with recall. Culturally sensitive care is emphasized. Vital signs show stable blood pressure (120/80 mmHg), heart rate (78 bpm), respiratory rate (16 breaths/min), and normal temperature (98.6°F). While physiological parameters are within limits, a comprehensive evaluation is needed to address cognitive concerns.

1. Considering Tahira's case, what challenges might health-care professionals face in diagnosing mild neurocognitive disorders, and how can cultural factors influence the diagnostic process?
2. As a nurse caring for Tahira, what nursing interventions could you implement to support her and her family in managing the cognitive decline associated with mild neurocognitive disorders?

Carlos, a seventy-eight-year-old male, is brought to the emergency department by his daughter due to sudden changes in behavior and cognition. Carlos's daughter reports that over the past forty-eight hours, he has become increasingly disoriented, agitated, and has exhibited fluctuations in attention. She notes that he has had difficulty recognizing family members, and his speech has become more incoherent. Carlos has a history of hypertension and type 2 diabetes, both well-managed with medication. He has no known psychiatric history. During the initial assessment, the nurse observes Carlos's vital signs, noting a blood pressure of 140/90 mmHg, a heart rate of 110 beats per minute, and a respiratory rate of 20 breaths per minute. His temperature is elevated at 101.2°F (38.4°C).

3. What key features in Carlos's case help distinguish delirium from dementia, and how might the sudden onset of symptoms influence the diagnostic process?
4. What specific nursing interventions can be implemented to support Carlos's overall well-being?
5. Given Carlos's medical history, which common causes of delirium might be relevant in his case, and how could these causes be further assessed or addressed in the emergency department?

Evgeniia, a seventy-five-year-old female, is brought to the clinic by her son due to concerns about her cognitive decline. Evgeniia has been experiencing increasing forgetfulness, confusion, and difficulty with daily activities, such as managing medications and meal preparation. Her son reports that she often repeats herself and has become socially withdrawn. Medical history reveals hypertension and osteoarthritis, both managed with medication. No significant psychiatric history is reported. During the initial assessment, the nurse observes Evgeniia exhibiting signs consistent with dementia, characterized by memory loss, impaired judgment, and changes in personality. Vital signs indicate a blood pressure of 130/85 mmHg, a heart rate of 76 beats per minute, a respiratory rate of 18 breaths per minute, and a normal temperature of 98.4°F (36.9°C).

6. Considering Evgeniia's symptoms, discuss which stage of neurocognitive disorder according to Reisberg's stages she might be in and elaborate on how these stages help in understanding the progression of cognitive decline in dementia.
7. Outline the approaches to treatment used for clients with dementia, focusing on how these approaches address the progressive and irreversible nature of the condition.
8. Discuss specific nursing interventions outlined in the chapter that contribute to the care of clients with dementia, especially those related to creating a supportive environment and addressing cognitive decline.

Competency-Based Assessments

1. Outline the key issues involved in diagnosing mild neurocognitive disorders, including the criteria mentioned in the *DSM-5* for mild neurocognitive disorder (MiND).
2. Describe the role of the nurse when a client is being treated for mild neurocognitive disorders, providing examples of nursing interventions that align with the outlined treatments.
3. Lay out the key differences in the diagnosis of delirium and dementia. How does the nurse contribute to the identification and assessment of these conditions in a clinical setting?
4. Define the various forms of dementia (major neurocognitive disorder) and provide an overview of their clinical manifestations.
5. Outline the approaches used in planning nursing care for a client with a major neurocognitive disorder. How can nurses assess and manage the environment to enhance the safety and well-being of individuals with dementia?

References

Administration for Community Living. (2021). *2020 profile of older Americans*. https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final_.pdf

Alzheimer's Association. (2023a). *Cognitive assessment and care planning services*. https://www.alz.org/media/Documents/Cognitive-Assessment-and-Care-Planning-Services_020323.pdf

Alzheimer's Association. (2023b). *Cognitive assessment*. https://www.alz.org/professionals/health-systems-medical-professionals/cognitive-assessment

Alzheimer's Association. (2023c). *Medications for memory, cognition and dementia-related behaviors.* https://www.alz.org/alzheimers-dementia/treatments/medications-for-memory

Alzheimer's Association. (n.d.) *Medications for memory, cognition and dementia-related behaviors.* https://www.alz.org/alzheimers-dementia/treatments/medications-for-memory

Alzheimer's Society. (2023a). *Delirium – symptoms, diagnosis and treatment*. https://www.alzheimers.org.uk/get-support/daily-living/delirium

Alzheimer's Society. (2023b). *Mild cognitive impairment (MCI).* https://www.alzheimers.org.uk/about-dementia/types-dementia/mild-cognitive-impairment-mci#content-start

Alzheimers.gov. (n.d.). *What is dementia?* https://www.alzheimers.gov/alzheimers-dementias/what-is-dementia

American Delirium Society. (2023). *About delirium*. https://americandeliriumsociety.org/

American Psychiatric Association. (2023, April). *What are dementia and Alzheimer's disease?*

https://www.psychiatry.org/patients-families/alzheimers/what-is-alzheimers-disease

American Psychological Association, APA Task Force for the Evaluation of Dementia and Age-Related Cognitive Change. (2021). *Guidelines for the evaluation of dementia and age-related cognitive change.* https://www.apa.org/practice/guidelines/guidelines-dementia-age-related-cognitive-change.pdf

Baptist Health. (2023). *Major and mild neurocognitive disorders*. https://www.baptisthealth.com/care-services/conditions-treatments/major-mild-neurocognitive-disorders

Centers for Disease Control and Prevention. (2021, October 18). *Creutzfeldt-Jakob disease, classic (CJD).* https://www.cdc.gov/prions/cjd/about.html

Centers for Disease Control and Prevention. (2022, November 14). *Creutzfeldt-Jakob disease, classic (CJD): Occurrence and transmission*. https://www.cdc.gov/prions/cjd/occurrence-transmission.html

Centers for Disease Control and Prevention. (2023, June 29). *Alzheimer's disease and healthy aging*. https://www.cdc.gov/aging/alzheimers-disease-dementia/about-dementia.html#commontypesofdementia

Cleveland Clinic. (2023). *Delirium tremens*. https://my.clevelandclinic.org/health/diseases/25052-delirium-tremens

Deshaies, S. (2023, March 23). *Caring for patients with dementia and Alzheimer's: Tips & resources for nurses*. NurseJournal.org. https://nursejournal.org/resources/nursing-care-patients-with-alzheimers-dementia/

Ellison, J. M. (2021). *Mild cognitive impairment: The essential facts*. BrightFocus Foundation. https://www.brightfocus.org/alzheimers/article/mild-cognitive-impairment-essential-facts

Emmady, P. D., Schoo, C., & Tadi, P. (2022, November 19). *Major neurocognitive disorder (Dementia)*. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK557444/

Hope, K. (2020). Role of nurses in addressing modifiable risk factors for early Alzheimer's disease and mild cognitive impairment. *British Journal of Nursing, 29*(8). https://doi.org/10.12968/bjon.2020.29.8.460

John Hopkins Medicine. (2023). *Frontotemporal dementia*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/dementia/frontotemporal-dementia

John Hopkins Medicine. (2024). *Lewy body dementia (LBD).* https://www.hopkinsmedicine.org/health/conditions-and-diseases/dementia/dementia-with-lewy-bodies

Lin, F., Vance, D. E., Gleason, C. E., & Heidrich, S. M. (2012). Caring for older adults with mild cognitive impairment: An update for nurses. *Journal of Gerontological Nursing*, *38*(12), 22–37. https://doi.org/10.3928/00989134-20121106-03

Marcantonio, E. R. (2017). Delirium in hospitalized older adults. *The New England Journal of Medicine, 377*(15), 1456–1466. https://doi.org/10.1056/NEJMcp1605501

Mayo Clinic. (2022, October 14). *Delirium*. https://www.mayoclinic.org/diseases-conditions/delirium/diagnosis-treatment/drc-20371391

Mayo Clinic. (2023, January 18). *Mild cognitive impairment (MCI).* https://www.mayoclinic.org/diseases-conditions/mild-cognitive-impairment/diagnosis-treatment/drc-20354583

MedlinePlus. (2021, December 2). *Delirium*. National Library of Medicine (US). https://medlineplus.gov/delirium.html

Mount Sinai. (2023). *Neurocognitive disorder*. https://www.mountsinai.org/health-library/diseases-conditions/neurocognitive-disorder

National Institute of Neurological Disorders and Stroke. (2023, January 20). *Huntington's disease.* https://www.ninds.nih.gov/health-information/disorders/huntingtons-disease

National Institute on Aging and National Institutes of Health. (2024, April 8). *What is mild cognitive impairment?* Retrieved April 8, 2024, from https://www.alzheimers.gov/alzheimers-dementias/mild-cognitive-impairment.

National Institute on Aging. (2023, October 12). *Sharing caregiving responsibilities.* https://www.nia.nih.gov/health/caregiving/sharing-caregiving-responsibilities

Psychology Today. (2019, April 4). *Neurocognitive disorders (mild and major).* https://www.psychologytoday.com/us/conditions/neurocognitive-disorders-mild-and-major

QSEN Institute. (n.d.) *QSEN competencies*. https://www.qsen.org/competencies-pre-licensure-ksas

Sheikh, N. (2022, January 13). *Defining the 6 key domains of cognitive function*. Altoida. https://altoida.com/blog/defining-the-6-key-domains-of-cognitive-function/

Tareke, M., Belete, T., Ergetie, T., Tadesse, M., Menberu, M., & Ketemaw, A. (2022). Triple burden of neurocognitive impairment and co-occurring depression and anxiety among people living with HIV in Bahir Dar, Ethiopia: A multicenter study. *Frontiers in Psychiatry*, *13*, 732229. https://doi.org/10.3389/fpsyt.2022.732229

UHealth Collective. (2018, September 19). *Thousands are misdiagnosed with dementia every year*. https://news.umiamihealth.org/en/its-not-always-dementia-heres-what-to-know/

Williams, S. S. (2016). The terrorist inside my husband's brain, *Neurology, 87*(13), 1308–1311. https://doi.org/10.1212/WNL.0000000000003162

CHAPTER 15

Schizophrenia Spectrum Disorder and Other Psychotic Disorders

FIGURE 15.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Schizophrenia spectrum disorders and other psychotic disorders all share the same common symptom, a loss of contact with reality that results in impaired functioning. While some of these disorders last from days to months with a total return to functioning, others within this spectrum of disorders cause lifelong disability, stigma, and significant cost. Early references to conditions containing the symptoms of schizophrenia appear in classical literature and the Bible. Eugen Bleuler, a Swiss psychiatrist, was the first to use the term schizophrenia in 1908. Until the 1950s, brain surgery, electric shock, sedative drugs, and sometimes life confinement were the only choices for the management of schizophrenia. With the invention of antipsychotics and the trend toward deinstitutionalizing those with mental health disorders, significant changes occurred for those diagnosed as being on the schizophrenia spectrum and having other psychotic disorders in the second half of the twentieth century. Nursing care is at the forefront of optimal care outcomes for those diagnosed with these disorders. Understanding the disturbance, symptoms, treatments, and care algorithms is essential in concordant nursing care.

15.1 Schizophrenia

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define schizophrenia and its prevalence, course, and causes
- Understand the symptoms associated with schizophrenia
- Explain the stages of schizophrenia
- Outline approaches used to treat schizophrenia
- Plan nursing care for a client living with schizophrenia

The severe mental illness and disturbance involving a collection of cognitive, affective, and behavioral symptoms that negatively affect social, educational, and/or occupational functioning is called **schizophrenia**. The course of the disorder varies. Some individuals endure episodes of the disease with asymptomatic breaks between them. Other people have continuous symptoms of the disorder with no remission. There are several theories of how this disturbance emerges, but there is no single etiology and no cure, only treatment for symptoms, including medications, therapies, and psychoeducation. The nurse's role is to assess clients for critical signs of the disorder, evaluate the impact of these symptoms on their functioning, plan and implement care during treatment, review the efficacy of drug and psychosocial interventions, and check for adverse events with medications.

UNFOLDING CASE STUDY

Schizophrenia: Part 1

The nurse is assessing a twenty-year-old male who reports to the emergency department with his mother and best friend.

PMH	Client is a second-year college student studying engineering. He is a bright young person attending college on a scholarship. He has no documented health issues outside of typical colds and ear infections as a child and a bout of influenza last year. Family history: Father has a history of bipolar disorder and substance use and has been out of their lives for fifteen years. Mother does not know his current whereabouts. Social history: Client has been active in sports and has played basketball through high school and up until last semester when he quit the team unexpectedly. Grades have been above average, and mother reports he has "never been in trouble." Mother reports the client has experimented with marijuana in the past, but she is not aware of any substance use at this time. The client has no current medications and no known allergies.
Nursing Notes	**1930: Triage Assessment** Client presents with confusion and delirium, pacing and muttering to himself. When questioned, he became agitated and suspicious of the staff's intent to help. Client declined to change into a gown and did not want vitals taken. Eventually he did comply, after talking with him and reassuring him he is safe. His Mother and friends report changes in personality over the course of the past several weeks with today becoming an acute emergency situation. The client was found taping tinfoil to his bedroom windows and made comments that there was a helicopter flying overhead and that the FBI was watching him. Client self-reports hearing voices in his head telling him to block the windows and hide. The client does not report any homicidal or suicidal ideation. Client unable to void to provide urine specimen.

Flow Chart	**1930: Triage Assessment** Blood pressure: 138/80 mmHg Heart rate: 107 beats/minute Respiratory rate: 22 breaths/minute Temperature: 99.1°F (37.2°C) Oxygen saturation: 98% on room air Pain: 0/10
Lab Results	Declining labs and unable to provide urine specimen

1. Reviewing the chart, the nurse identifies which of the following that requires further evaluation? (Select all that apply.)
   a. change in personality of client over past several weeks
   b. blood pressure 130/80 mmHG
   c. client oriented to time
   d. client hearing voices in his head
   e. respiratory rate 22 breaths/minute
   f. client is agitated and suspicious
   g. oxygen saturation 98 percent on room air
   h. heart rate 98 beats/minute

2. Based on the recognized cues, the nurse determines the client has symptoms that could indicate electrolyte imbalance (calcium and sodium), head trauma, or mental health disorder. Designate which condition the cue is associated with.

Cue	Electrolyte Imbalance	Head Trauma	Mental Illness
Confusion			
Agitation			
Hallucinations			
Altered personality			
Suspicion			
Altered vitals			

Defining Prevalence, Course, and Causes of Schizophrenia

It is posited that schizophrenia is created from a diverse genetic, environmental, and neurobiological etiology that manifests in specific neuronal changes in childhood that result in a cluster of positive, negative, and cognitive symptoms. The disturbance is seen globally and in all ethnic groups, and it usually emerges in early adulthood.

Prevalence of Schizophrenia

Schizophrenia affects nearly twenty-four million people or one in 222 adults (World Health Organization, 2022). Schizophrenia is found in every culture and population across the globe. Although it is not as common as other mental health disorders, the burden of the disease is high. Costs associated with schizophrenia in the United States exceed $150 billion annually (Kadakia et al., 2022). Aside from health-care costs like frequent hospital admissions, there are expenses related to lost work productivity of the person with the disorder and their caregivers and

expenditures for legal problems encountered by those with symptoms. Individuals with schizophrenia have a higher risk of suicide, greater involvement with the legal system and incarceration, and increased incidence of homelessness. Schizophrenia is associated with significant functional limitations, distress, and familial and social impairment. The lifespan of those burdened with the disturbance is fifteen years shorter than average due to common comorbidities, such as cardiovascular disease, metabolic disturbance, other mental health disorders, substance misuse, suicide, and infection (Hjorthøj et al., 2017).

The Course of Illness

The age of onset for schizophrenia varies with the average first episode at 23.7 years of age. Youth-onset schizophrenia's average age of onset is 13 years, and late-onset schizophrenia appears on average at 60.7 years of age. Earlier onset is associated with a poorer prognosis (Immonen et al., 2017). Subtle signs of the illness, such as language, motor, and cognitive abnormalities, may be present during childhood. Children who later develop schizophrenia demonstrate some social disturbances such as social withdrawal. Children who experience subtle prepsychotic symptoms are at higher risk for developing psychotic disorders later in life. These children may present with neuromotor delays, speech or language impairments, and lower IQ or declining IQ scores (Liu et al., 2015).

The course of the illness is highly variable. Some clients will have a single acute episode and then achieve complete remission; some may have several acute episodes with remissions in between them, while others may have continuous psychosis. Long term, however, most clients achieve remission and recovery after the initial illness, can go several years between psychotic episodes, and can find meaningful employment.

Potential Causes of Schizophrenia

The cause of schizophrenia is unknown. There are no biomarkers to assist in the diagnosis. Laboratory exams and radiographic studies do not confirm the diagnosis. There are some genetic and environmental factors that do, however, appear to increase individual risk for developing schizophrenia.

Heritability appears to have a significant influence on the development of schizophrenia. The risk of schizophrenia in the general population is 1 percent. Those with siblings diagnosed with schizophrenia have a 10 percent risk of developing the disease. Monozygotic twins will have a concordance rate of 40 to 50 percent rate of disease expression while dizygotic twins have a 15 percent rate (Imamura et al., 2020).

There is also evidence that in utero stressors may alter neurodevelopment (changes in glutamate receptors) and predispose a client to developing schizophrenia. These stressors include exposure to viruses, starvation, and complications during pregnancy. Other risk factors during early development include paternal age over fifty and under twenty, winter birth (in the Northern Hemisphere), and birth in urban areas. Risk factors during childhood and adolescence include being raised in an urban environment, migration, cannabis use, stressful life events, and trauma. Other factors that raise the risk of developing the disturbance include epilepsy or Huntington disease, head injury, tumors, cerebrovascular accidents, myxedema, Wilson disease, being from a lower socioeconomic class, having inadequate nutrition, and the absence of prenatal care.

There are three general neurobiological theories for the causes of schizophrenia. The first theory is that there is hyperactivity of dopamine in the mesolimbic pathway of the brain. The mesolimbic pathway connects the ventral tegmental area and the nucleus accumbens in the limbic system. It is here that the brain manages the reward system and desires. An overload of dopamine in this system increases the potential for aggression and psychotic symptoms.

The second hypothesis involves the neurotransmitter glutamate. Glutamate is a major excitatory neurotransmitter in the brain and is responsible for transmitting most of the sensory information in the body. The theory holds that due to genetic influences, changes in utero, or during critical neurodevelopmental stages, a hypofunction occurs in the N-methyl-D-aspartate (NMDA) receptors on glutamatergic neurons. This hypofunction results in two downstream effects: (1) too much dopamine in the mesolimbic dopamine pathways causing signs of psychosis, and (2) hypofunction in the mesocortical dopamine pathway in the prefrontal cortex causing the cognitive and negative symptoms of schizophrenia (Steullet et al., 2016). The final theory involves the neurotransmitter serotonin and its receptors. Hyperfunction, or too much activity at these receptors, causes the same hyperactivity in the mesolimbic dopamine pathway, leading to symptoms of psychosis.

There are four major dopamine pathways in the brain. These are important to know because the medications used

to treat psychosis impact all four of them and potentially cause side effects:

- Mesolimbic pathway: This pathway connects the ventral tegmental area in the midbrain to the ventral striatum of the basal ganglia in the forebrain. This pathway is responsible for memory, emotions, arousal, and pleasure. Increases in dopamine cause psychosis and aggression.
- Mesocortical pathway: This pathway connects the prefrontal cortex to the ventral tegmentum. It promotes higher-order functions, such as cognition, planning, organization, motivation, learning, and social behaviors. Decreased dopamine in this pathway can cause adverse symptoms, such as affective flattening, apathy, anhedonia, and lack of motivation.
- Nigrostriatal pathway: This pathway connects the substantia nigra and the basal ganglia. It is involved with bodily movement. Decreases in dopamine or neuronal degeneration in this pathway are associated with Parkinson disease and extrapyramidal symptoms, such as tardive dyskinesia.
- Tuberoinfundibular: This pathway connects the hypothalamus with the pituitary gland and manages metabolism, temperature control, thirst, digestion, and other endocrine actions. Decreases in dopamine in this pathway can cause amenorrhea or galactorrhea.

Symptoms of Schizophrenia

According to the *DSM-5*, to be diagnosed with schizophrenia, a client must experience at least two of the following symptoms for most of the time during a one-month period: (1) the presence of delusions, (2) hallucinations, (3) disorganized speech, (4) disorganized or catatonic behavior, (5) or negative symptoms. One of the two symptoms must be delusions, hallucinations, or disorganized speech. Signs of these symptoms must be present continuously for at least six months, and they cannot result from a medical disorder, another mental health disorder, or a substance. In addition, those with schizophrenia often experience cognitive deficits, such as memory problems, attentional shortfalls, and issues with problem-solving.

Defining Psychosis

As defined, **psychosis** is a severe mental condition where a person loses the ability to recognize reality or has lost contact with external reality, causing a loss of function and disorganization of personality. Schizophrenia is one type of psychotic disorder, though psychosis can be caused by medical illnesses, such as brain tumor and hyperthyroidism; substance misuse; or disorders, such as schizophrenia, schizoaffective disorders, delusional disorder, mania, severe depression, and personality disorders. The symptoms of psychosis include one or more of the following: delusions, hallucinations, disorganized thinking or speech, disorganized behavior, and negative symptoms.

Positive and Negative Symptoms of Schizophrenia

Active symptoms of schizophrenia include both positive symptoms and negative symptoms. **Positive symptoms** are symptoms that are "added" to a person who is nonpsychotic. These include any changes to behaviors or thought content, consisting of excessive, distorted thoughts and perceptions and the presence of symptoms, including hallucinations and delusions. **Negative symptoms** are symptoms that involve the "subtraction" or lessening of normal functions being "taken away" or are in deficit, such as behaviors that the individual is no longer demonstrating, including cognitive decline, apathy, anhedonia, and so forth.

Positive Symptoms of Schizophrenia

Positive symptoms of schizophrenia include delusions, hallucinations, and disorganized thoughts, speech, and behavior. These are symptoms the disease has "added" to the person. This section will cover some of the most common positive symptoms of schizophrenia.

A **delusion** is a fixed false belief that cannot be changed in the mind of those who hold them despite evidence to the contrary. Delusions can exist as a symptom of schizophrenia or as a symptom of a separate disorder called delusional disorder, which is discussed in detail in 15.3 Delusional Disorder. There are a number of different types of delusions experienced by clients who have been diagnosed with schizophrenia.

- Paranoid delusions, also known as persecutory delusions, are beliefs that the person who holds them is being watched, harmed, or stalked.
- Referential delusions are beliefs that ordinary events have a message or hidden meaning specifically for them.
- Grandiose delusions or delusions of grandeur are those where the individual believes they have unique gifts,

are essential, or are influential.
- Somatic delusions are those that involve bodily functions or health. The individual believes that something is wrong with them despite evidence to the contrary.
- Religious delusions involve faith-based themes. These beliefs are outside normative cultural beliefs and usually involve the individual believing they are a supreme being or the devil.
- Erotomatic delusions feature unfounded assumptions that others are in love with them.
- Nihilistic delusions are those where the person believes that they have no existence, that life has no meaning, or that something catastrophic will happen. These delusions are commonly found in those diagnosed with severe depression and paranoid schizophrenia.

Delusions can be classified further as bizarre or non-bizarre; a **bizarre delusion** involves fixed false beliefs with content that is not reasonably possible in this world. They are strange, eccentric, and unrealistic. An example of a bizarre delusion is when an individual believes that an alien has implanted a chip in the person's head, and that their parents are speaking to them through the chip. A **non-bizarre delusion** is a fixed false belief containing content that is plausible but inconsistent with evidence. An example of a non-bizarre delusion is one where the individual believes that a provider has removed their hymen during a medical procedure (a pap smear) and is insistent that the provider put it back. Sometimes it is difficult to discern a non-bizarre delusion from reality, especially if the client has experienced significant trauma, torture, political upheaval, or unrest.

Another common symptom of schizophrenia, a **hallucination** is the perception of sensory experiences without natural external stimuli. Types of hallucinations include auditory, visual, tactile, gustatory, and olfactory. An **auditory hallucination** is the altered perception of hearing in the absence of external stimuli. These hallucinations can be single or multiple voices or murmuring. They can include noise, music, or other sounds. A subset, command auditory hallucinations direct the individual to do things, like commit violence toward self or others. The person experiencing the symptom may or may not heed the command. A **visual hallucination** is a false sensory experience that is seen. They can be people, things, or flashes of light, sometimes in the periphery. A **tactile hallucination** is a false sensory perception involving the sense of touch; something is on the skin, crawling, biting, or touching.

Having a **gustatory hallucination** involves a false perception involving taste. It is usually strange or unpleasant flavors, such as something metallic. An **olfactory hallucination**, or *phantosmia*, is a false sensory experience involving the sense of smell.

These are more commonly caused by head injuries, aging, seizures, and tumors and often involve detecting scents not in the person's immediate environment.

Many people afflicted with schizophrenia exhibit signs of disorganized thoughts, speech, and behavior. Table 15.1 provides information on these language and behavioral abnormalities and examples.

Abnormality	Definition	Clinical Example
Loose association	When a client switches from one unrelated topic to another	"I like hotdogs. Come take a look at my houseboat."
Circumstantial thinking	When a person delays getting to the point of a conversation, providing random, tedious, and unnecessary details	When asked about their day, the client provides all the tiny details of everything they did that day.
Tangentiality	Occurs when a person answers a question with indirectly related or unrelated information but never gets to the point of the topic	"I have a date tonight. Do you like dates? I think that all fruit is necessary for good fiber intake. I need to use the restroom."

TABLE 15.1 Language and Behaviors in Schizophrenia (Hitczenko et al., 2021)

Abnormality	Definition	Clinical Example
Concrete thinking	A literal interpretation of ideas or environmental stimuli with a lack of abstract thinking, such as being unable to understand metaphors or analogies	A client who is asked to shower takes their clothes off immediately regardless of where they are.
Neologism	Making up new words that have no meaning to others but make sense to the individual	"I have moxyplams for my tadonxses."
Word salad	The random connection of words without logic	Cab Abu use eat too oh hi.
Clang associations	Connecting words according to sound	Cat bat mat sap lap.
Mutism	The inability to speak	The client does not respond when asked a question.
Perseverating	When someone repeatedly uses the exact words, phrases, and ideas when communicating	A client references the same person over and over again during a session.
Echolalia	The repetition of words that one hears from another person	A client is asked to sit down for dinner and responds, "Dinner, dinner, dinner, I want to go to dinner, dinner, dinner."
Echopraxia	The imitation of the movement of others	The client mimics the movement of the nurse with whatever they do with their body position or limbs.
Catatonia	An abnormality of movement and behaviors	The client is found lying stiff in bed.
Negativism	Resistance to movement and instructions	The client does not move or respond when another client asks them to.
Stupor	A complete lack of response	The client is conscious but not interacting at all.
Catatonic excitement (or psychomotor agitation)	Excessive and stereotypic movements	The client is pacing, rocking, and grimacing.
Waxy flexibility	When a client allows their limbs to be placed in any position for long periods	The nurse puts the client's hand up in a stop position, and the client does not move it at all.

TABLE 15.1 Language and Behaviors in Schizophrenia (Hitczenko et al., 2021)

Negative Symptoms of Schizophrenia

The negative symptoms of schizophrenia "take away" from normative emotional expression. Negative symptoms often involve a decrease or absence of motivation, interest, and expression. Two specific and common negative symptoms include diminished or inappropriate affect and anhedonia. A diminished affect occurs when there is a decrease in the emotional expression of the client. It can range from restricted to flat, a complete lack of emotional

expression. Inappropriate affects are emotional expressions incongruous with a current situation, such as crying during a comedy or laughing during a sad event, and anhedonia, an inability to feel pleasure. Other negative symptoms include poverty of speech (alogia), general apathy, lack of interest in self-care or physical energy, and lack of concentration.

Cognitive Symptoms of Schizophrenia

Some clients experience **cognitive symptoms**, deficits in their ability to think or reason. These symptoms can include deficits in working memory, such as the ability to do mental math; decision-making capabilities, such as the ability to make choices; organization, such as making mental arrangements or coordinating activities; problem-solving, such as identifying causes, solutions, and implementing processes; and, finally, the overall ability to process information.

Moreover, some clients may not understand that they are ill or psychotic. When a client is unaware that they are ill because of the illness itself, it is called **anosognosia**. It creates a situation where they often do not engage in treatment, leading to nonadherence to medications. Nonadherence to medication results in adverse outcomes, such as symptom relapse, repetitive hospitalizations, and interactions with the legal system (involuntary commitments or incarceration). Clients who are experiencing paranoia may become aggressive or assaultive, but those with the disease are more likely to be victims than aggressors. Table 15.2 summarizes the symptoms of schizophrenia.

Positive Symptoms of Schizophrenia	Negative Symptoms of Schizophrenia	Cognitive Symptoms of Schizophrenia
Delusions Persecutory Referential Grandiose Somatic Religious Erotomaniac Nihilistic Hallucinations Auditory Visual Tactile Gustatory Olfactory Disordered thought Loose associations Circumstantial thinking Tangentiality Concrete thinking Disordered Speech Echolalia Echopraxia Disordered behavior Aggression Stereotypy Catatonic excitement	Affective Affective flattening Decreased eye contact Inappropriate affect Disordered movement Negativism Avolition Anergia Disordered speech Poverty of speech Mutism Alogia Disordered behavior Apathy Decreased response to social interaction	Slow thinking Difficulty understanding Poor concentrating Difficulty with memory Disorganized thoughts Difficulty with vigilance Difficulty with reason Difficulty with problem-solving

TABLE 15.2 **Positive, Negative, and Cognitive Symptoms of Schizophrenia** (Carbon & Correll, 2014)

PSYCHOSOCIAL CONSIDERATIONS

Implicit Bias and Psychosis

Implicit bias includes humans' automatic and often unintentional beliefs based on experiences, thoughts, and other previously learned behaviors. These biases are learned associations or pairings that can occur with human or social qualities, ethnicities, or gender; they can influence health outcomes. In mental health, provider implicit bias influences client interactions, treatment decisions, and health outcomes. Some providers have perceived Black and Latinx clients as less adherent, noncooperative, and as having risky behaviors. As a result, these clients are more likely to receive a diagnosis of a severe mental illness, such as schizophrenia than their White counterparts. At the same time, they are less likely than White clients to receive the most effective treatments (Kopera et al., 2015).

Management of implicit bias in nursing starts with education on implicit bias and self-assessment. The National Institutes of Health offers a free implicit bias course specific to health-care (https://openstax.org/r/77ImplicitBias) professionals. Additionally, individuals can anonymously assess self-implicit associations through Project Implicit, a partnership with Harvard University. Through this nonprofit organization, the individual can select an implicit association test (https://openstax.org/r/77ImplicitAssoc) through the study portal to facilitate self-awareness.

Additional strategies to mitigate bias in the health-care workplace include:

- identifying and transforming strategies to eliminate norms that perpetuate bias
- establishing monitoring systems in client outcomes
- implementing clinical procedures that protect clinicians and nurses from the high cognitive load that can perpetuate implicit bias

Stages of Schizophrenia

There are three phases of schizophrenia: prodromal, acute, and recovery. The prodromal phase is when nonspecific symptoms first appear. Active psychotic symptoms characterize the acute phase. The recovery phase is when the individual begins to notice symptoms diminishing.

Prodromal Phase

The first phase is the prodromal phase, which occurs before the first signs of psychosis appear. During the prodromal phase, there is a gradual onset of nonspecific behaviors, such as sleep disturbances, suspiciousness, decreased attention to activities of daily living, disconnection with peers and family members, depressed mood, irritability, and problems focusing or understanding. The prodromal phase can last for a few weeks to several years. Of those diagnosed with schizophrenia, almost 75 percent have expressed prodromal symptoms.

Acute Phase

The second phase is the acute phase, which features active psychotic symptoms. During this phase, clients often encounter the medical and mental health system of care for the first time. During this phase, the disease is most visible and clients exhibit both the positive and negative symptoms of psychosis.

UNFOLDING CASE STUDY

Schizophrenia: Part 2

See Schizophrenia: Part 1 for a review of the client data.

Nursing Notes	1945: Intervention Client became aggressive with staff, mother, and friend, and tried to hit the friend. The client fell out of the bed and landed on buttocks. No head trauma, bruising, or bleeding noted. Security called; client was restrained.

3. Based on the change in the condition of the client, which action would the nurse prioritize?

a. protect the friend
b. remind the client that they are not permitted to assault others
c. determine whether the client has sustained an injury
d. ensure that the client will not harm other people

4. Based on the change in the condition of the client, which of the following actions would be Recommended, Not Recommended, or Irrelevant for this client at this time?

Actions	Recommended	Not Recommended	Irrelevant
Administer haloperidol			
Urodynamic study (UDS)			
Close observation			
Administer insulin			
Bandage head of client			
Let the mother sit with client			
Comprehensive metabolic panel (CMP)			

Recovery Phase

The next stage of the progression is called the recovery or residual phase. During this phase, there is a quieting of the symptoms, a diminishing of the active symptoms or "clearing," and more clarity of thought. In this phase, additional mood symptoms can emerge, such as depression, as the client considers the impact of the disease on the trajectory of their life. Although the residual phase is mainly devoid of active, psychotic symptoms, clients in this phase often do report blunted affect, conceptual disorganization, and social withdrawal. The progression or continuation in this stage depends on treatment, medication adherence, and determinants of health, such as housing, transportation, education, income, access to food, language, health literacy skills, and social support.

The phases may not be entirely linear. Remember that clients can lapse into another active phase of psychosis at any time; most clients with schizophrenia relapse multiple times during their lifetime. Risk factors of relapse include nonadherence to medications, substance misuse, another mental health diagnosis, short treatment duration, disparities in mental health treatment, and preexisting childhood adversity (Saria et al., 2014).

REAL RN STORIES

Nurse: Maria, staff nurse
Years in Practice: Three
Clinical Setting: Inpatient adult unit
Geographic Location: Urban

A nurse assessed a twenty-one-year-old male who was a musician in a professional marching band. His friends and bandmates noticed he was "not himself" and had not been that way for some time. About seven months ago, he changed from being outgoing and garrulous to being withdrawn and noncommunicative. He stayed in his room most of the day in his bed, refusing to come out for practice or for social time with his best friends. He began to be more and more paranoid. When his friends came to his room, he would crack open the door and peer out at them from the opening. He would not let them in the room and stopped taking their phone calls. He was not taking care of himself,

going for days without showering. Finally, his employer contacted his parents due to concerns about his behavior; he had not attended work or practice in weeks.

When his parents arrived at his apartment, he refused to let them in. He told them they were "imposters" and that "aliens had implanted chips in his head and told him that his parents were not real." On hearing this, his parents contacted the police, and the client was brought to the hospital for evaluation and treatment. The psychiatric nurse provider completed an evaluation. The client refused inpatient hospitalization. A petition for commitment was submitted and completed by an outside provider, which resulted in the client being involuntarily committed to the facility for psychotic behavior. After admission to the psychiatric unit, the client refused to leave his room. Instead, he would stare at the nursing staff through the crack in the door.

He told them the "aliens were reporting to him that no one was real." These "aliens" were also telling the client that he "should not trust anyone" and that he "should escape now!" These hallucinations prompted the client to make several escape attempts from the unit.

During one of the elopements, the client attempted to jump out of a second-story window after listening to the alien voices telling him "to jump to escape the imposters." The client refused nursing and medical intervention multiple times. Finally, staff administered injectable antipsychotic medications. As the client became responsive to the medications and the psychotic symptoms began to clear, he became more communicative with the nursing staff and his family. The voices in his head seemed "duller" and less "clear," and he became less paranoid of those around him. As the client continued his recovery, he noted that he had no memory of the events that led up to and during the first days of his hospitalization.

Treatment of Schizophrenia

Treatment options for schizophrenia require ongoing assessment and management of active symptoms and how they manifest and impair daily functioning. Collaboration with the family and/or primary caregivers and mental health providers is essential in developing the treatment platform. Families can be affected by stigma, stress, grief, anxiety, and isolation as they navigate the trajectory of the disturbance with their loved ones. Recommendations for family support groups and family therapy are paired with improved outcomes in those with schizophrenia. Finally, the inclusion of community-based resources helps clients to optimize treatment outcomes. Treatment for those with schizophrenia should be client-centered and include a combination of medication and psychosocial interventions.

Client-Centered Care Approaches

When a client presents for care with a possible diagnosis of schizophrenia, it is essential to take a client-centered care approach. Client-centered care considers client preferences, health literacy, treatment barriers, cultural beliefs, and lifestyle when helping clients to make decisions about their health. Determine realistic outcomes and psychosocial interventions that align with the client's availability of resources and support systems. Clients diagnosed with schizophrenia have optimal outcomes when they have psychopharmaceutical intervention in conjunction with nonpharmacological options. Part of determining the best treatment options is to complete a full assessment inclusive of medical and social history, medication history, family history, and support systems. Safety is paramount; risk for suicide and violence should be part of every assessment.

Medications

Medications used to treat schizophrenia belong to a class called antipsychotic medications. These medications generally block dopamine to reduce the positive symptoms of psychosis. Antipsychotics were developed as a preanesthetic medication in the 1950s, but with further research, the first medication, chlorpromazine, treated mania effectively, ultimately leading to the first generation of antipsychotic medications.

First-Generation Antipsychotics

After the invention of chlorpromazine, a dopamine and serotonin receptor antagonist, in the 1950s, the first-generation antipsychotics, or *neuroleptics*, were introduced into mainstream psychiatry. These medications included haloperidol, trifluoperazine, thioridazine, and fluphenazine, and their primary function was to block dopamine (D2) receptors. They also have some actions at histamine, cholinergic, and alpha-adrenergic receptors. The high-potency medications (haloperidol, trifluoperazine, and fluphenazine) have a high risk for extrapyramidal

side effects. The low potency medications (chlorpromazine and thioridazine) have significant anticholinergic properties, are sedating, and can cause weight gain, but do not cause as many extrapyramidal side effects. Overall, any of these first-generation antipsychotics can cause extrapyramidal symptoms, sedation, anticholinergic symptoms, prolactin elevation, QT prolongation and potential for sudden death, lowering of the seizure threshold, orthostatic hypotension, sexual dysfunction, and metabolic disturbance. They have significant drug/drug interactions. Due to the sedating nature of some of these medications, assessment for fall risk is essential, especially in vulnerable populations.

Second-Generation Antipsychotics

Second-generation antipsychotics entered psychiatric practice in the 1970s with the invention of clozapine. These drugs function by antagonizing dopamine and serotonin (2A) receptors. This atypical antipsychotic medication class has fewer extrapyramidal symptoms due to their dual actions on dopamine and serotonin receptors. Second-generation antipsychotics include aripiprazole, asenapine, brexpiprazole, cariprazine, clozapine, iloperidone, lumateperone, lurasidone, olanzapine, paliperidone, pimavanserin, quetiapine, risperidone, and ziprasidone. Like their first-generation family members, second-generation antipsychotics also have potential interactions with other medications. Table 15.3 summarizes antipsychotic medications.

Medication	Common Side Effects	Routes of Administration	Contraindications
Chlorpromazine (Thorazine) Fluphenazine Haloperidol (Haldol) Thioridazine Trifluoperazine	Extrapyramidal side effects (dystonia, akathisia, tardive dyskinesia, pseudoparkinsonism, neuroleptic malignant disturbance), galactorrhea and amenorrhea, sexual dysfunction, hypotension, anticholinergic symptoms (dry mouth, constipation, blurred vision), weight gain, and risk for metabolic syndrome	Pill, liquid, depot (haloperidol)	Use with caution in older adult populations, in those with cardiac disease, in clients with seizure disorder
Aripiprazole (Abilify) Asenapine (Saphris) Brexpiprazole (Rexulti) Cariprazine (Vraylar) Clozapine (Clozaril) Iloperidone (Fanapt) Lumateperone (Caplyta) Lurasidone (Latuda) Olanzapine (Zyprexa) Paliperidone (Invega) Pimavanserin (Nuplazid) Quetiapine (Seroquel) Risperidone (Risperdal) Ziprasidone (Geodon)	Metabolic side effects (insulin resistance, hyperglycemia, dyslipidemia, weight gain), nausea, constipation, dry mouth, lowered incidence for extrapyramidal side effects (dystonia, akathisia, tardive dyskinesia, pseudo-Parkinson's, neuroleptic malignant disturbance), agranulocytosis, neutropenia (for Clozaril), galactorrhea and amenorrhea (risperidone)	Pill, depot (Risperdal, Invega, aripiprazole, olanzapine)	Use with caution in older adult populations, in those with cardiac disease (quetiapine, ziprasidone), in clients with seizure disorder

TABLE 15.3 Antipsychotic Medications (Doyle, 2015)

Medication recommendations depend upon different variables, such as the presence of positive or negative symptoms, medication efficacy, side effect management, and nonadherence. The first-line choice for managing positive symptoms is second-generation antipsychotics, except for clozapine due to its risk for neutropenia. The second line choice is clozapine and first-generation antipsychotics. In acute cases, choices for managing positive symptoms include first- and second-generation antipsychotics and benzodiazepines. For the treatment of mainly negative symptoms, second-generation antipsychotics are the first choice, with antidepressants, modafinil, and clozapine as secondary choices. First-line choices for clients concerned about weight gain include ziprasidone, lurasidone, and aripiprazole. To enhance sedation, the best choices include quetiapine, clozapine, asenapine, and olanzapine. First-line choices for clients concerned about sedation include ziprasidone, lurasidone, and aripiprazole. Finally, for clients who struggle with nonadherence, choose depot forms of both first- and second-generation antipsychotics (National Library of Medicine, 2016). Depots are long-acting injectable forms of antipsychotic medications. They promote medication adherence because the drug is injected every two to six months. Table 15.4

summarizes the nursing interventions for the side effects of antipsychotic medications.

Side Effect	Intervention or Education
Extra pyramidal symptoms	• Assess and document onset and location of symptoms • Document functional impairment if any • Administer medications if ordered • Observe for response to treatment if any and document
Anticholinergic	
Dry mouth	• Assess and document onset of symptoms • Offer ice, water, hydration • Provide candy or gum • Attend to oral care
Blurred vision	• Implement fall-risk protocols • Remind client that side effects can resolve in a week or two • Ask that they do not operate heavy machinery during this time
Constipation	• Encourage hydration, high fiber diet, laxatives as prescribed, and increase in physical activity if not contraindicated
Urinary hesitancy	• Assess and document symptoms; notify provider • Monitor intake and output
Sedation	• Assess and document sedation • Assess and document risk for falls • Implement fall-risk protocol • Communicate with provider about timing of medications • Educate client not to operate heavy machinery while taking sedating medications
Orthostatic hypotension	• Assess and document blood pressure • Communicate with provider assessment details • Educate client about rising slowly, sitting before standing, using handrails
Amenorrhea/ gynecomastia	• Assess and document findings; notify provider • Educate client about mechanism of side effects • Discuss with provider and client about possibility of alternate medication/decrease in medications
Metabolic side effects (Metabolic syndrome)	• Assess weight and BMI before and during regular intervals while taking medication • Assess fasting glucose and lipids with provider orders • Communicate findings with providers • Educate client on healthy diet and exercise

TABLE 15.4 Nursing Interventions for Antipsychotic Side Effects (Young et al., 2014)

Side Effect	Intervention or Education
ECG changes	• Assess and document ECG findings before initiation and during treatment • Communicate findings with provider • Educate client about notifying providers/team about palpitations, dizziness, weakness, shortness of breath
Agranulocytosis	• Assess and document white blood cell count and absolute neutrophil count at initiation of treatment and during treatment (according to REMS protocol with Clozaril clients) • Communicate findings with provider

TABLE 15.4 Nursing Interventions for Antipsychotic Side Effects (Young et al., 2014)

The blockade of dopamine in the nigrostriatal pathway has the potential to cause movement disorders and side effects called extrapyramidal side effects (Table 15.5). These can be movement side effects, such as dystonia, pseudoparkinsonism, tardive dyskinesia, and akathisia, or critical side effects, such as neuroleptic malignant disturbance, a medical emergency.

Extrapyramidal Side Effect	Symptoms	Treatments
Akathisia	Subjective complaints of leg or arm movements, rocking, pacing, feeling restless like they cannot sit still Develops within the first few weeks of starting or increasing dose of medication or reducing or removing a medication that is used to mitigate EPS	Dose reduction, switch to another antipsychotic medication, treatment with beta blocker, benzodiazepine, or amantadine
Dystonia	Involuntary contractions and spasms of the muscles, painful, starts in the face, neck, shoulders Develops within a few days of starting or increasing dose of medication or reducing or removing a medication that is used to mitigate EPS	Dose reduction, and switch to another antipsychotic medication, treatment with Cogentin or Benadryl
Tardive dyskinesia	Involuntary facial movements, sucking, chewing, lip smacking, tongue protruding, blinking eyes	Dose reduction, removal of the offending agent, and switch to another antipsychotic medication, treatment with tetrabenazine or deutetrabenazine

TABLE 15.5 Extrapyramidal Side Effects and Treatments (Caroff & Campbell, 2016; Ware et al., 2018)

Extrapyramidal Side Effect	Symptoms	Treatments
Pseudoparkinson's (Drug induced parkinsonism)	Shuffling gait, stiff facial muscles, tremors, bradykinesia, akinesia Develops within a few weeks of starting or increasing a dose of medication or reducing or removing a medication that is used to mitigate EPS	Dose reduction, removal of the offending agent and switch to another antipsychotic medication, treatment with amantadine or levadopa
Neuroleptic malignant disturbance	Onset is usually two weeks after the initiation of antipsychotic treatment or a change in dosage High fever (102 to 104 degrees Fahrenheit), irregular pulse, tachycardia, tachypnea, muscle rigidity, confusion, hypertension, diaphoresis *This is a medical emergency*	Removal of the offending agent, supportive care, maintenance of cardiovascular status through monitoring, mechanical respiration, medications, maintenance with IV fluids, treatment of hyperthermia with cooling blankets, benzodiazepines for agitation, and dantrolene for muscle rigidity and elevated CK and bromocriptine/amantadine for moderate to severe symptoms

TABLE 15.5 **Extrapyramidal Side Effects and Treatments** (Caroff & Campbell, 2016; Ware et al., 2018)

CLINICAL JUDGMENT MEASUREMENT MODEL

Side Effects: AIMS

A twenty-three-year-old client has been admitted to the inpatient psychiatric unit after spending two days waiting on a bed in the emergency department. The client had been experiencing auditory and visual hallucinations and delusions that the government has been watching them. The client was irritable and aggressive while in the emergency department. They were given several doses of haloperidol 5 mg with 25 mg of Benadryl by mouth during their time in the emergency department. Upon arrival to the inpatient unit, the client is calm but still experiencing hallucinations. The client was given an additional dose of haloperidol 5 mg with another 25 mg of Benadryl. During their one month on inpatient, the client was transferred to risperidone, and is now taking 3 mg by mouth at bedtime. One evening, after the nighttime dose of their medication, the client approached the nurse complaining that their mouth felt like it was "twitching." Consider these skills in the assessment of this client using the Abnormal Involuntary Movement Scale (AIMS) (see Appendix B Abnormal Involuntary Movement Scale).

1. Recognize cues: The RN uses assessment skills to evaluate potential side effects of antipsychotic medications, such as extrapyramidal side effects like tardive dyskinesia. Using the AIMS assessment tool, the entire examination can be completed in ten minutes by the nurse. There are twelve items on the scale that are assessed in various areas of the body.

The first step in completing the AIMS exam is to monitor the client discreetly while at rest. Then ask if they are wearing dentures or mouth fixtures. If so, do they or their teeth hurt the client? Then ask the client to sit with their hands on their knees and feet flat on the floor. Observe for movement. Then ask the client to put their hands between their knees unsupported. Observe again for movement. Then ask if there is any unusual movement in their body. If the answer is yes, ask if the movement is bothersome or interferes with any daily activities. Then have the client open their mouth and stick their tongue out twice. Observe any tongue movements. Then ask the client to tap their fingers to their thumbs rapidly. Have them do this on both hands. Then ask the client to stand. Observe the client in profile and look for any abnormal movements. Then have them extend their hands out with palms down. Observe for movement. Then have the client walk back and forth. Have them do this twice, observing for abnormal movement. After this is done, complete the AIMS form.

2. Analyze cues: Analyze any cues to abnormal movements in the body. Are there any mouth or facial movements, any in the hands or legs? Is the client aware of these movements, and if so, are they bothersome to the client? If it is bothersome to the client, how bothersome? This is also a good time to assess for any other extrapyramidal symptoms, such as parkinsonism, dystonia, and akathisias.

3. Prioritize hypotheses: If there are signs and symptoms of tardive dyskinesia, identify possible medications that could be contributing to the adverse events. While antipsychotics are the most likely culprits, other medications have been known to cause the symptoms: antidepressants, antiemetics, and stimulants.

4. Generate solutions: The intended outcome is reduction in adverse events related to the medication.

5. Act: Notify provider of assessment details, take vital signs, administer medications as needed, monitor client response per agency policy, and evaluate the effects of the medications by reassessing the client one-hour postadministration.

6. Evaluate outcomes: Evaluate the client's response to the medications provided. Assess for worsening of symptoms, worsening of side effects, and functional impairment.

Psychosocial Treatments

Psychopharmaceutical treatments are the cornerstone for managing clients with schizophrenia. But the long-term success for clients also depends on the psychosocial and rehabilitative treatment options available in medical, nursing, and community settings. Treatment options include social skills training, cognitive remediation, cognitive behavioral therapy, family therapy, support groups, peer-to-peer counseling, occupational therapy, school and work assistance programs, and care management. Communication and collaboration between care providers, avoiding gaps in service delivery, and managing transitions of care are all critical in managing psychosocial treatments for clients.

Social Skills Training

Clients diagnosed with schizophrenia frequently experience symptoms causing them to struggle socially, often resulting in stigma and isolation. Social skills training improves social competence by providing skills, such as basic conversation, medication management, and community reintegration. Social skills interventions have been influential in reducing mental health symptoms, decreasing repeated hospitalizations, and improving social outcomes.

Cognitive Remediation

Cognitive symptoms of schizophrenia can result in deficits in processing, attention span, and memory. Cognitive training or remediation focuses on repetitive exercises designed to reorganize information, aid in learning, and provide behavioral prompts to assist in memory.

Family Education Groups

These groups focus on two interventions to assist clients, family members, and loved ones of those with schizophrenia. The first treatment approach emphasizes coping skills related to stress from living with the illness. The second approach highlights education on the diagnosis, symptoms, interventions, medications, side effects, and adverse events. Those engaging in family groups and interventions have seen positive outcomes, such as decreased relapse rates, fewer hospitalizations, and greater adherence to medications.

Cognitive Behavioral Therapy

Up to half of all clients with schizophrenia experience hallucinations and delusions. Using CBT to treat some of the positive symptoms of psychosis helps clients to challenge what they are experiencing and restructure what is happening to them. The cognitive model assumes that life events and experiences mold and shape core beliefs. It follows then that these beliefs influence everyday automatic thoughts. Automatic thoughts, like delusions and hallucinations, influence emotions, behaviors, and physiological responses. Therefore, the goal for CBT with respect to hallucinations and delusions is to facilitate a scenario with the client where they can challenge what they are experiencing:

"Is this a symptom, or is this actually happening to me?"

REAL RN STORIES

Nurse: Pam, advanced practice psychiatric nurse practitioner
Years in Practice: Ten
Clinical Setting: Outpatient treatment facility
Geographic Location: Southeast United States

I was an advanced practice psychiatric nurse practitioner with ten years of experience and certified in CBT. I was doing a psychotherapy session with a client in the recovery stage of schizophrenia. The client was experiencing delusions that "people were looking at her and talking about her all the time." This occurred daily as she went about managing her tasks in the community.

During the session, the client mentioned that she was walking to her therapy session and noticed a person who walked by her. She had a thought that he was "talking on the phone about her." I asked the client if we could use this for their therapy session today, and the client said we could. I asked to identify what evidence, if any, that the person was talking about her. The client could not name any. I then asked to identify evidence that the person was not talking about her. The client then came up with several facts or scenarios as to why he was not talking about her.

I then asked her: What is more likely to be true?

A. The thoughts that you are having are symptoms of your illness.
B. The person was talking about you.

The client could use the evidence to identify that the thoughts were part of her symptoms. She was then able to use this method daily to challenge her delusions when walking in public.

Nursing Care for a Client Suffering from Schizophrenia

Nurses should develop a plan of care that is in accord with the client, their family, and other caretakers and that is relevant and culturally appropriate. It should involve evidence-based medical and psychosocial interventions that will assist the client in meeting their treatment goals in the least restrictive environment.

Nursing Assessment

Nursing interventions for those with schizophrenia begin with an assessment. For those experiencing psychosis, crowded, noisy, bright rooms can be very distracting during an interaction. Ensure that the assessment is done in a quiet room, with soft lighting, without interruptions. Allow access to the door for egress for both the nurse and the client, even if safety is not a concern.

Ensure the safety of self and client. If the client is acting aggressively, use a soft, soothing voice, move slowly, and approach with hands in front and palms open (Table 15.6). Ask one question at a time, and allow the client time to answer questions. Observe their behavior. Are they looking at the interviewer or like they are responding to internal stimuli (hallucinations)? If they look like they are hallucinating, ask them if they see or hear things other than the interviewer's voice. Have them describe what they see or hear. If the hallucinations are command in nature, ask about the content and keep them from acting on those commands. Assess for suicidal or homicidal content. Ask the client about delusions. Do not challenge their beliefs, but explore the nature of any expressed delusion. Assess any risk to self or others that may accompany the delusional thoughts.

Category	Techniques
Environmental	Remove distractions, lower bright lights, take to a quiet place with fewer people.
Personal	Calm and center self; do not take things personally. Be aware of body language and take an assertive but nonconfrontational stance (hands in front at sides, palms open). Give personal space. Speak in a calm, quiet, low voice. Listen, provide empathy. Do not judge. Do not make promises. Give choices. Use active listening skills to determine sources of frustration. Allow the person to vent frustration. Provide a sense of safety if the person is exhibiting paranoia. Seek consensus resolution. Be flexible.

TABLE 15.6 De-escalation Techniques (Gaynes et al., 2017)

Nursing Clinical Judgment

The goal for the client with schizophrenia is to maintain stability through adherence to medications, continued interaction with health-care providers, mitigation of adverse reactions and side effects, optimal nutritional status, and social and occupational functioning. The nursing clinical judgment measurement model assists the nurse in formulating clinical decisions based on critical thinking through client presentations to achieve optimal client outcomes. To prioritize clinical judgment, consider differing treatment and outcome goals through acute and maintenance phases of schizophrenia.

UNFOLDING CASE STUDY

Schizophrenia: Part 3

See Schizophrenia: Part 2 for a review of the client data.

Nursing Notes	**2025: Assessment** Physical Examination: Client is clean and appropriately dressed, alert and oriented ×1, unable to state time, place, or why he is in the hospital. Confused as to why there are so many people in his "bunker." HEENT: Pupils equal, reactive to light (PERRL), mucus membrane dry, pharynx without lesions, palate intact. No thyroid enlargement. Lymphatic: Tonsillar and cervical lymph nodes noted but not enlarged, hard, palpable left axillary lymph nodes, tender to touch; no enlargement of right axillary or inguinal nodes, no pain or tenderness noted. Respiratory: Clear to auscultation bilaterally, no stridor, no crackles or murmur. Cardiovascular: Regular rate and rhythm, no edema, peripheral pulses 2+ Abdomen: Bowel sign present in all four quadrants, no organomegaly or tenderness. Musculoskeletal: Bone and joint pain, full ROM Skin: Pale and dry, bruising noted on both elbows and forearms that are unexplained. Slight irritation and erythema around wrists and ankles due to attempts to remove restraints. Mental assessment: Client denies any depression or suicidal ideation, exhibits fear and suspicion of others; mood and affect: labile and incongruent
Flow Chart	**2025: Assessment** Blood pressure: 140/82 mmHg Heart rate: 96 beats/minute Respiratory rate: 22 breaths/minute Temperature: 99.3°F (37.3°C) Oxygen saturation: 98% on room air Pain: 3/10
Lab Results	Urine obtained. UDS: positive for marijuana

5. Following lab results, the UDS and CMP, it is confirmed that the client's condition has not resulted from any underlying physical cause and is to be treated as a mental health problem. Which actions will be taken with this client? (Select answers from the appropriate lists.)

The nurse knows that the client will be prescribed ___List 1___ that may result in side effects such as ___List 2___, ___List 2___, and ___List 2___. The client will be evaluated for improvement in his condition as evidenced by the client ___List 3___ and ___List 3___.

List 1
lithium carbonate (Carbolith)
benztropine (Cogentin)
benzodiazepine (Alprazolam)
risperidone (Risperdal)
amitriptyline (Elavil)

List 2
blurred vision
diarrhea
urinary frequency
constipation
hyperactivity
dry mouth

List 3

pacing only in the mornings
engaging in therapeutic modalities
seeing the FBI not in a helicopter
only using tinfoil on windows when voices tell him to do so
phones his mother to complain directly to her
complying with his medication

6. The nurse would use clinical judgment to ascertain if the following behaviors by the client demonstrate that treatment has been Effective, Ineffective, or is Irrelevant.

Behavior	Effective	Ineffective	Irrelevant
Takes his medications			
Watches television			
Complains that people are following him			
Is isolated and talking to himself			
Talks in group therapy sessions			
Talks to his mother on the telephone			
Can talk about what might trigger a psychotic episode			

Treatment and Outcome Goals

The client and the health-care team should identify realistic short- and long-term treatment goals. These can include taking medication as directed; mitigating side effects and adverse events associated with drugs; reducing positive, negative, and cognitive symptoms; improving self-care deficits; improving social/occupational/educational functioning; and engaging in therapeutic modalities. Each stage of schizophrenia will have different outcome goals that require attention.

Outcomes Identification for the Acute Phase

Priority goals for clients in the acute phase of the illness include decreasing psychotic symptoms and maintaining the client's and others' safety. Utilize internal safety protocols to maintain a safe environment for both the client and staff. Use the least restrictive measures when managing aggression in violent and paranoid clients, and continuously assess and document carefully after any hands-on interventions. Other treatment goals in the acute phase include medication adherence, minimizing side effects and adverse effects of medications, establishing trust, and transitioning to lower levels of care in the community.

Outcomes for Stabilization and Maintenance Phase

During the stabilization and maintenance phases, preservation of stability and reestablishment into the community are optimal goals for outcomes. This is done through connecting the client with community resources, pharmacy assistance programs, crisis intervention and assertive community treatment teams (ACT), social workers, case managers, faith-based organizations, and the Schizophrenia and Psychosis Action (https://openstax.org/r/77SchizPsyAssoc) Alliance, an organization for support, advocacy, and research. Best nursing outcomes are specific, measurable, achievable, relevant, and time-bound (SMART). Other outcomes include mitigating side effects, ensuring medication adherence, coping with diagnosis/symptoms, and managing stigma.

Implementation of Nursing Care

After assessment and setting treatment measures to meet goals, it is time to implement nursing care. Implementation strategies during the acute phase include:

- ensuring the least restrictive care environment and its safety, management of the safety of the client and others
- mitigating risks if present
- completing safety checks in the milieu and per unit safety protocols
- monitoring for changes to mental status, medication adherence, side effects, the effectiveness of medication management; and client data, such as vital signs, intake and output, and height and weight

Implementation during the stabilization and maintenance phase includes:

- safe transfers of care
- communication with other health-care providers
- transfer of health records according to HIPAA requirements
- coordination with other community care providers
- facilitating the use of cognitive interventions with clients to help challenge residual hallucinations
- establishing therapeutic communication and trust with clients experiencing delusions and then helping the client to focus on reality-based themes
- working with family, friends, and other supportive caregivers to develop a relapse prevention plan
- working with the client to identify warning signs of psychosis, stressors, side effects, or behaviors that lead to medication nonadherence, and things to do and people to call when concerned about relapse or safety

Implementation of treatment during this phase also includes family education about resources, medication, side effects, health, diet, and exercise. There are a number of issues pertaining to the recovery of the client that have to be shared with the client and the family. The information for the client relates to their personal recovery and ability to remain healthy. The information shared with the family is in the form of explaining the condition to them and giving advice on how to support the client and maintain their role within the family (Table 15.7).

Client Education	Family Education
Education on illness	Education on illness
Side effects of medications	Stigma
Adverse events and drug/drug interactions	Reentry into community
Diet, exercise, nutrition	Living with the illness
Smoking cessation	Symptoms
Substance use mitigation	Side effects of medications
Relapse prevention	Adverse events and drug/drug interactions
Peer support groups	Relapse prevention
Medical treatment adherence	Caregiver stress
Community support groups	Peer support groups
Therapy options	Therapy options
Reentry into the community	

TABLE 15.7 Client and Family Education (Habibi et al., 2015)

One notable type of philosophy for care of those diagnosed with schizophrenia is a therapeutic milieu, which is a holistic, safe, and structured environment that helps facilitate emotional well-being and recovery. The idea behind milieu therapy is that the environment affects how one feels or thinks. The optimal milieu therapy for an individual experiencing psychotic symptoms is a quiet, safe, and nonthreatening one. The milieu will help reduce aggression and violence in those with schizophrenia. Specific components of milieu therapy to support the client with psychosis include:

- Structure: Ensure predictable times, places, appointments, and schedules. Ensure that the client is in the same room, receives meals and medications in the same place, and has uninterrupted morning and evening routines.
- Containment: The client is maintained on specific safety protocols and levels according to their current level of risk. This limits access to things considered a risk to self-harm or harm to others. Communicate these limitations clearly and consistently to everyone on the treatment team, including the client and family

members.
- Safety: The milieu must be safe for clients and staff. Ensure that it is emotionally safe by projecting empathy and consistency with staff.
- Flexibility: A healthy milieu is adaptable and supportive, not rigid or controlling.
- Socialization: The milieu provides an opportunity to apply social skills and to have others reciprocate.

A highly functioning milieu will help accelerate recovery from the psychotic process, establish trust, and develop social skills and communication with others. In addition, it will help to build a sense of safety and security and provide a supportive environment for the client to build new psychosocial skills. The nurse's role is to manage the milieu, set and enforce healthy boundaries, establish routines, and provide a supportive environment.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Safety During and After the Restraint

Definition: Minimizes risk of harm to clients and providers through both system effectiveness and individual performance (QSEN Institute, n.d.).

A psychiatric RN was involved in a behavioral restraint with a male client who attacked a staff member with the leg of a chair. The client was diagnosed with a psychotic disorder; the etiology had yet to be determined. The least restrictive interventions were not successful, including the option to take oral medications. Orders were given for restraint by the provider. A five-person team gathered, and the client was placed in four-point restraints in the room designated for that purpose. The client was given an injection of olanzapine 10 mg in the right buttock. The restraint room has a video camera, but the RN sat one to one with the client as per protocol. The RN documented information about what led up to the restraint, including all least restrictive efforts employed. As soon as the client was placed into restraints, vital signs were assessed along with neurovascular status on all four extremities. After seven minutes, the client became calm. One arm was released without incident. Vital signs and neurovascular status were assessed every fifteen minutes and they were allowed to use the restroom if needed. The client was monitored for pressure ulcers and signs and symptoms of rhabdomyolysis (muscle cramps, aches, or dark urine). Once the client was released from the restraints, vital signs were repeated, and a mental status evaluation was done. Assessments were documented on the standardized form used by the facility as per protocol. The client was continuously monitored for the remainder of the day. The staff completed a debrief that included evaluation of the situation, performance, and adherence to training requirements.

Evaluation of Nursing Care

Evaluating the effectiveness of treatment and the progression toward recovery is integral in client-centered care. This involves gathering information from all stages of care, and all sources of care and communicating the information with all care providers and team members, including the client, their family, and other care providers. Nurses should evaluate the following after implementing treatment for clients with schizophrenia:

- reduction of harm to clients and staff during restraints
- integration of safety practices that reduce harm to clients (medication reconciliation, five rights, falls prevention)
- assessment for risk of violence and suicide using evidenced-based tools
- assessment and monitoring of side effects and adverse events of psychotropic medications
- identification of client preferences, health literacy, and other client-centered outcomes in client records
- promotion and documentation of "warm handoffs" and communication between providers, systems, and clients during care transitions; warm handoffs are communications (over the phone or in person) between providers when a care transfer occurs
- involvement of case management services, social work, and other community transition services to ensure recovery-oriented practices (Mayo Clinic, 2020)

15.2 Schizophrenia Spectrum Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Recall the different types of schizophrenia spectrum disorders
- Outline evidence-based approaches to treating and caring for a client with a schizophrenia spectrum disorder

Schizophrenia is a disturbance that includes positive, negative, and cognitive symptoms in those who have expressed them for over six months. Several other disorders, though resembling schizophrenia symptomatically, do not quite meet this criterion. This section reviews these disorders, how they differ from schizophrenia, and their management.

Schizophrenia Spectrum Disorders

Psychotic disorders include brief psychotic disorder, substance/medication-induced psychotic disorder, psychotic disorder due to a medical condition, schizophreniform disorder, schizoaffective disorder, and catatonia. Schizophrenia spectrum disorders are other psychotic disorders that share similar symptoms with schizophrenia: delusions, hallucinations, disorganized thinking or speech, disorganized behavior, and negative symptoms. The three schizophrenia disorders are schizophreniform disorder, schizoaffective disorder, and schizophrenia.

Schizotypal personality disorder is considered on the spectrum for schizophrenia spectrum disorders, but it is a personality disorder. Those with schizotypal personality disorder have shared genetic and neuropsychiatric commonalities with schizophrenia; a small number of those diagnosed with the disorder do go on to develop schizophrenia. More information on schizotypal personality disorder can be found in Personality Disorders. Schizophrenia is a diagnosis of exclusion, meaning that providers rule out medical, substances, and all other causes for psychotic behaviors before diagnosing schizophrenia. This next section will discuss the diagnostic criteria and treatments for schizophrenia spectrum disorders (American Psychiatric Association [APA], 2022).

Brief Psychotic Disorder

Brief psychotic disorder is the presence of psychotic symptoms for one day and less than one month. Symptoms include delusions, hallucinations, disorganized speech, or disorganized behavior. At least one of the symptoms must be delusions, hallucinations, or disorganized speech to qualify for the disorder. These symptoms cannot be caused by any other mental health disorder or by a substance. In some cases, there can be a clearly defined precipitating stressor for psychotic symptoms, such as a peripartum onset; in other cases, there is not. The brief psychotic disorder accounts for 2 to 7 percent of psychotic presentations globally. It can be present across the lifespan but usually occurs in late teens or early adulthood. Despite the symptoms lasting less than a month, almost half of those diagnosed with brief psychotic disorder experience another psychotic episode (APA, 2022).

Substance/Medication-Induced Psychotic Disorder

A substance or medication-induced psychotic disorder is the presence of hallucinations or delusions soon after use, intoxication, withdrawal, or exposure to a substance or medication. These symptoms cannot occur during a delirium (a transient state of altered consciousness due to a medical condition or substance) and the substance must be capable of producing the psychotic effect. Substances known to cause these effects include alcohol, cannabis, phencyclidine, hallucinogens, inhalants, sedatives, hypnotics, anxiolytics, stimulants, cocaine, toxins, insecticides, and fuel or paint. Medications known to cause these effects include anesthetics, anticholinergics, cardiovascular drugs, antiparkinsonian medications, and muscle relaxants. The symptoms can present differently depending on the substance, medication, or toxin. The symptoms may abate immediately or persist, even to the point of a later diagnosis of a schizophrenia spectrum disorder.

Psychotic Disorder Due to Another Medical Condition

Psychotic disorder due to a medical condition is more prevalent in older age groups due to comorbid medical conditions that are more common later in life. Causative conditions affiliated with this disturbance include neurological (head injury, neoplasms, cerebrovascular accidents, epilepsy), hypo and hyper thyroid, hypoxia, hypercarbia, hypoglycemia, hepatic insufficiency, renal insufficiency, infection, and fluid or electrolyte imbalances. The diagnostic criteria are the presence of hallucinations or delusions as the direct consequence of a medical condition. The symptoms cannot be due to a mental health disorder or substance. The course of the symptoms

depends on the course of the medical illness or disease. Once the client has managed the underlying condition, the psychotic symptoms will resolve.

Schizophreniform Disorder

Consider the timeline of symptoms that falls between brief psychotic disorder and schizophrenia; this is schizophreniform disorder. The diagnostic criterion for this disorder is the presence of delusions, hallucinations, disorganized speech, disorganized behavior, and negative symptoms for at least one month but less than six months. At least one of the symptoms must be delusions, hallucinations, or disorganized speech. The symptoms cannot be attributed to a substance or a medical condition. The course of the illness is dependent on whether the client continues to experience symptoms or they remit. If the symptoms continue, the diagnosis may evolve to a diagnosis of schizophrenia.

Schizoaffective Disorder

Schizoaffective disorder is the presence of a mood disorder, either a major depressive disorder, a manic episode or bipolar disorder, in conjunction with the symptoms for schizophrenia. The client must have six months of symptoms to meet the diagnosis of schizophrenia. They then either have a major depressive episode or a manic episode during that same six months. A depressive episode means a sad mood, decreased energy/motivation, guilt, decreased/increased appetite, insomnia/hypersomnia, anhedonia, and/or suicidal thoughts for at least two weeks. A manic episode is characterized by the presence of an elevated mood, decreased need for sleep, pressured speech/talkative, flight of ideas, distractibility, increase in goal-directed activity, and increase in risky behaviors for at least one week. During the remission of the mood episode, the client must continue to experience psychotic symptoms (delusions or hallucinations) for at least two weeks, and a substance, another mental health condition, or a medical condition cannot bring on the symptoms. Males and females equally express the bipolar subtype, while females are twice as likely to express the depressive subtype.

REAL RN STORIES

Nurse: George W., RN
Years in Practice: Ten
Clinical Setting: Crisis Intervention Unit
Geographic Location: Mississippi

I was a psychiatric nurse working for about ten years as a nurse generalist. A client was admitted to the inpatient unit for psychotic behavior and aggression. The client was a 310-pound male champion weightlifter. He abused weight loss supplements for six months to boost his performance. These supplements included ephedra, yohimbe, and phentermine. Mostly calm throughout the day, the client would randomly and unexpectedly go into confused rages and throw another client against the wall, accusing them of "getting into my head and talking about me!" After these episodes, the client would pace, take off his clothes, and mumble to himself. The client took haloperidol for these outbursts, and his routine medication was a second-generation antipsychotic. Despite these two medications, the client was unable to settle or sleep. It was not until the addition of chlorpromazine that the client could sleep at night and the violent outbursts subsided.

One day, as I was standing behind the desk, the client approached me. This was right after the client had assaulted another client on the unit. The client was calm and smiling. He looked at me and asked me if he could hug me. I told him that it would not be a good idea. He insisted that he come and hug me. I again said to him that it was not a good idea. I could see out of the corner of my eyes, the male staff getting nervous about the potential for another assault, this time on a female staff member. The client said, "I am going to come hug you." I decided to make myself very calm and took a nonthreatening stance as he moved his massive frame around the desk to me. He hugged me and then left. There was a collective sigh of relief as he moved away, and we did not have to engage in a potentially dangerous client redirection.

Catatonia

Catatonia is a disturbance caused by neurotransmitter signal disruptions manifesting as motor, affective, and cognitive symptoms. It can happen in the context of another mental health disorder, such as schizophrenia

spectrum disorder, depression, bipolar disorder, or a medical condition. It stems from neurodevelopmental, mental health, and medical disorders. Twelve types of behaviors are part of the diagnostic criteria for catatonia, and they are divided into three subtypes (Healthline, 2024b):

- retarded, which entails mutism, inhibited movement, posturing, rigidity, negativism, and staring
- malignant, characterized by fever, autonomic instability, delirium, and rigidity
- excited, which looks like excessive motor activity, stereotypy, impulsivity, and combativeness

Malignant catatonia can be life-threatening and usually warrants admission to the intensive care unit for treatment and monitoring. The diagnostic criteria include the presence of three of the clinical symptoms of catatonia (Table 15.8). These symptoms resolve with the management of the underlying psychiatric or medical condition. Most evidence-based treatment recommends using either benzodiazepines or ECT to manage catatonia. It is important to know the symptoms of catatonia because the nurse needs to be able to recognize them, although they might not be seen very often or could be mistaken for the symptoms of another condition. Table 15.8 outlines the full range of symptoms that might be experienced by a client with catatonia.

Symptom	Description
Stupor	No motor activity, not relating to the environment
Catalepsy	Passive induction of a posture held against gravity
Waxy flexibility	Positioning by examiner held by client
Mutism	Little or no verbal response
Negativism	Opposition to or no response to instructions or external stimulus
Mannerism	Acting out mannerisms in an odd way
Posturing	Spontaneous and active maintenance of posture against gravity
Stereotypy	Repetitive, frequent, non-goal directed movements
Agitation	Excited or irritable
Grimacing	Of the facial features
Echolalia	Mimicking other's speech
Echopraxia	Mimicking other's movements

TABLE 15.8 Symptoms of Catatonia

Evidenced-Based Approaches to Treatment for Schizophrenia Spectrum Disorders

The approaches to treatment of those with schizophrenia spectrum disorders are similar to those of schizophrenia. Medication includes the use of first- and second-generation antipsychotics. Adding mood stabilizers and antidepressants to paliperidone (the only second-generation antipsychotic FDA-approved for schizoaffective disorder) sometimes helps minimize the symptoms of depression and mania seen in schizoaffective disorder. For conditions resulting from substance use, medications, or medical disturbances, psychotic symptoms resolve when the underlying causes have been treated. Treatment for catatonia entails first stopping any offending agent and treating the underlying disorder, be it bipolar disorder, psychotic disorder, or psychotic depression. First-line treatments for catatonia include benzodiazepines or electroconvulsive therapy depending upon the type of catatonia and severity of presentation. Nursing care involves monitoring clients with malignant catatonia for

hyperthermia, hypertension, and lethal arrhythmias. Avoid dopaminergic-blocking drugs in those with catatonia, including antipsychotic medications. They are contraindicated in clients with malignant catatonia.

Psychosocial approaches to managing spectrum disorders are also similar to those that are effective for clients with schizophrenia. These treatments include psychosocial therapy, family therapy, cognitive behavioral therapy, and social skills training for those with longer-standing disturbances. Successful outcomes rely upon medication adherence, successful transition from higher levels of care to community care models, and integration into social, educational, and occupational functioning.

Nursing treatments for those with catatonia must first consider symptoms, vital signs, fluid intake and output, cardiopulmonary status, and nutrition. For clients with limited movement, managing skin integrity is critical to decreasing the incidence of pressure ulcers. This includes passive range of motion exercises to decrease the potential for muscle contractures.

Clients with excited catatonia and excessive motor activity require the least restrictive interventions to mitigate risk of injury. Interventions that reduce environmental stimuli may be the most effective management strategies for aggressive behaviors.

15.3 Delusional Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define and understand the diagnosis of delusional disorder
- Outline the common types of delusions experienced in delusional disorder
- Recall the treatment approaches used in delusional disorder

Although there are some similarities, delusional disorder differs from schizophrenia because diagnosis only requires the presence of delusions and none of the other earmarks of psychosis. Those with delusional disorder may not be impaired like those with other psychoses. This section will focus on delusional disorder, the different types, treatments, and complications.

Defining and Diagnosing Delusional Disorder

Delusions are fixed false beliefs based on inaccurate judgment of an external reality. Delusional disorder is characterized by clients having one or more non-bizarre delusions that have lasted for one month or more. These clients do not appear functionally impaired other than by the ramifications of the delusion(s). Those with delusional disorders often present with other mental health disorders, most commonly depression and anxiety. The delusions cannot result from a medical or known substance or medication. In other words, delusional symptoms caused by medical illnesses or diseases do not constitute delusional disorders.

Diagnosing delusional disorder can be complex. These clients usually function well when focused on something other than the delusion. When focused on the delusion, however, they will spend significant and sometimes inordinate amounts of time attempting to accrue evidence or align others with their beliefs. Individuals suffering from this disorder may contact health-care professionals, attorneys, private detectives, the police, and even the court system to confirm their beliefs. They do not have insight into their delusion. Attempts to dissuade them from their delusion will likely result in a negative response by the client, including hostility and aggression. The best way to determine the presence of the disorder is to assess the validity of their claim. Rule out any medical cause and differentiate the delusional disorder from another mental health disorder. For instance, suppose a client claims to have bugs in their urine (delusional parasitosis). The diagnostic assessment entails obtaining copies of the client's medical records, collecting collateral information from family members, physical examination and labs, ascertaining if the client has taken any other medications or substances, and communicating with the providers they have seen over the past several years (Healthline, 2024a).

Prevalence, Risk, Causes, and Course of Delusional Disorder

The risk of delusional disorder is small, 0.05 to 0.1 percent in population-based studies. Risk factors include family members with schizotypal personality disorder and schizophrenia (Jadhav et al., 2014). The age of onset is between thirty-five and forty-five years but can range between eighteen and eighty years. The cause of delusional disorders is unknown. There is evidence that dysfunction in dopamine neurotransmitter functioning may play a role, along with

medial/frontal and anterior cingulate cortex brain abnormalities. The disorder can emerge suddenly or gradually. For example, an acute onset might happen as a part of a stressful event. The course of the illness is relatively stable and chronic. When considering this diagnosis, consider normative cultural beliefs; Western cultures may misdiagnose some traditional and faith-based beliefs as delusional behavior.

CULTURAL CONTEXT

Kufungisisia

Stress is expressed differently from the lens of varying cultural frames. To ensure that these concepts of distress are conceptualized from these perspectives, it is essential to frame these experiences as the client experiences them. A Shona concept is *kunfungisisa* or "thinking too much," and can be a precursor to anxiety, depression, and somatic complaints ("My heart hurts"). This is prominent in the Shurugi district in Zimbabwe. It is a perseverative process focusing on bodily symptoms, including aches, lack of appetite, and sleeplessness. The symptoms can also include anxiety, depression, panic, anger, hallucinations, suicidal thoughts, and substance misuse. Recognition of the concept is imperative. It is a sign of stress and anxiety, not a somatic delusion. Nursing interventions focus on the recognition of the cultural concept of distress and the implementation of culturally appropriate care, such as faith-based spiritual and community support and potential medication management for anxiety and or depression.

(Patel et al., 1995)

Those who suffer from delusional disorder have good outcomes when treated. If not treated, several adverse outcomes can result from behaviors related to the delusions.

Social Isolation

Paranoia can make someone feel alone; other people do not understand or may feel threatened by the person with the delusions. Interactions with other individuals may cause their delusions or moods to worsen. They may become irritable, threatening, or volatile. In such cases, social isolation might result from others staying away or the individuals protecting themselves from others. Social isolation might serve to maintain or further aggravate the delusions.

Depression and Self-Harm

Social isolation and mistrust can lead to mood symptoms, such as depression, creating a cycle. The symptoms of depression—no energy, no motivation, anhedonia, guilt, sad mood, irritability, problems sleeping, and suicidal thoughts—can worsen this social isolation by increasing the need to stay at home. Additionally, those suffering from certain delusions can engage in self-harming behaviors. For instance, a client with delusional parasitosis or a belief that their body is infested may scratch themselves repeatedly to rid themselves of the infestation. Assessment of those with those beliefs for self-harming behaviors is essential in ensuring their health and well-being.

Legal

The intersectionality between mental health and the legal system is involved when commitment is a concern (danger to self, others, or gravely disabled), when there is a question regarding the capacity to participate in their defense during criminal cases, and if there was diminished capacity when committing a crime. In general, those suffering from mental illness are overrepresented in the criminal justice system. Substance Abuse and Mental Health Services Administration (SAMHSA, 2022) estimates 18 percent of the general population have a mental illness, though 37 to 44 percent of incarcerated individuals have a mental illness.

Those suffering from erotomaniac, jealous, and persecutory delusions, for instance, can become involved in the legal system if they stalk their object of desire, cross boundaries, or attempt to harm others. The nursing role in forensic settings is to provide safety and security for the client while providing nonjudgmental care and maintaining appropriate boundaries (Dhaliwal & Hirst, 2016).

Common Types of Delusions

Delusional disorder usually involves non-bizarre delusions but can have bizarre content. The types of delusions and subtypes include erotomaniac, grandiose, jealous, persecutory, and somatic.

Erotomaniac

Erotomaniac delusions involve thoughts of an idealized love between the client and another individual. They usually involve a celebrity or someone who they have never met before. The person affected by the delusion might attempt to connect with or communicate with the celebrity. The belief usually starts with an initial encounter and develops over time as the feelings grow, and the delusion becomes set. These beliefs might lead to stalking or assaultive behaviors, resulting in involvement with the legal system. Celebrities with delusional stalkers include Rihanna, Madonna, Selena Gomez, and Taylor Swift. The stalking behaviors resulted in arrests, probations, home relocations by the celebrities, and restraining orders. The individuals affected by these delusions are often vulnerable, isolated, sexually repressed, and have poor social skills (Seeman, 2016).

Grandiose

Grandiose delusions involve the idea that the individual has done something great or is someone extraordinary. These beliefs might include that they have great wealth, they have power or influence, they are a world-renowned scientist or novelist, or they are greatly admired. This differs from the grandiosity of mania because the mood symptoms affiliated with mania are not present with the delusion. Clients with delusional disorder, grandiose type, are rare and may present as a comorbidity with a psychotic or mood process (Healthline, 2024a).

Jealous

Jealous delusions are when the individual believes their partner or spouse is cheating on them or will cheat despite evidence to the contrary. Delusionary beliefs of the jealous type can lead to dangerous behaviors, including harm to the partner.

Persecutory

Persecutory or paranoid delusions involve the central theme that people are out to get them. They are the most prevalent of the delusional disorder subtypes. Those suffering from persecutory delusions believe they are being watched, harassed, or obstructed. Anxiety and worry have a significant role in the mechanism of these types of delusions (Startup et al., 2016) and can be a target for psychological intervention. These individuals may also present themselves as irritable or aggressive, guarded, suspicious, or isolative. These individuals may believe that others are trying to hurt them, poison them, spy on them, or acting against them. They often socially isolate, live away from others, and do not interact with others. Additionally, they may involve the legal system to get justice for the wrongs they believe have been done to them.

Somatic

Somatic or "of the body" delusions involve health, bodily symptoms, or undiagnosed disease. Onset is either acute or gradual, unremitting; these clients usually do not receive mental health care. When they do, they typically present first in infectious disease, medical, or dental clinics and are referred to mental health as a consultant. Delusional parasitosis is a type of somatic delusion where the individual believes they are infected with insects or parasites, for instance. Those with delusional parasitosis often present with comorbid psychiatric illnesses, such as depression, substance misuse, and anxiety. The clients will usually claim that they have extensive knowledge of their infestation and that their family members have been exposed or affected; they may bring a sample of their infestation and may experience **formication**, a hallucination that bugs are crawling on the skin (Campbell et al., 2019).

REAL RN STORIES

Nurse: Pam, advanced practice psychiatric nurse
Years in Practice: Twelve
Clinical Setting: Outpatient mental health facility
Geographic Location: Community, rural

I was an advanced practice psychiatric nurse and received a referral from an infectious disease clinic. The client arrived with a cup of urine in their hands. The client stated, "I have a leishmaniasis infection. Look at my urine." The client had traveled to Australia and came home with symptoms of urinary frequency and burning. They had a friend who traveled to Central America and came home to find that they had the infection; the friend received significant treatment afterward. The client was convinced that they now had the same infection. After receiving word from the

infectious disease clinic that leishmaniasis is not endemic to Australia and that the client had a simple urinary tract infection remedied by antibiotics, the client was not convinced. They went to another infectious disease clinic and were told the same thing. The client has been to several providers and clinics, insisting they suffered from the infection. The client was now being evaluated by me today as a referral from the last infectious disease clinic.

I first spent time developing trust and therapeutic alliance with the client. I did not challenge the delusions and encouraged the client to engage in medication therapy after a few sessions. The client was initiated on a second-generation antipsychotic and a serotonin reuptake inhibitor for their comorbid anxiety disorder (OCD). After eight weeks on the medication, the client reported to me that they no longer needed "to see someone for their leishmaniasis. I am cured."

Treatment of Delusional Disorder

The initial step to treating delusional disorder is establishing therapeutic rapport and trust. These clients need to feel validated and engaged in their treatment through empathy and understanding. It is crucial to align treatment decisions with the client, including their support system, to facilitate adherence to treatment. Medical and psychosocial interventions follow the establishment of the trusting therapeutic relationship.

Medications

Clients with delusional disorder often do not have insight into their illness. It is not easy to come to agreement on first-line treatments when the client disagrees that they have a psychotic disorder. The first step is to give the client space and time to consider the diagnosis; sit with it, take time to understand it, and allow themselves to become comfortable with it. Educating the client when they are calm and open to information is the best approach to medication adherence and optimal outcomes. Overall, second-generation antipsychotics are the first choice in medications used to treat delusional disorders. Risperidone (Risperdal) is the medication most frequently cited in case studies with olanzapine (Zyprexa) and quetiapine (Seroquel) as second and third choices. Other medications used in delusional disorders are SSRIs and SNRIs in combination with second-generation antipsychotics. This combination assists with depression and anxiety, often seen in those with delusional disorder. For those clients who struggle with nonadherence to medication, long-acting injectables (LAI) have also been useful (Jalali Roudsari et al., 2015).

Psychosocial Approaches to Treatment

If the client is not willing or does not have the insight into their illness to take medications, adjunctive psychotherapy is the other option. The best outcomes for individuals with delusional disorder have been with cognitive behavioral therapy aimed at identifying the evidence, challenging the delusions, and targeting comorbid anxiety and depression. A clinical example of cognitive therapy for delusional disorder is the Thinking Well Intervention. This therapy involves having the client slow down their thinking, look for more evidence, generate alternative explanations and thoughts rather than delusions, find other ways to think about more logical and less distressing things, and then consider how their thinking affects their mood. This type of intervention has been effective in generating positive outcomes for distress in those with paranoid delusions (Waller et al., 2015). Supportive psychotherapy helps clients work through their experiences with the disorder, provides a framework for coping skills, and eases emotional distress.

Summary

15.1 Schizophrenia

Schizophrenia is a disorder usually beginning when a person is in their late teens or early twenties. The etiology of the condition is unknown, although there are a range of theoretical perspectives, and it is thought to involve neurotransmitter signal disruption. The client can pass through acute, stabilization, and maintenance phases when experiencing the disorder. There is no one characteristic for schizophrenia, but clients can experience symptoms such as delusions, hallucinations (usually auditory), incoherence, catatonic or hyperactive behavior, and flat effect. Symptoms are categorized as being positive and negative. Treatment is often dependent on medications that can have serious side effects, with psychosocial techniques also being used to help the client return to their role in society.

15.2 Schizophrenia Spectrum Disorders

Schizophrenia spectrum disorders include schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, medication and substance-induced psychotic disorder, catatonia, and psychotic disorder due to another medical condition. The key to understanding the differences between these disorders is the timing and duration of symptoms and precipitating events. Treatment for most of them include removing offending agents, treating the underlying condition, and managing psychosis with second-generation antipsychotic medications, therapy, and psychosocial techniques.

15.3 Delusional Disorder

Delusional disorders differ from other psychotic disorders because the clients may not appear to be functionally impaired. Types of delusions include jealous, somatic, grandiose, erotomaniac, and persecutory. Treatments for delusional disorders remain relatively unaltered from treatments for clients with schizophrenia. Clients are offered medication management in conjunction with psychosocial therapy, family therapy, cognitive behavioral therapy, and consultation and collaboration with general health providers and legal professionals in some cases. Successful outcomes depend on medication adherence, decreased behaviors involving the legal system, and continued communication with other health-care and team members.

Key Terms

anosognosia not having insight or awareness into disease
auditory hallucination altered perception of hearing in the absence of external stimuli
bizarre delusion fixed false beliefs with content that is not reasonably possible in this world
cognitive symptoms deficits in ability to think or reason
delusion fixed false belief that cannot be changed in the mind of those who hold them despite evidence to the contrary
formication hallucination that bugs are crawling on the skin
gustatory hallucination false perception involving taste
hallucination perception of sensory experiences without natural external stimuli, including auditory, visual, tactile, gustatory, and olfactory types
negative symptoms "take away" from a person's personality, including cognitive decline and apathy
non-bizarre delusion fixed false belief containing content that is plausible but inconsistent with evidence
olfactory hallucination false sensory experience involving the sense of smell
positive symptoms changes to behaviors or content of thought, or the presence of symptoms, including hallucinations and delusions
psychosis severe mental condition where a person loses the ability to recognize reality or has lost contact with external reality, causing a loss of function and disorganization of personality
schizophrenia severe mental illness and disturbance involving a collection of cognitive, affective, and behavioral symptoms that negatively impact social, educational, or occupational functioning
tactile hallucination false sensory perceptions involving the sense of touch
visual hallucination false sensory experience that is seen

Assessments

Review Questions

1. What is a positive symptom of schizophrenia?
    a. delusion
    b. anhedonia
    c. apathy
    d. mutism

2. What is a type of hallucination?
    a. erotomanic
    b. referential
    c. gustatory
    d. tangential

3. What neurotransmitter is implicated in the neurobiology of schizophrenia?
    a. GABA
    b. glutamate
    c. norepinephrine
    d. acetylcholine

4. The nurse is assessing a client who is taking paliperidone. What is true regarding this medication?
    a. It is likely to cause neutropenia.
    b. The medication is only in oral form.
    c. It is a first-generation antipsychotic.
    d. It is less likely to cause dystonia.

5. A nurse is getting ready to transfer a client diagnosed with schizophrenia to a partial hospital program. What is the next best step before that client is discharged?
    a. Send the records to the client and then discharge them.
    b. Give the client's family a copy of the records and then discharge them.
    c. Call the partial program, review the client's history with the staff, then transfer the records to the program.
    d. Transfer the records to the program, provide a copy to the client, then discharge them.

6. A client diagnosed with schizophrenia and treated with risperdal arrives in the emergency department. They walk in with their mouth open and they are having trouble talking. They display muscle rigidity in their neck and mouth. What is the recommended treatment for this client?
    a. benzodiazepine
    b. Cogentin
    c. propranolol
    d. valbenazine

7. A nurse is assessing a client who is presenting with symptoms of hallucinations and delusions. They have had these symptoms for a week. The client does not have a history of a mood disorder; they do not have any medical conditions or history of substance misuse. What is the client's most likely diagnosis?
    a. schizophrenia
    b. schizoaffective disorder
    c. brief psychotic disorder
    d. catatonia

8. A client is mimicking every movement that the provider is making. What behavior are they displaying?
    a. echolalia

b. echopraxia
c. stereotypy
d. posturing

9. A client presents with psychotic symptoms: hallucinations, delusions, disorganized speech and behavior. They do not have medical comorbidities and do not use any substances. The signs have been present for five months. What diagnosis is suspected?
   a. delusional disorder
   b. brief psychotic disorder
   c. schizophreniform disorder
   d. schizophrenia

10. A client presents with the belief that they are going to marry Prince Harry. What delusion are they experiencing?
   a. erotomaniac
   b. grandiose
   c. somatic
   d. persecutory

11. A client believes that their partner is having an internet affair. They are spending most of their time stalking their partner on the internet, hacking into their email and social media accounts looking for evidence. What delusion are they experiencing?
   a. erotomaniac
   b. grandiose
   c. persecutory
   d. jealous

12. A client believes that their uterus was removed when they had a gynecological examination. Despite evidence on ultrasound that it is still intact, they hold firm to the belief. What delusion is the client experiencing?
   a. grandiose
   b. jealous
   c. persecutory
   d. somatic

Check Your Understanding Questions

1. What are the possible side effects of second-generation antipsychotics?
2. What are the differences between first- and second-generation antipsychotics?
3. What are the diagnostic criteria for schizophrenia?
4. What is the difference between schizoaffective disorder, schizophreniform disorder, and brief psychotic disorder?
5. What medications can cause psychotic symptoms?
6. List two different types of treatments for catatonia.

Reflection Questions

1. What are the differences in nursing interventions between the acute and maintenance phases of schizophrenia?
2. What are the differences between positive and negative symptoms of schizophrenia? Give examples of both.
3. What are examples of nursing education for clients with schizophrenia?
4. How can involving the client's family in the treatment and care process contribute to better outcomes for

individuals with schizophrenia spectrum disorders?

5. When you are taking care of a client with delusional disorder, how can you support that client in maintaining a connection to reality, particularly when experiencing persistent delusions?

Critical-Thinking Questions about Case Studies

1. Refer to Schizophrenia: Part 3.
   For the client diagnosed with schizophrenia, what are the potential risk factors for his schizophrenia and how do they contribute to his condition?
2. Refer to Schizophrenia: Part 3.
   What nursing interventions would be appropriate to address the immediate needs of the client and ensure his safety?
3. Refer to Schizophrenia: Part 3.
   How can the nursing team support the client in achieving the long-term management of his condition and prevent future psychotic episodes?

Competency-Based Assessments

1. Develop a nursing care plan for a client living with schizophrenia. Consider both medical and psychosocial aspects.
2. As a clinical nurse, how would you tailor your approach to treating and caring for a client with paranoid schizophrenia differently compared to someone with catatonic schizophrenia, considering the unique characteristics of each subtype?
3. Do some research and discuss the ethical considerations related to obtaining informed consent for treatment in individuals with delusional disorder, considering potential challenges in decision-making capacity.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Campbell, E. H., Elston, D. M., Hawthorne, J. D., & Beckert, D. R. (2019). Diagnosis and management of delusional parasitosis. *Journal of the American Academy of Dermatology, 80*(5), 1428–1434.

Carbon, M., & Correll, C. U. (2014). Thinking and acting beyond the positive: The role of the cognitive and negative symptoms in schizophrenia. *CNS spectrums, 19*(S1), 35–53.

Caroff, S. N., & Campbell, E. C. (2016). Drug-induced extrapyramidal disturbances: Implications for contemporary practice. *Psychiatric Clinics, 39*(3), 391–411.

Dhaliwal, K., & Hirst, S. (2016). Caring in correctional nursing: A systematic search and narrative synthesis. *Journal of Forensic Nursing, 12*(1), 5–12.

Doyle, B. B. (2015). Stahl's essential psychopharmacology: Prescriber's guide. *The Journal of Clinical Psychiatry, 76*(5), 1964.

Gaynes, B. N., Brown, C. L., Lux, L. J., Brownley, K. A., Van Dorn, R. A., Edlund, M. J., Coker-Schwimmer, E., Weber, R. P., Sheitman, B., Zarzar, T., Viswanathan, M., & Lohr, K. N. (2017). Preventing and de-escalating aggressive behavior among adult psychiatric patients: A systematic review of the evidence. *Psychiatric Services, 68*(8), 819–831.

George, M., Maheshwari, S., Chandran, S., Manohar, J. S., & Sathyanarayana Rao, T. S. (2017, October-December). Understanding the schizophrenia prodrome. *Indian J Psychiatry, 59*(4), 505–509.

Habibi, R., Sirati Nayer, M., & Khaghanizade, M. (2015). Educational needs of families of patients with schizophrenia: A literature review. *International Journal of Medical Reviews 2*(2), 250–255.

Healthline. (2024a). *What do you want to know about schizophrenia?* https://www.healthline.com/health/

schizophrenia/delusional-disorder-vs-schizophrenia#treatment

Healthline. (2024b). *What you need to know about catatonia*. https://www.healthline.com/health/catatonia

Hitczenko, K., Mittal, V. A., & Goldrick, M. (2021). Understanding language abnormalities and associated clinical markers in psychosis: The promise of computational methods. *Schizophrenia Bulletin, 47*(2), 344–362.

Hjorthøj, C., Stürup, A. E., McGrath, J. J., & Nordentoft, M. (2017). Years of potential life lost and life expectancy in schizophrenia: A systematic review and meta-analysis. *The Lancet Psychiatry, 4*(4), 295–301.

Imamura, A., Morimoto, Y., Ono, S., Kurotaki, N., Kanegae, S., Yamamoto, N., Kinoshita, H., Tsujita, T., Okazaki, Y., & Ozawa, H. (2020). Genetic and environmental factors of schizophrenia and autism spectrum disorder: Insights from twin studies. *Journal of Neural Transmission, 127*, 1501–1515.

Immonen, J., Jääskeläinen, E., Korpela, H., & Miettunen, J. (2017). Age at onset and the outcomes of schizophrenia: A systematic review and meta-analysis. *Early Intervention in Psychiatry, 11*(6), 453–460.

Jadhav, B. S., Shah, B., Dhavale, H., Sharma, P. (2014). Delusional disorder: prevalence, clinical correlates and comorbidity. *Andhra Pradesh Journal of Psychological Medicine, 15*(1), 99–102.

Jalali Roudsari, M., Chun, J., & Manschreck, T. C. (2015). Current treatments for delusional disorder. *Current Treatment Options in Psychiatry, 2*(2), 151–167.

Kadakia, A., Catillon, M., Fan, Q., Williams, G. R., Marden, J. R., Anderson, A., Kirson, N., & Dembek, C. (2022). The economic burden of schizophrenia in the United States. *The Journal of Clinical Psychiatry, 83*(6), 43278.

Keepers, G. A., Fochtmann, L. J., Anzia, J. M., Benjamin, S., Lyness, J. M., Mojtabai, R., Servis, M., Walaszek, A., Buckley, P., Lenzenweger, M. F., Young, A. S., Degenhardt, A., Hong, S.-H., & (Systematic Review). (2020). The American Psychiatric Association practice guideline for the treatment of clients with schizophrenia. *American Journal of Psychiatry, 177*(9), 868–872.

Kopera, M., Suszek, H., Bonar, E., Myszka, M., Gmaj, B., Ilgen, M., & Wojnar, M. (2015). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal, 51*, 628–634.

Lecomte, T., Potvin, S., Samson, C., Francoeur, A., Hache-Labelle, C., Gagné, S., Boucher, J., Bouchard, M., & Mueser, K. T. (2019). Predicting and preventing symptom onset and relapse in schizophrenia—A metareview of current empirical evidence. *Journal of Abnormal Psychology, 128*(8), 840.

Lecturio Medical. (n.d.). *Schizophrenia: Assessment – Psychiatry*. https://www.youtube.com/watch?app=desktop&v=MPHa2hga9fs

Li, R., Ma, X., Wang, G., Yang, J., & Wang, C. (2016, September). Why sex differences in schizophrenia? *J Transl Neurosci, 1*(1), 37–42.

Liu, C. H., Keshavan, M. S., Tronick, E., & Seidman, L. J. (2015). Perinatal risks and childhood premorbid indicators of later psychosis: Next steps for early psychosocial interventions. *Schizophrenia Bulletin, 41*(4), 801–816.

Mayo Clinic. (2020). *Schizophrenia*. https://www.mayoclinic.org/diseases-conditions/schizophrenia/diagnosis-treatment/drc-20354449.

Modi, S., Dharaiya, D., Schultz, L., & Varelas, P. (2016). Neuroleptic malignant disturbance: Complications, outcomes, and mortality. *Neurocritical Care, 24*, 97–103.

Mojtabai, R., Fochtmann, L., & Bromet, E. (2017). Other psychotic disorders. In: B. J. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Kaplan & Sadock's comprehensive textbook of psychiatry* (pp. 3616–3667). Wolters Kluwer.

National Library of Medicine. (2016). *First-generation versus second-generation antipsychotics in adults: Comparative effectiveness [Internet]*. https://www.ncbi.nlm.nih.gov/books/NBK107237/

Patel, V., Simunyu, E., & Gwanzura, F. (1995). Kufungisisa (thinking too much): A Shona idiom for non-psychotic mental illness. *The Central African Journal of Medicine, 41*(7), 209–215.

Pinna, F., Sanna, L., Perra, V., Randaccio, R. P., Diana, E., Carpiniello, B., & Cagliari Recovery Study Group. (2014). Long-term outcome of schizoaffective disorder. Are there any differences with respect to schizophrenia? *Rivista di Psichiatria, 49*(1), 41–49.

QSEN Institute. (n.d.) QSEN Competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Rogers, J. P., Oldham, M. A., Fricchione, G., Northoff, G., Ellen Wilson, J., Mann, S. C., Francis, A., Wieck, A., Wachtel, L. E., Lewis, G., Grover, S., Hirjak, D., Ahuja, N., Zndi, M. S., Young, A. H., Fone, K., Andrews, S., Kessler, D., Saifee, T., … David, A. S. (2023). Evidence-based consensus guidelines for the management of catatonia: Recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology, 37*(4), 327–369.

Sariah, A. E., Outwater, A. H., & Malima, K. I. (2014). Risk and protective factors for relapse among individuals with schizophrenia: A qualitative study in Dar es Salaam, Tanzania. *BMC Psychiatry, 14*(1), 1–12.

Seeman, M. V. (2016). Erotomania and recommendations for treatment. *Psychiatric Quarterly, 87*(2), 355–364.

St Clair, D., & Lang, B. (2021). Schizophrenia: A classic battle ground of nature versus nurture debate. *Science Bulletin, 66*(10), 1037–1046.

Startup, H., Pugh, K., Dunn, G., Cordwell, J., Mander, H., Černis, E., Wingham, G., Shirvell, K., Kingdon, D., & Freeman, D. (2016). Worry processes in patients with persecutory delusions. *British Journal of Clinical Psychology, 55*(4), 387–400.

Steullet, P., Cabungcal, J. H., Monin, A., Dwir, D., O'Donnell, P., Cuenod, M., & Do, K. Q. (2016). Redox dysregulation, neuroinflammation, and NMDA receptor hypofunction: A "central hub" in schizophrenia pathophysiology? *Schizophrenia Research, 176*(1), 41–51.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2022). *About criminal and juvenile justice*. https://www.samhsa.gov/criminal-juvenile-justice/about

Vieta, E., Garriga, M., Cardete, L., Bernardo, M., Lombraña, M., Blanch, J., Catalán, R., Vásquez, M., Soler, V., Ortuño, N., & Martínez, Arán, A. (2017). Protocol for the management of psychiatric patients with psychomotor agitation. *BMC Psychiatry, 17*(328). https://doi.org/10.1186/s12888-017-1490-0.

Waller, H., Emsley, R., Freeman, D., Bebbington, P., Dunn, G., Fowler, D., Hardy, A., Kuipers, E., & Garety, P. (2015). Thinking well: A randomised controlled feasibility study of a new CBT therapy targeting reasoning biases in people with distressing persecutory delusional beliefs. *Journal of Behavior Therapy and Experimental Psychiatry, 48*, 82–89.

Ware, M. R., Feller, D. B., & Hall, K. L. (2018). Neuroleptic malignant disturbance: Diagnosis and management. *The Primary Care Companion for CNS Disorders, 20*(1), 27030.

World Health Organization. (2022). *Schizophrenia*. https://www.who.int/news-room/fact-sheets/detail/schizophrenia

Young, S. L., Taylor, M., & Lawrie, S. M. (2014). "First do no harm." A systematic review of the prevalence and management of antipsychotic adverse effects. *Journal of Psychopharmacology, 29*(4), 353–362.

CHAPTER 16
Mood Disorders and Suicide

FIGURE 16.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Health-care professionals will come in contact with clients who have been diagnosed with a variety of mental health conditions, including mood disorders. Normal mood variations are transient and can be linked to specific events or circumstances, such as feeling elated after receiving good news or feeling sad after a disappointment. These feelings usually do not impair daily functioning and are generally short-lived (American Psychiatric Association, 2022). A **mood disorder**, on the other hand, involves disturbances in a person's emotional state that are intense, long-lasting, and not necessarily tied to any specific event or situation. These disturbances can significantly impair a person's ability to function socially, occupationally, or academically (American Psychiatric Association, 2022).

In recent years, there has been increasing recognition and discussion of a spectrum approach to understanding mood disorders. This perspective suggests that mood disorders exist on a continuum. According to this perspective, mood disorders are not discrete, isolated conditions but feature a range of overlapping symptoms, severity, and functional impairments (Paris, 2014). This model suggests that clients may not neatly fit into the traditional categories as defined by the *Diagnostic and Statistical Manual of Mental Disorders*. For example, some individuals may experience symptoms that do not meet the full criteria for a depressive disorder but still suffer significant

distress or impairment in daily functioning (American Psychiatric Association, 2022).

Nursing care is crucial in treating and managing mood disorders. Nurses play a vital role in monitoring clients' responses to treatment, managing side effects, providing client and family education, and offering emotional support. It is essential to remember that these disorders are typically chronic, requiring ongoing care and management.

16.1 Depressive Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the spectrum and presentations of mood disorders
- Explain the approaches for treating mood disorders

Mood disorders comprise a category of mental health conditions with significant disturbances in mood, emotions, and overall affect. These disorders profoundly affect an individual's emotional well-being and functioning. In addition, mood disorders often significantly influence relationships, work or academic performance, and overall quality of life. Accurate diagnosis and classification of these disorders according to established guidelines are crucial for effective treatment planning and improving the well-being of individuals affected by these conditions (American Psychiatric Association, 2022).

UNFOLDING CASE STUDY

Depression: Part 1

The nurse is assessing a seventy-six-year-old male who has been admitted to the inpatient psychiatric unit accompanied by his son.

PMH	Client is a seventy-six-year-old male who is recently widowed and living in an assisted living community. He has a medical-surgical history of prostatitis, hypertension, and hyperlipidemia. He has a surgical history of a right knee replacement in 2017. **Family History:** Client reports a family history of depression and anxiety. Per the client, his brother had been diagnosed with bipolar II disorder and he died in 2010 from a heart attack. His mother and father both appeared to have depression throughout their lives, but never sought treatment. His sister had two suicide attempts when she was in her mid-thirties. **Social History:** Client is widowed for three years and has four children, all adults, as well as three grandchildren. He lives in an assisted living community and one of his sons lives about thirty miles away. The rest of his children live out of state. He worked for the postal service for forty years until he retired six years ago. He states that his son visits him once a week, but that he otherwise feels lonely and isolated at the assisted living community, and he misses his wife. He denies alcohol or drug use. He is not a smoker or a former smoker. He and his wife used to attend church, but since moving to the assisted living community, he has been unable to go to services. He does listen to them through his computer occasionally. **Current Medication:** Carvedilol 25mg BID, Atorvastatin 20mg daily, Tamsulosin 0.4mg daily, Sertraline 12.5mg daily, and no known allergies.
Nursing Notes	**1345: Admission Assessment** **Physical examination:** Client clean and appropriately dressed, alert and oriented ×4, stooped posture, unsteady gait and utilizing a cane. He appears thin. **HEENT:** Pupils equal, reactive to light (PERRL), mucus membrane dry, pharynx without lesions, palate intact. No thyroid enlargement. **Lymphatic:** Tonsillar and cervical lymph nodes noted but not enlarged; no enlargement of right axillary or inguinal nodes, no pain or tenderness noted. **Respiratory:** Clear to auscultation bilaterally, no stridor, no crackles or murmur. **Cardiovascular:** Regular rate and rhythm, slight edema to lower extremities, peripheral pulses 2+. **Abdomen:** Bowel sounds present but slowed in all four quadrants, no organomegaly or tenderness. **Musculoskeletal:** Within normal limits, unsteady gait with assistive device. **Skin:** Dry and intact. No skin injuries noted. **Mental assessment:** Client appears anxious, passive suicidal ideation, blunted affect, depressed mood, mood congruent with affect, denies AVH. **Blood pressure:** 145/92 mmHg. **Heart rate:** 89 beats/minute. **Respiratory rate:** 18 breaths/minute. **Temperature:** 98.5°F (36.9°C). **Oxygen saturation:** 99% on room air. **Pain:** Denies.

Flow Chart	**1345: Admission Assessment** The client is a seventy-six-year-old male who is recently widowed and living in an assisted living community. He has a medical-surgical history of prostatitis, hypertension, and hyperlipidemia. He has a surgical history of a right knee replacement in 2017. He reports a decreased and depressed mood for the past month, with low energy and periods of feeling sad. His appetite is diminished, and he has experienced weight loss of approximately nine pounds in the past month. He uses nutritional supplement shakes for his meal replacement due to his low appetite. He reports that he has not been participating in any of the activities of the assisted living because he has lost enjoyment and pleasure in being around people, including visits from his son. He states he has suicidal thoughts but does not have a plan to act on them; rather, he would just like to go to sleep and not wake up in the morning. **Current Medication:** Carvedilol 25mg BID, Atorvastatin 20mg daily, Tamsulosin 0.4mg daily, Sertraline 12.5mg daily, and no known allergies.
Provider's Orders	Complete admission assessment CMP/CBC Close observation

1. What cues indicate the need for further evaluations?
2. From the information given for this client, which of these cues would the nurse find to be an underlying factor that Contributes, Does Not Contribute, or is Irrelevant to the client's depression?

Cue	Contributes	Does Not Contribute	Irrelevant
Oxygenation level			
Chronic health conditions			
Family history of depression			
Orientation to person, place, and time			
Use of alcohol			
Isolation			
Audio-visual hallucinations			

The Spectrum of Mood Disorders

As defined by the *DSM-5*, the most common mood disorders include depression, bipolar disorder, and dysthymia. Mood disorders are characterized by disturbances in mood that are intense, persistent, and interfere significantly with an individual's daily life. These disorders can have severe repercussions on one's physical health, interpersonal relationships, and overall quality of life (Sekhon & Gupta, 2020).

The *DSM-5* defines **depression** as feelings of sadness and/or loss of interest in activities once considered enjoyable (Torres, 2020). By contrast, **bipolar disorder** is a recurrent illness that involves changes in mood and energy that may be severe and involves both depression and mania, or hypomania (Howland & El Sehamy, 2021). Previously known as dysthymia, **persistent depressive disorder** is a milder, but longer lasting form of depression (John Hopkins Medicine, 2019). Additionally, **mania** is a condition in which a person's mood is abnormally elevated and is accompanied by high energy or activity.

Mood disorders have traditionally been viewed in categorical terms. This means that an individual either meets the specific criteria for a diagnosis or they do not. Recent research, however, indicates a shift toward understanding these disorders on a spectrum or continuum (Mason et al., 2016) (Figure 16.2). This shift in perspective allows for a more nuanced understanding of mood disorders, acknowledging the diversity and complexity of symptom presentations.

FIGURE 16.2 Mood disorders are now considered to exist on a spectrum, rather than being in discrete categories. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

A more inclusive and flexible approach to understanding, diagnosing, and treating these conditions, the **spectrum model of mood disorders** acknowledges the variability in symptom presentations and offers a framework for individualized care. By moving away from rigid categorical definitions, it allows for a broader understanding of the diverse experiences of those with mood disorders (McIntyre et al., 2018). For example, the spectrum model accommodates those with atypical or mixed features. An individual might exhibit symptoms of both depression and mania but not meet the full criteria for bipolar disorder. In a categorical model, this could lead to challenges in diagnosis and treatment. Yet by understanding these symptoms as existing on a continuum, health-care professionals can offer tailored interventions that address the specific needs of the individual (Zimmerman et al., 2015).

Varying moods are a natural and expected part of the human experience. Everyone, at different points in their life, will experience fluctuations in their mood, feeling elated at times and downcast at others. These mood variations can be influenced by a myriad of factors, ranging from environmental stimuli, interpersonal relationships, stress, physiological changes, or hormonal fluctuations (Karl et al., 2018). It is when these mood variations begin to interfere with an individual's daily functioning that they may be indicative of a mood disorder. The distinction between normal mood variations and clinically significant mood disturbances is primarily based on their duration, intensity, and impact on daily functioning (American Psychiatric Association, 2022). For instance, feeling sad or down after a negative life event, like the loss of a job or the end of a relationship, is expected. If this sadness persists for weeks, impairs one's ability to perform daily tasks, affects relationships, or leads to thoughts of self-harm or suicide, it may be indicative of major depressive disorder (American Psychiatric Association, 2022).

LIFE-STAGE CONTEXT

Age Considerations in Clients Diagnosed with Mood Disorders

Age plays a significant role in the presentation, diagnosis, treatment, and outcomes of mood disorders. Age-related considerations are pivotal in the accurate diagnosis and effective treatment of mood disorders. Recognizing the varied presentations across age groups, understanding the unique challenges posed by each age group, and tailoring interventions accordingly can lead to optimal client outcomes (American Psychiatric Association, 2022). Table 16.1 compares mood disorders among age groups.

Age Group	Presentation	Differential Diagnosis
Children and adolescents	May not exhibit classic symptoms but may exhibit irritability, academic difficulties, or behavioral problems (Cleveland Clinic, 2018).	Attention-deficit hyperactivity disorder or conduct disorders
Adults	Classic symptoms, such as persistent sadness, anhedonia, changes in sleep and appetite, and feelings of guilt or hopelessness (American Psychiatric Association, 2022).	Bipolar disorder and other mood-related conditions (American Psychiatric Association, 2022)
Older adults	Somatic complaints, cognitive disturbances, or a decreased ability to function, rather than typical depressive symptoms (Devita et al., 2022).	Age-associated memory impairment or other neurocognitive disorders (Devita et al., 2022). In older adults, mood disorders, such as depression, can sometimes mimic symptoms of neurocognitive disorders.

TABLE 16.1 Mood Disorders by Age Group

Mood disorders encompass a wide range of conditions that can affect an individual's mood regulation. To provide a nuanced understanding of these disorders, the *DSM-5* introduces *specifiers*. Specifiers are descriptors that can be added to the core diagnosis to offer more specific information about the presentation of the disorder (American Psychiatric Association, 2022).

For major depressive disorder (MDD), some of the key specifiers include:

- With Anxious Distress: Describes individuals who exhibit two or more symptoms of anxiety (e.g., feeling on edge, experiencing restlessness)
- With Mixed Features: Signifies the presence of at least three manic symptoms, though not enough for a full-blown manic or hypomanic episode
- With Melancholic Features: Characterized by profound anhedonia or lack of reactivity to positive stimuli, along with other symptoms, such as early morning awakening or significant weight loss
- With Atypical Features: Includes mood reactivity (i.e., mood brightens in response to positive events) and two or more additional symptoms, such as increased appetite or hypersomnia (American Psychiatric Association, 2022)

For bipolar disorders, specifiers can be used to detail the nature of the current or most recent episode (manic, hypomanic, or depressed). Some specifiers for bipolar disorders include:

- With Rapid Cycling: Indicates the occurrence of at least four mood episodes (depressive, manic, or hypomanic) within a twelve-month period
- With Mixed Features: Can be applied to manic, hypomanic, or depressive episodes if there are symptoms from the opposing mood polarity present
- With Anxious Distress: As with MDD, denotes the presence of two or more symptoms of anxiety (American Psychiatric Association, 2022)

The *DSM-5* includes other specifiers applicable to both MDD and bipolar disorders, such as "With Psychotic Features," which suggests the presence of delusions or hallucinations, and "With Catatonia," which describes a range of psychomotor symptoms like mutism or posturing (American Psychiatric Association, 2022).

Approaches to Treating Mood Disorders

Mood disorders are serious mental health conditions with potentially debilitating effects. A comprehensive understanding of these conditions and their management strategies is paramount for health-care professionals to provide effective client care. It is equally essential to foster an empathetic and nonjudgmental approach when

working with these clients, promoting their mental health and overall well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022).

Treating mood disorders involves a combination of medication, psychotherapy, and lifestyle changes. Pharmacological treatment is currently considered an essential component in managing mood disorders. Health providers may prescribe antidepressants, mood stabilizers, and antipsychotic medications depending on the specific diagnosis and symptom severity. These medications can help balance brain chemistry, reduce the severity of symptoms, and improve quality of life.

Cognitive behavioral therapy, interpersonal therapy (IPT), and other forms of psychotherapy are often used to help individuals understand and manage their symptoms. These therapies can provide strategies for managing stress, improving relationships, and promoting healthier thinking patterns.

Electroconvulsive therapy is a medical procedure that involves the passage of a controlled electric current through the brain, inducing a brief seizure while the client is anesthetized (Salik & Marwaha, 2020). Historically, ECT has been the subject of controversy due to its portrayal in popular media and concerns about adverse effects (Cabrera et al., 2021). In recent years, however, it has gained recognition as an effective and safe intervention for specific psychiatric disorders, particularly when other treatments have failed. Mood disorders, such as MDD and bipolar disorder, can be debilitating. In some instances, clients do not respond adequately to traditional treatments like pharmacotherapy or psychotherapy. For these individuals, ECT can be a valuable alternative (American Psychiatric Nurses Association, 2021).

Lifestyle changes, such as regular physical exercise, a healthy diet, adequate sleep, and avoiding alcohol and illicit substances, also help in treating mood disorders. These changes can enhance the effectiveness of therapy and medication and improve overall health and well-being (Hollon et al., 2014).

Overview of Medications Used to Treat Mood Disorders

Medication is a critical component in treating mood disorders, managing symptoms, and restoring balance in brain chemistry. Antidepressants, mood stabilizers, and antipsychotic medications (see Schizophrenia Spectrum Disorder and Other Psychotic Disorders) commonly treat these disorders.

Antidepressants, such as SSRIs and SNRIs, frequently treat major depressive disorder and dysthymia. Antidepressants function by modulating the concentrations of neurotransmitters. These neurotransmitters, including serotonin, norepinephrine, and dopamine, play crucial roles in regulating mood, energy, sleep, and appetite (Moraczewski & Aedma, 2020).

Mood stabilizers, including lithium and certain anticonvulsants, are the cornerstone of treatment for bipolar disorder. These medications help to regulate mood swings and prevent episodes of mania and depression. Antipsychotic medications are indicated where psychotic symptoms, such as hallucinations or delusions, are present; such episodes can occur in severe depressive episodes or during manic episodes in bipolar disorder (Yatham et al., 2018).

Overview of Psychosocial Approaches to Treat Mood Disorders

Psychosocial interventions are essential in treating mood disorders, providing individuals with strategies to manage their symptoms, improve their functioning, and enhance their quality of life. CBT, IPT, and family-focused therapy (FFT) are among the most researched and commonly used psychosocial treatments (Chatterton et al., 2017).

CBT helps individuals identify and modify maladaptive thought patterns and behaviors that may contribute to their mood disorder. It also teaches coping strategies to manage stress and prevent future depressive episodes. IPT, on the other hand, focuses on improving interpersonal relationships and social functioning, which mood disorders often affect negatively. It helps individuals navigate relationship difficulties, role transitions, and unresolved grief that may contribute to their depressive symptoms (Rajhans et al., 2020).

FFT and DBT are commonly used in the treatment of bipolar disorder. FFT includes psychoeducation about the disorder, communication enhancement training, and problem-solving skills training. FFT aims to improve the family environment because a supportive family environment can often help manage bipolar disorder symptoms and prevent relapse (Guarnotta, 2023). DBT is a talk therapy focused on helping an individual deal with intense emotions. It revolves around how thoughts affect the emotions and eventual behavior of the individual (Cleveland

Clinic, 2022). In addition to these structured therapies, psychosocial interventions may include self-help strategies and peer support, which can enhance the effectiveness of other treatments and improve the overall prognosis.

Overview of Lifestyle Changes That Help Treat Mood Disorders

While lifestyle changes alone may not replace the need for traditional treatments, they can significantly complement them and lead to enhanced mood stability and improved overall well-being in individuals with mood disorders (Ee et al., 2020). Engaging in regular physical activity has been linked to reduced symptoms of depression and anxiety. Exercise promotes the release of endorphins, which are natural mood elevators, and helps in regulating neurotransmitters like serotonin and norepinephrine that play a role in mood regulation (American Psychological Association, 2020). Likewise, consuming a well-balanced diet rich in fruits, vegetables, whole grains, lean protein, and omega-3 fatty acids can positively influence mood. For instance, omega-3 fatty acids, found in fish like salmon, have anti-inflammatory properties and are associated with a reduced risk of depression (Gómez-Pinilla, 2008). Maintaining a consistent sleep schedule and ensuring adequate rest is crucial for mood stability. Sleep disturbances, such as insomnia or oversleeping, can exacerbate symptoms of mood disorders. It is recommended to establish a regular bedtime routine, avoid electronics before sleep, and create a sleep-conducive environment (Saghir et al., 2018). Alcohol and certain drugs can interact with medications and can lead to mood swings or worsen depressive or manic symptoms. It is best to avoid these substances (World Health Organization, 2023).

16.2 The Spectrum of Mood Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the diagnosis, types, incidence, and possible causes of depression
- Describe the clinical symptoms of depression
- Recall the approaches used in the treatment of depression

Mental health conditions characterized by persistent feelings of sadness, loss of interest in activities, and difficulties in carrying out daily activities are called **depressive disorders**. These conditions can significantly impair a person's quality of life, social relationships, and physical health, and they often require medical intervention for management and recovery. Treatments typically include psychotherapy, medications, or a combination of both. The exact cause of depressive disorders is unknown but is thought to involve a combination of genetic, biological, environmental, and psychological factors. Despite their serious nature, with appropriate treatment, individuals with depressive disorders can lead fulfilling lives (American Psychiatric Association, 2022).

Diagnosis, Types, Incidence, and Cause

Depression, clinically referred to as major depressive disorder, is a common and serious medical illness that negatively affects how a person feels, thinks, and acts. It is characterized by persistent feelings of sadness and a lack of interest or pleasure in activities. It can lead to various emotional and physical problems and decrease a person's ability to function at work and at home.

The exact causes of depression are not fully understood, but current research suggests that it is caused by genetic, biological, environmental, and psychological factors. Depression can run in families, suggesting a genetic link. Changes in the brain's neurotransmitter levels, particularly serotonin, norepinephrine, and dopamine, also play a role. Environmental factors, such as early childhood trauma, stress, or exposure to certain medications or drugs can trigger the onset of the disease. Additionally, certain personality traits, such as low self-esteem or being overly dependent, can make an individual more susceptible to depression (American Psychiatric Association, 2022).

DSM-5 Definition of Depression

Major depressive disorder (MDD) is not just a bout of the blues; it is a mood disorder that affects one's quality of life. Individuals with MDD may experience significant changes in appetite or weight, sleep disturbances (either insomnia or hypersomnia), fatigue, feelings of worthlessness or excessive guilt, difficulty concentrating or making decisions, and recurrent thoughts of death or suicidal ideation. Physical symptoms, such as aches or pains without a clear physical cause, can also be present. These symptoms can lead to significant impairments in daily functioning and quality of life, making early identification and intervention crucial (American Psychiatric Association, 2022).

For a diagnosis of depression, at least five of these symptoms must be present most of the day, nearly every day for

at least two weeks, and they must cause significant distress or impairment in social, occupational, or other important areas of functioning. It is important to note that these symptoms can be related to a number of medical conditions or can be caused by certain substances, so it is always important to rule out other causes before confirming a diagnosis (American Psychiatric Association, 2022).

Types of Depression

Depression exists as a variety of related disorders. The *DSM-5* identifies several types of depressive disorders. MDD is what most people think of when they hear "depression." MDD is characterized by one or more major depressive episodes, during which an individual experiences a depressed mood or a loss of interest or pleasure in activities, along with other symptoms, such as changes in weight or sleep, fatigue, feelings of worthlessness or guilt, and thoughts of death or suicide (American Psychiatric Association, 2022).

Persistent depressive disorder (PDD), formerly known as dysthymia, is a chronic form of depression. Unlike MDD where individuals might experience severe depressive episodes, PDD is characterized by a steady, low-grade depressive mood that lasts for at least two years. While the symptoms might not be as intense as those of MDD, they can still pose a significant challenge in daily functioning and well-being of the affected individual (American Psychiatric Association 2022).

Premenstrual dysphoric disorder (PMDD) is a type of depression that occurs the week before the onset of menstruation, and is marked by mood swings, irritability, and anxiety, among other symptoms. Perinatal depression is a mood disorder that can affect women during pregnancy and after childbirth. The term *perinatal* encompasses both the prenatal (occurring during pregnancy) and postpartum (occurring after childbirth) periods. It involves a significant depressive episode with symptoms, such as feelings of sadness, issues bonding with the baby, appetite and sleep pattern alterations, and thoughts of self-harm or harming the baby (National Institute of Mental Health [NIMH], 2021).

Depressive disorder due to another medical condition is distinguished from MDD by the direct causative relationship between a separate medical condition and the onset of depressive symptoms. Rather than being a primary mental health disorder, the depression in these cases arises as a physiological consequence of a different medical condition or its treatment. Such conditions might include neurological disorders (e.g., Parkinson disease, multiple sclerosis, or traumatic brain injuries), endocrine disorders (e.g., hypothyroidism), or autoimmune diseases, among others. The clinical presentation can include symptoms similar to MDD, such as persistent sadness, loss of interest in activities, fatigue, and feelings of worthlessness (American Psychiatric Association, 2022).

Seasonal affective disorder (SAD) is a specific type of depression that corresponds with the seasons. This disorder is seen more frequently during the fall and winter months when there is less sunlight. People with SAD may experience symptoms, such as low mood, lack of energy, increased sleep, and weight gain, which subside during the spring and summer.

Other specified depressive disorder and unspecified depressive disorder are categories of depression used when depressive symptoms cause significant distress or impairment but do not meet the full criteria for any of the specific disorders (American Psychiatric Association, 2022). Other types of depression may be related to specific circumstances or events. For example, adjustment disorder with depressed mood occurs in response to a stressful life event, such as the loss of a loved one or a major life change. Substance/medication-induced depressive disorder is characterized by depressive symptoms arising from the use or withdrawal of certain substances or medications (American Psychiatric Association, 2022). Depression encompasses a range of distinct conditions, each with unique features and characteristics. The *DSM-5* outlines several types of depression based on specific diagnostic criteria (Table 16.2).

Type	Definition
Major depressive disorder (MDD)	Persistent feelings of sadness or a lack of interest in previously enjoyed activities Symptoms must last at least two weeks
Persistent depressive disorder (dysthymia)	Less severe than MDD but chronic, lasting for at least two years; there may be periods of improvement involved, but these periods last no longer than two months
Seasonal affective disorder (SAD)	Occurs at a specific time of year, usually in the winter months
Perinatal depression	Affects some women before or after giving birth; symptoms include extreme sadness, anxiety, and exhaustion, making it difficult for the new mothers to complete daily care activities for themselves or for others

TABLE 16.2 Types of Depression

Incidence of Depression

According to the World Health Organization (WHO), as of 2023, almost 280 million people of all ages suffer from depression worldwide (World Health Organization, 2023). This pervasive condition is more prevalent in women than men, with studies indicating that approximately one in three women will experience a major depressive episode in their lifetime compared to one in five men (American Psychiatric Association, 2022). In the United States, the incidence of depression is particularly striking. According to the National Institute of Mental Health (NIMH), in 2020, approximately twenty-one million adults in the United States, or roughly 8.4 percent of the adult population, had at least one major depressive episode in the past year (NIMH, 2020a).

Despite the high incidence of depression, many people suffering from the condition do not receive appropriate treatment. For example, the WHO reports that less than 75 percent of those affected receive adequate treatment (World Health Organization, 2023). This lack of treatment may be due to various barriers, including the stigma associated with mental health disorders, a lack of available resources, and insufficient training of health-care professionals in mental health.

The COVID-19 pandemic brought about unprecedented challenges to the global population, and its effects on mental health have been profound. Children and teenagers, a demographic historically resilient to many stressors, have been noticeably affected. They faced disruptions in their daily routines, including school closures, limited social interactions, and changes in familial dynamics due to economic hardships or health concerns. Studies have indicated an increase in symptoms of anxiety and depression among this group. For instance, Loades et al. (2020) found that young people who were already at risk of anxiety were particularly vulnerable to the effects of social isolation, leading to heightened symptoms. Furthermore, there have been concerns about the long-term effects on academic progress, social skills, and emotional development (Loades et al., 2020).

UNFOLDING CASE STUDY

Depression: Part 2

See Depression: Part 1 for a review of the client data.

Nursing Notes	**1940: Ongoing Assessment** The client is in bed and does not come out for dinner. He is awake and is not sleeping. When the PCT rounds and reminds him of dinner, he states, "I am not hungry." He reports to the nurse that he has no energy, but is unable to sleep and has been having disrupted sleep for the past several days. Prior to that he was sleeping fourteen hours a day. **1255: Intervention** Assess for suicide Promote nutrition Promote sleep **2330: Ongoing Assessment** The client remains awake in bed, and on rounding the nurse notices he is tearful. He states that he just wants to die.
Provider's Orders	1:1 observation Meal supplement Trazodone 50 mg HS PRN

3. Based on the recognized cues, the nurse determines the client has symptoms that could indicate suicide risk, insomnia, and poor nutrition. The nurse anticipates that this is due to depression, anxiety, or insomnia. Designate which condition the cue is associated with.

Cue	Depression	Anxiety	Insomnia
Anxiety			
Poor sleep			
Low appetite			
Low mood			
Suicidal ideation			
Withdrawn			

4. What cue would the nurse give priority to in the planning of care for this client?
   a. risk of suicide
   b. insomnia
   c. poor nutrition
   d. lack of energy

Possible Causes of Depression

Depression is a complex condition arising from various interrelated genetic, biological, environmental, and psychological factors. Genetic factors play a significant role in the development of depression. Research indicates that individuals with a family history of depression have a higher likelihood of experiencing the condition themselves, suggesting a hereditary component.

Alterations in brain structure and function, along with imbalances in neurotransmitters, such as serotonin, norepinephrine, and dopamine, are known to be associated with depression. The neuroendocrine system has also been implicated in depression; chronic stress can lead to dysregulation in the system, leading to increased production of cortisol, which has been linked to depression.

Environmental factors, including exposure to trauma, abuse, neglect, or stressful life events, can also trigger the onset of depression. Such circumstances can lead to an emotional response that overwhelms an individual's capacity to cope, leading to depression.

Lastly, psychological factors, such as personality traits, are significant contributors. For example, individuals with a tendency toward negative thinking or low self-esteem are more susceptible to depression (American Psychiatric Association, 2022).

Symptoms of Depression

Depression is characterized by a collection of symptoms that affect an individual's mood, physical health, and cognitive functioning. According to the *DSM-5*, the primary symptoms of major depressive disorder include a persistent feeling of sadness or a lack of interest or pleasure in almost all activities. These core symptoms must be present most of the day, nearly every day, for at least two weeks for a diagnosis (American Psychiatric Association, 2022). For diagnosis, the person has to experience five or more symptoms outlined in the *DSM-5* during a two-week period. These include:

- depressed mood for most days
- decreased interest in pleasure in all or most activities
- significant weight gain or loss
- insomnia or hypersomnia
- psychomotor agitation or retardation nearly every day
- fatigue or loss of energy
- feelings of worthlessness
- diminished ability to concentrate
- recurrent thoughts of death or recurrent suicidal ideation (MDCalc, 2024)

Depression often manifests through emotional, cognitive, and physical symptoms. Therefore, individuals experiencing depression typically report persistent feelings of sadness, emptiness, or hopelessness and may display anhedonia, which is a marked disinterest or lack of pleasure in activities they once enjoyed. Additionally, significant changes in weight or appetite (either increase or decrease), sleep disturbances (including insomnia or hypersomnia), anergia, which is a pervasive sense of fatigue or loss of energy, and feelings of worthlessness or disproportionate guilt are common. Cognitive impairments, such as difficulties with concentration, decision-making, and recurrent thoughts of death or suicidal ideation, may also be present. In some cases, individuals might endure somatic complaints without clear medical origins, further highlighting the comprehensive impact of depression on one's well-being (American Psychiatric Association, 2022).

The severity and frequency of these symptoms can vary widely among individuals. Some clients experience most or all of these symptoms, while others only experience a few. Additionally, the manifestation of these symptoms can be influenced by the individual's cultural context and may present differently across different cultures (American Psychiatric Association, 2022). Culture plays a pivotal role in shaping how depression is experienced, expressed, and understood in different populations. Cultures differ in their norms and values regarding emotional expression, coping mechanisms, familial roles, and perceptions of mental health (Mental Health First Aid, 2019). For instance, in some cultures, depression might not be articulated in terms of sadness but rather in terms of physical symptoms or spiritual afflictions. Additionally, certain cultures may value stoicism or suppress emotional displays, which can influence the presentation and diagnosis of depressive symptoms. In other cultural settings, mental health challenges might be stigmatized, deterring individuals from seeking appropriate help or disclosing their feelings. Consequently, understanding the cultural nuances and putting the client's symptoms in the context of their own culture are paramount for clinicians to ensure accurate diagnosis, culturally sensitive interventions, and effective therapeutic outcomes (Salchi, 2022). Furthermore, in older adults, depression may present with somatic complaints, such as fatigue, sleep disturbances, or unexplained physical ailments, rather than the classic mood disturbances seen in younger populations.

CLINICAL JUDGMENT MEASUREMENT MODEL

Recognizing and Analyzing Cues: CJMM Clients with Depression

The National Council of State Boards of Nursing (NCSBN) Clinical Judgment Measurement Model (CJMM) offers a structured approach to developing clinical judgment in nursing students, encompassing five layered aspects: recognizing cues, analyzing cues, prioritizing hypotheses, generating solutions, and taking action, followed by evaluating outcomes (National Council of State Boards of Nursing, 2019). When applied to a client experiencing depression, this model can serve as a useful guide for nursing students.

In the "recognizing cues" phase, nursing students should be alert to both overt and subtle signs of depression, including mood changes, social withdrawal, or shifts in daily routines. Physical symptoms, such as fatigue or changes in appetite, can also be indicative of an underlying depressive disorder (World Health Organization, 2023).

The "analyzing cues" phase involves assessing the significance of these cues. Students should consider whether the observed signs are isolated or persistent, as well as their severity and impact on the client's well-being. At this stage, it is important to differentiate symptoms of depression from those of other possible conditions, like anxiety disorders or medical illnesses (American Psychiatric Association, 2022).

Treatment of Depression

Depression is a multifaceted condition that requires a comprehensive, multimodal treatment approach. According to the American Psychiatric Association (2022), first-line treatment options for major depressive disorder generally include pharmacotherapy, psychotherapy, or a combination of the two.

Pharmacotherapy, primarily involving antidepressant medications, is an essential component of treatment. Psychotherapy, including CBT and IPT, has been shown to be effective in treating depression (Cuijpers et al., 2014). Lifestyle modifications, including regular exercise, a balanced diet, adequate sleep, and social support, also help to manage depression and improve overall well-being. For clients with severe or treatment-resistant depression, additional interventions, such as ECT, transcranial magnetic stimulation (TMS), or ketamine infusion may be indicated (Pradhan et al., 2015).

ECT is a procedure where controlled electric currents are passed through the brain, intentionally triggering a brief seizure, which is thought to cause a rapid increase in neurotransmitters, alleviating depressive symptoms (Mayo Clinic, 2018). TMS, on the other hand, uses magnetic fields to stimulate nerve cells in the brain in the motor cortex and improve symptoms of depression. It is a noninvasive procedure that targets specific areas of the brain associated with mood (NIMH, 2016). Lastly, ketamine infusion, a dissociative anesthetic, has shown rapid antidepressant effects, even in clients suffering from treatment-resistant depression. The mechanism behind its antidepressant effect is believed to be related to its ability to restore synaptic connections in the brain (Sanacora et al., 2017). While these treatments can be effective, they come with specific risks and considerations, requiring careful assessment and monitoring by health-care professionals (NIMH, 2016).

Medications

Pharmacotherapy is a critical component in managing major depressive disorder, often used as first-line treatment or in combination with psychotherapy. SSRIs and SNRIs are both classes of antidepressant medications found to be effective in the treatment of depression (Cipriani et al., 2018). SSRIs work by selectively inhibiting the reuptake of serotonin, a neurotransmitter associated with mood, sleep, and appetite (Chu & Wadhwa, 2021). Commonly prescribed SSRIs include fluoxetine, paroxetine, and citalopram. SNRIs, on the other hand, inhibit the reuptake of both serotonin and norepinephrine, another neurotransmitter linked to mood and alertness. Examples of SNRIs include venlafaxine, duloxetine, and desvenlafaxine (Fanelli et al., 2021). SSRIs and SNRIs are frequently used due to their effectiveness and tolerable side effects (Cipriani et al., 2018). The decision to use an SSRI over an SNRI, or vice versa, depends on the client's specific symptoms, the side effect profile that is acceptable to the client, and any other comorbid conditions. For instance, SNRIs might be preferred for clients with chronic pain conditions because of the role of norepinephrine in pain modulation (Robinson et al., 2022). Additionally, for clients who do not respond adequately to SSRIs, switching to an SNRI might be beneficial (Tundo et al., 2015).

These medications typically take several weeks to reach their full effect, and individual responses may vary. Combining an SSRI with another serotonergic agent can cause a rare but potentially life-threatening condition called serotonin syndrome, characterized by agitation, fever, rapid heartbeat, muscle stiffness, and hallucinations (Scotton et al., 2019). Serotonin syndrome is a medical emergency.

For clients who do not respond to or cannot tolerate SSRIs or SNRIs, other options include atypical antidepressants, like bupropion or mirtazapine, and older classes of medications, such as tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). One of the major concerns with TCAs is their potential for toxicity in overdose. Even a small overdose can be fatal due to cardiac toxicity and central nervous system depression (Moraczewski & Aedma, 2020). MAOIs are one of the oldest classes of antidepressant medications, initially introduced in the 1950s for the treatment of depression. While effective, they are generally used as a last resort due to their more significant side effect profiles and potential for severe drug and food interactions (Cleare et al., 2015). Hypertensive crisis can occur when foods high in tyramine (e.g., aged cheeses, cured meats, fermented foods) are consumed while taking an MAOI. This results from the inhibition of intestinal and liver MAO-A, which normally metabolizes dietary tyramine. Accumulated tyramine can then induce excessive norepinephrine release, leading to a sharp rise in blood pressure (Gillman, 2018).

Antipsychotics may be utilized as an adjunctive treatment in cases of treatment-resistant depression (Rybakowski, 2023). The choice of medication depends on the individual's specific symptoms, the side effect profile of the medication, the presence of any other psychiatric or medical conditions, and the individual's response to medication (Stroup & Gray, 2018). More recently, ketamine and esketamine have shown promise for treatment-resistant depression, although this treatment requires more research (Popova et al., 2019). These medications affect the primary excitatory pathway within the CNS that is responsible for cognition, memory, learning, emotion, and mood (Halaris & Cook, 2023). Table 16.3 lists the common medications used to treat depression.

Class	Examples	Mode of Action	Side Effects
Selective serotonin reuptake inhibitors	Fluoxetine (Prozac) Sertraline (Zoloft) Citalopram (Celexa)	Inhibit uptake of serotonin, thus increasing levels of serotonin in the brain	Agitation, anxiety, nausea, dizziness, blurred vision, lowered libido
Serotonin and norepinephrine reuptake inhibitors	Venlafaxine (Effexor) Duloxetine (Cymbalta)	Inhibit uptake of serotonin and norepinephrine, increasing the levels of serotonin and norepinephrine in the brain	Nausea, diarrhea, decreased libido, erectile dysfunction, weight gain, dizziness, drowsiness, headache, insomnia, serotonin syndrome
Tricyclic antidepressants (TCAs)	Amitriptyline (Elavil) Nortriptyline (Pamelor)	Affect several neurotransmitters in the brain, including serotonin and norepinephrine	Dry mouth, blurred vision, constipation, orthostatic hypotension, weight gain, sexual dysfunction, increased risk of seizures, toxicity in overdose

TABLE 16.3 Medications Used to Treat Depression (Moraczewski & Aedma, 2020; Rush, 2024; Sub Laban & Saadabadi, 2019)

Class	Examples	Mode of Action	Side Effects
Monoamine oxidase inhibitors (MAOIs)	Phenelzine (Nardil) Tranylcypromine (Parnate)	Inhibit the breakdown of norepinephrine, serotonin, dopamine, and tyramine, thus increasing their levels and allowing them to continue to influence the cells that have been affected by depression	Orthostatic hypotension, dizziness, drowsiness, insomnia, sexual dysfunction, weight gain, hypertensive crisis
Atypical antidepressants	Bupropion (Wellbutrin)	Shifts the levels of dopamine and norepinephrine in the brain	Gastrointestinal issues, orthostatic hypotension, sedation, weight loss, sexual dysfunction, increased risk of seizures
	Mirtazapine (Remeron)	Increases the levels of serotonin and norepinephrine in the brain	Drowsiness, sexual dysfunction, weight gain
Antipsychotics	Aripiprazole (Abilify) Quetiapine (Seroquel) Olanzapine (Zyprexa)	Augment the therapeutic effects of antidepressants when they alone have proven insufficient in treating depressive symptoms	Weight gain, elevated blood sugar levels, metabolic syndrome, increased lipid profiles, tremors, akathisia, dystonia, sedation

TABLE 16.3 Medications Used to Treat Depression (Moraczewski & Aedma, 2020; Rush, 2024; Sub Laban & Saadabadi, 2019)

PSYCHOSOCIAL CONSIDERATIONS

Psychosocial Factors Affecting Depression

It is essential to remember that psychosocial factors play a significant role in the onset, course, and recovery from depression. These factors include the individual's social environment (such as relationships with family, friends, and coworkers), their psychological resources (such as coping skills and resilience), and the cultural context within which they live.

Depression often impacts and is impacted by these psychosocial factors. For example, a person with depression may withdraw from their social network, leading to feelings of isolation that can exacerbate their depressive symptoms. Additionally, ongoing stressors, such as financial difficulty or relationship problems, can contribute to the development and persistence of depression. Understanding and addressing these psychosocial factors is crucial to the treatment of depression (Remes et al., 2021).

Psychotherapeutic Approaches to Treating Depression

There are several psychotherapeutic approaches that are effective in treating depression, such as CBT and IPT (American Psychological Association, 2019). CBT works by helping individuals identify and change negative thought patterns and behaviors that may contribute to their depression. At the same time, IPT focuses on improving interpersonal relationships and social functioning, both of which are often impaired in individuals with depression. In addition, research has shown that mindfulness-based cognitive therapy (MBCT) can help prevent relapse in individuals with recurrent depression by teaching them mindfulness skills to disengage from habitual depressive

thoughts (White, 2015). Group therapy, family therapy, and other supportive therapies can also be beneficial, particularly in cases where social support and relationship issues play a role in the onset or maintenance of depression (American Psychological Association, 2019).

CLINICAL SAFETY AND PROCEDURES (QSEN)

Client-Centered Care for Clients with Depression

Quality and Safety Education for Nurses (QSEN) underscores the importance of applying the six competencies in delivering client-centered care, particularly when treating conditions such as depression. Client-centered care demands that health professionals acknowledge clients as individuals with unique needs and respect their values and choices about their care (QSEN Institute, 2020).

Provide client-centered care for depression in a respectful, nonjudgmental, empathic manner to ensure dignity, decrease the stigma associated with depression, and promote better health outcomes. This care involves actively involving clients in their care plans and decision-making processes. The nurse should conduct a thorough assessment, considering the client's emotional, mental, and physical health, lifestyle, social factors, and personal beliefs about health and treatment. Then, the care team should establish a personalized care plan that reflects the client's preferences and respects their autonomy. This care plan might include a variety of interventions like psychotherapy, pharmacotherapy, self-management strategies, and complementary therapies, if suitable (American Psychological Association, 2019).

Communication is also a vital part of client-centered care. Nurses should provide clear, jargon-free explanations about the nature of depression, available treatments, possible side effects, and the expected course of recovery. Encourage clients to voice their concerns, ask questions, and express their views about their disorder and course of treatment. Moreover, recognize that families and caregivers are crucial members of the care team. They should be involved in care decisions and given proper education and support to understand and cope with the client's condition.

Planning Nursing Care for a Client with Depression

A comprehensive care plan for a client with depression begins with a holistic assessment of the client, including physical, emotional, and mental health, along with psychosocial factors, such as support systems and lifestyle factors. It is important to assess the client's risk of self-harm or suicide and take appropriate safety precautions.

The management of a depressed client with self-harm potential presents significant safety challenges that must be carefully addressed. A depressed client may exhibit various forms of self-harm behaviors, such as cutting, burning, or ingesting harmful substances, often as a maladaptive coping strategy for emotional pain or distress (SAMHSA, 2023b). In these cases, a comprehensive safety plan is essential and should include thorough risk assessment, close monitoring, and environmental modifications. This may involve removing items that could be used for self-harm, such as sharp objects, from the client's vicinity (SAMHSA, 2020a). Medications prescribed should be carefully selected, ideally opting for those with a lower risk of lethality in case of overdose (Carpenter et al., 2021). Clients should be closely monitored for the warning signs of self-harm or increasing emotional distress (SAMHSA, 2020a).

Establish specific, measurable, achievable, realistic, and timely (SMART) goals in collaboration with the client. For example, these goals could involve managing symptoms, enhancing coping strategies, improving function in daily activities, or engaging in social interactions (Smith, 2018). Tailor interventions to the individual's needs and preferences. These might include facilitating therapeutic communication, promoting self-care activities, assisting with symptom management, advocating for treatment adherence, educating about depression and its management, and coordinating care with other health-care professionals. Evaluate the care plan regularly to monitor the client's progress and adjust the plan as necessary. The ultimate goal is to support the client in managing depression, improving their quality of life, and preventing relapse.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Applying Client-Centered Care to a Client with Depression

Client: John, a thirty-five-year-old male

Presenting issue: John has been feeling persistently sad, tired, and disinterested in activities that he usually enjoys for the past two months. In addition, he reports significant difficulty sleeping and a loss of appetite, which resulted in a ten-pound weight loss over the last month. John was admitted to an inpatient psychiatric unit after expressing feelings of worthlessness and reports that he has had recurrent thoughts of suicide, though he denies any specific plan or intent.

Past medical history: No significant past medical history.

Family and social history: John is single and lives alone. His father committed suicide at forty-two when John was a teenager. John has a stable job but admits that he has been missing work because he "just can't get out of bed." He has no significant history of substance use.

Diagnosis, risk factors, nursing interventions, evaluation: John's symptoms align with the criteria for MDD as defined by *DSM-5*. Persistent sadness, loss of interest or pleasure, significant weight loss, insomnia, fatigue, feelings of worthlessness, and recurrent thoughts of death or suicide are indicative of this condition (American Psychiatric Association, 2022).

John's risk factors include a family history of depression and suicide (his father), living alone (potential social isolation), and possibly work-related stress.

Nursing interventions for John may include regular safety assessments given his suicidal ideation; facilitating therapeutic communication to provide emotional support and encouragement; promoting self-care activities, such as regular physical activity, a healthy diet, and adequate sleep; educating John about depression and its management; supporting medication adherence, if prescribed; and coordinating care with other health-care professionals, such as a psychiatrist or psychologist (Cleare et al., 2015).

The overarching goal of John's treatment is to alleviate his depressive symptoms, reduce suicidal ideation, and equip him with coping skills for his reintegration into the community. Evaluating the success of John's care in an inpatient psychiatric unit necessitates a multifaceted approach and may include the following measures:

- Clinical assessment: Repeated use of standardized clinical scales like the Hamilton Depression Rating Scale (HDRS). A significant reduction in scores could indicate treatment efficacy (Rush et al., 2021).
- Behavioral indicators: Observe for behavioral changes, such as increased engagement in activities, improved sleep, better appetite, and increased social interaction, which can be positive signs of treatment efficacy (Rost et al., 2023).
- Medication review: Ensure that John's medication regimen has been effective in treating his symptoms without causing intolerable side effects. Adjustments in medication may demonstrate attentive care, but may also suggest that they have not yet found the optimal treatment (Informed Health, 2020).

16.3 Self-Harm and Suicide

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe how self-harm can be related to mental illness
- Outline the challenges in dealing with attempted suicide in clients with a mental health problem
- Plan nursing care for a client who is contemplating suicide
- Define nonsuicidal self-injury and the approaches used to care for clients who may self-injure

Depression and suicide are deeply intertwined and represent significant public health challenges. Depression is a leading cause of disability worldwide, affecting more than 280 million people, and is a major risk factor for suicide (World Health Organization, 2023). Suicide is not a normal response to stress, but is most commonly driven by a mental disorder, such as depression or a substance use problem (American Psychiatric Association, 2022; NIMH,

2020b).

The term **suicidal ideation** refers to thoughts, fantasies, or preoccupations with suicide. It can range from fleeting thoughts of ending one's life to detailed plans, with specific details on the timing or execution. Suicidal ideation is often considered a symptom or manifestation of an underlying psychiatric condition, such as depression, though it can also occur in the absence of a diagnosable mental health condition. The severity can vary significantly from person to person and it can exist on a spectrum that ranges from passive thoughts about being dead to active thoughts about how to carry out the detailed plan for suicide (Harmer et al., 2023). It is crucial for health-care providers, including nurses, to conduct a thorough risk assessment when suicidal ideation is present.

A **lethality assessment** refers to the structured evaluation of the risk factors associated with a person's potential for engaging in a life-threatening behavior, such as suicide. This assessment aims to gauge the immediacy and severity of the risk to help determine the appropriate level of intervention or treatment required. Several factors are typically examined during a lethality assessment, including the presence of a detailed plan, the availability of means, the availability to carry out the plan (e.g., weapons or drugs), previous suicide attempts or violent behavior, current mental state, and other situational factors, such as social support and recent life events (Minnesota Department of Health, 2019).

Health-care providers, including nurses, often use standardized instruments like the Columbia-Suicide Severity Rating Scale (C-SSRS), the SAD PERSONS Scale, or other clinical interview protocols to guide the lethality assessment. Such assessments are vital in determining the immediate next steps, such as hospitalization, close monitoring, or outpatient treatment, as they help to identify individuals who are at higher risk and therefore require more intensive interventions (Andreotti et al., 2020).

UNFOLDING CASE STUDY

Depression: Part 3

See Depression: Part 2 for a review of the client data.

PMH	The client indicates that he has a plan to suffocate himself in the bed sheets in the hospital. He declines to come out of his room and continues to appear withdrawn and tearful.

5. What actions would the nurse take with this client? Select all that apply.

a. arrange for the client to be placed under observation
b. communicate therapeutically with the client
c. arrange for someone from assisted living community to visit him
d. encourage the client to come out of his room
e. withhold his medication in case he is "cheeking" it
f. provide emotional support for the client
g. validate the experiences and feelings of the client
h. leave the client to eat on his own in private
i. identify enjoyable activities for the client

6. What would be expected outcomes or unexpected outcomes for this client following the treatment that he is given in the unit?

	Expected Outcome	Unexpected Outcome
Joins in activities in the assisted living community		
Does not wish to meet with his son		

Takes his medication		
Wants to keep living		
Loses weight		
Eats meals in private		

Self-Harm and Mental Illness

Often referred to as self-injury or self-mutilation, **self-harm** is a behavior that involves deliberately causing harm to one's own body as a way to cope with emotional distress or regain a sense of control (Klonsky et al., 2014). Self-harm does not necessarily indicate a desire to end one's life; instead, it often serves as a maladaptive coping mechanism for overwhelming feelings or situations (Elena-Rodica et al., 2023). It is, however, a significant risk factor for suicide, particularly when associated with mental disorders (Harris et al., 2019). Many mental health conditions can be associated with self-harm, including, but not limited to, borderline personality disorder, depression, anxiety disorders, and eating disorders (American Psychiatric Association, 2022). In many instances, individuals who self-harm may be attempting to manage intolerable emotional pain or regulate their emotions, express self-directed anger, distract themselves from emotional distress, or communicate their emotional state to others (Elena-Rodica et al., 2023).

Identifying signs and symptoms of self-harm is vital for health-care providers because it enables timely intervention and treatment planning. Physical signs often include visible cuts, burns, or bruises, frequently observed on wrists, arms, thighs, or other less noticeable body parts (Elena-Rodica et al., 2023). Behavioral indicators may include social isolation, wearing long sleeves or pants even in warm weather to conceal injuries, and the unexplained possession of sharp objects like knives or razors (Clarke et al., 2019). Emotional symptoms can involve increased emotional instability, impulsivity, and verbal expressions of hopelessness or overwhelming stress (Klonsky et al., 2014). Further, nurses may notice evasiveness or dishonesty when questioned about the source of injuries, along with frequent episodes of "minor accidents" that could serve as a facade for self-harm activities (Klonsky et al., 2014). Multiple visits to health-care facilities for the treatment of ambiguous physical injuries may also serve as a red flag (Plener et al., 2015). Early recognition of these signs is crucial for initiating comprehensive care, which may include risk assessments, psychotherapy, and medication management for underlying mental health conditions (Klonsky et al., 2014).

Suicide and Mental Health Problems

Suicide is a significant public health issue often linked to mental health problems. According to the WHO, more than 700,000 people die by suicide every year worldwide. Suicide is the fourth leading cause of death among individuals between the ages of fifteen and twenty-nine (World Health Organization, 2021). In the United States alone, in 2022, nearly 50,000 people died by suicide, close to four times as many males as females (Centers for Disease Control and Prevention [CDC], 2023).

A substantial proportion of individuals who die by suicide have a diagnosed mental disorder. Mental health conditions, such as depression, bipolar disorder, schizophrenia, and anxiety disorders, significantly increase the risk of suicidal thoughts and behaviors (NIMH, 2020b). Substance use disorders are also strongly associated with an increased risk of suicide, as are certain personality disorders, particularly borderline personality disorder (American Psychiatric Association, 2022).

Several factors can heighten the risk of suicide among people with mental health problems, including feelings of hopelessness, social isolation, poor adherence to treatment, high levels of impulsivity and aggression, and previous suicide attempts (American Psychiatric Association, 2022). Comprehensive mental health services, including assessment, diagnosis, and treatment, are essential to suicide prevention. Interventions often involve psychotherapy, medication management, and strengthening social support. Additionally, immediate crisis intervention is vital for individuals expressing suicidal thoughts or demonstrating suicidal behaviors. The National

Suicide Prevention Lifeline is available at 1-800-273-TALK and the Suicide and Crisis Lifeline is available at 988 (NIMH, 2020b).

PSYCHOSOCIAL CONSIDERATIONS

The Link between Depression and Suicide

Depression is a major risk factor for suicide. The feelings of hopelessness, worthlessness, and a persistent sense of overwhelming despair that often accompany depression can lead individuals to perceive suicide as the only viable option to escape their pain (American Psychiatric Association, 2022).

Several psychosocial factors can increase the risk of suicide among people with depression. These include social isolation, relationship problems, significant life stressors, previous suicide attempts, and inadequate social support (NIMH, 2020b). Therefore, the nurse needs to assess these factors when treating individuals with depression.

Recognizing signs of suicidal ideation in individuals with depression is crucial. These signs include talking about wanting to die, expressing feelings of unbearable pain or being a burden to others, and demonstrating changes in behavior, such as withdrawal, increased substance use, giving away personal items, discontinuing activities they previously enjoyed, or exhibiting risky behaviors (NIMH, 2020b).

Pharmacological therapy for depression is helpful but does pose a risk for the client especially early in treatment. One danger associated with medications is the potential increase in motivation to attempt suicide. This is especially true during the initial stages of treatment when the medication begins to alleviate depressive symptoms. At this time, clients may experience an increase in energy and motivation before their suicidal ideation decreases, potentially leading to higher risk of suicide attempts (Baldessarini et al., 2017). Please note that there is a black box warning on all antidepressants about increased suicidal ideation, especially in adolescents and young adults.

Another significant concern is the potential for medication hoarding or storing up medications for the purpose of a suicide attempt by overdose (Hawton et al., 2010). In some cases, individuals may pretend to take their medication but instead keep it to accumulate a lethal dose. This highlights the importance of direct observation during medication administration in high-risk populations (Baldessarini et al., 2017).

Additional interventions for preventing suicide among individuals with depression include CBT and DBT, both aimed at enhancing coping and problem-solving skills, improving emotion regulation, and building resilience (American Psychiatric Association, 2022). ECT is considered an effective and fast-acting intervention for severe depressive disorders and may be especially relevant for clients exhibiting acute suicidal ideation or behavior. The primary advantage of ECT in treating suicidality associated with depression is its rapid onset of action. Unlike pharmacotherapy, which can take weeks to show effects, ECT often produces a significant reduction in depressive symptoms and suicidality within a week or even after a single session. This can be critical in cases where immediate risk reduction is essential (Rönnqvist et al., 2021).

Methods Used in Suicide

Understanding the various methods of suicide is a critical aspect of suicide prevention and risk assessment in health-care settings. The most common methods of suicide vary by region and gender but generally include hanging, self-poisoning (including drug overdose), and firearms (Stone et al., 2018). In the United States, firearms are the most commonly used method of suicide, particularly among men (CDC, 2020). Hanging is the most frequently used method worldwide, especially in countries where firearms are less accessible. Self-poisoning, which includes overdose of medications or ingestion of toxic substances, is more common among women (Stone et al., 2018).

Health-care providers, including nurses, must be aware of these methods when assessing suicide risk. Access to lethal means can increase the risk of a suicide attempt being fatal, so a crucial part of a safety plan may involve working with clients and families to limit access to these means (Sidwell et al., 2023). Safety, empathy, and providing resources for help should always be the primary focus of such conversations (NIMH, 2020b).

Conversations about suicide with clients are a delicate yet essential task that health-care providers must navigate skillfully. Open and empathetic dialogue can serve as a powerful tool for risk assessment and therapeutic

intervention. Conducting conversations with a nonjudgmental approach, employing open-ended questions, and actively listening to the client's narrative are all techniques that may allow the client to feel comfortable enough to share sensitive information (Slade & Sergent, 2020). Providers should aim to uncover the depth of the individual's suicidal ideation, including the existence of a plan, a means, and a timeline, as these factors significantly correlate with imminent risk (Weber et al., 2017). Clients should not only be asked about their thoughts of dying but also about their reasons for living; exploring the ambivalence between the wish to die and the wish to live can be a crucial element in a safety plan (Minnesota Department of Health, 2019). Failure to assess or inadequate assessment of suicide risk can have severe consequences, including possible legal repercussions for the health-care provider (Pinals, 2019).

CULTURAL CONTEXT

Cultural Perspectives on Suicide

Cultural norms and beliefs significantly influence attitudes toward mental health and suicide. Different cultures may interpret suicide differently, with some viewing it as a sin, a crime, a symptom of mental illness, or even an honorable act (Clay, 2018). For instance, in some cultures, suicide has historically been viewed as an honorable way to atone for failure or to preserve the dignity of one's family. On the other hand, in some cultures, suicide is typically perceived as a tragic outcome of untreated mental illness (Steele et al., 2018). In indigenous communities, high rates of suicide are often understood in the context of historical trauma and ongoing systemic inequities (Connors, 2021). Therefore, understanding the cultural nuances is crucial for health-care providers in implementing effective prevention strategies and delivering sensitive care.

Many cultures and religions have strong stigmas and taboos surrounding suicide, which can prevent individuals from seeking help when experiencing suicidal thoughts. This stigma can be exacerbated by a lack of understanding or misconceptions about mental health (National Alliance on Mental Illness, n.d.). Religion can have a protective or risk-enhancing role, depending on its teachings and the individual's relationship with their faith. In the Catholic religion, the act of suicide is considered a sin, adding another layer of stigma and complicating prevention efforts (Adamiak & Dohnalik, 2023). In some Islamic cultures, suicide is considered a sin and is highly stigmatized, making it difficult for individuals to seek assistance due to fear of social ostracization. Similarly, in some African and Caribbean communities, mental health issues may be attributed to spiritual or moral shortcomings, limiting the use of formal mental health-care services (Gearing & Alonzo, 2018). In some Chinese cultures, the concept of maintaining social standing can deter people from talking openly about mental health challenges (Yin et al., 2020). Understanding these dynamics can help health-care providers tailor their approaches to suicide prevention (Ariapooran et al., 2018).

Providing culturally competent care is essential in addressing suicide risk. This care includes understanding cultural influences on suicide, reducing stigma, and providing culturally appropriate treatment and intervention strategies (American Psychological Association, 2017). CBT can be adapted to incorporate cultural elements and rituals important to the individual, such as incorporating prayer for clients from highly religious backgrounds (de Abreu Costa & Moreira-Almeida, 2022). Engaging with religious and community leaders can help to diminish stigma and encourage more people to seek help (Minot, 2023).

Suicide Risks in Care Settings

Suicide risk within health-care settings is a critical issue that requires immediate attention from health-care professionals. The risk is not confined to psychiatric units but extends to emergency departments, medical-surgical floors, and even outpatient settings (King et al., 2017). Identifying and managing suicide risk involves comprehensive screening, vigilant observation, and strategic intervention. The Columbia-Suicide Severity Rating Scale (C-SSRS) is commonly used to assess the immediate risk of suicide among clients (Bjureberg et al., 2022). Assessment tools are not foolproof, however, and require accompanying clinical judgment and ongoing assessment.

Environmental safety measures are also crucial. Monitoring protocols, like one-on-one observation or frequent safety checks, can further mitigate risk (Quinlivan et al., 2016).

Effective communication among health-care team members is essential to maintain a high level of vigilance.

Handoffs between staff should include detailed information about the client's mental state, triggers, and coping mechanisms. Staff should also be trained in crisis intervention techniques to address acute episodes of suicidal ideation (SAMHSA, 2020a). The transition periods during admission and after discharge are times of elevated risk and require comprehensive risk assessment, safety planning, effective handoff communication, and follow-up procedures (Chammas et al., 2022).

All health-care providers must be trained adequately to recognize the signs of suicidal ideation, conduct risk assessments, provide immediate crisis intervention, and refer clients to appropriate mental health services. Collaboration and communication among health-care providers, clients, and their families is also crucial. Furthermore, integrating suicide prevention strategies into the wider health-care system, such as incorporating regular suicide risk screenings into routine care, implementing safety planning, and providing post-discharge follow-up, can help reduce suicide risk (American Psychological Association, 2019). Nurses should be skilled at identifying suicide risk factors. The SAD PERSONS Scale is a widely used clinical tool designed to assess suicide risk. The acronym stands for Sex, Age, Depression, Previous attempt, Ethanol use, Rational thinking loss, Social supports lacking, Organized plan, No spouse, and Sickness. Each factor is assigned a score, usually either 0 or 1, and the total score is used to estimate the risk level for suicide. The SAD PERSONS Scale offers the advantages of being quick and straightforward, making it a useful tool for busy health-care settings, such as emergency departments (Katz et al., 2017). After a suicide in a hospital, postvention strategies, including debriefing and support for affected staff and clients, are essential to promote healing and prevent further suicides (Andriessen et al., 2017).

LINK TO LEARNING

The Zero Suicide Institute's mission is to decrease the incidence of suicide in clients under the care of a health-care provider. Their website provides information (https://openstax.org/r/77ZeroSuicide) for implementation in clinics and practices.

Preventing Suicide in Care Settings

Preventing suicides in health-care settings requires a multifaceted approach encompassing self-awareness, risk assessment, environmental safety, staff training, and continuous client monitoring. Regular screening for suicide risk, as part of routine care, is essential, especially for clients with known mental health disorders, a history of suicidal behavior, or other risk factors (Chammas et al., 2022).

Self-awareness plays a critical role in suicide prevention within health-care settings. Being cognizant of one's own biases, emotions, and knowledge gaps can directly influence the care provided to at-risk clients and may even impact outcomes. Health-care providers may hold conscious or unconscious biases related to suicide and mental health that could affect their judgment or interaction with clients. Being self-aware enables health-care professionals to recognize these biases and work toward mitigating their effects (Knaak et al., 2017). Providers must be aware of their emotional reactions when dealing with suicidal clients. Emotional responses like fear, discomfort, or frustration can impair clinical judgment and interfere with effective communication (Weber et al., 2017). Maintaining appropriate professional boundaries is crucial. Emotional involvement may cloud clinical judgment, whereas detachment may result in lack of empathy. Self-awareness assists in balancing empathy with professionalism (Banerjee et al., 2020). Providers should also recognize the emotional toll that managing high-risk clients can take and engage in appropriate self-care strategies, including debriefing sessions and consultations with peers or mental health professionals (SAMHSA, 2021).

Environmental safety measures can prevent suicides. These measures can include limiting access to means of suicide, such as certain medications or medical equipment that could be used for self-harm, and designing inpatient units with reduced opportunities for hanging or jumping (Chammas et al., 2022). Staff training is another key aspect of prevention. Staff should be trained to recognize signs of suicidal ideations, such as verbal or written expressions of suicidal thoughts, behavioral cues like withdrawal or agitation, and emotional indicators like severe anxiety or hopelessness (Zalsman et al., 2016).

Continuous client monitoring is a key component of effective suicide risk management within health-care settings. The level of monitoring should be aligned with the individual client's risk level to ensure that adequate safety

measures are in place. Those identified as high risk often require continuous one-to-one observation to ensure their immediate safety. This could include constant visual observation, sometimes even during personal activities like showering, to minimize any opportunity for self-harm. Those at moderate or lower risk may not require constant monitoring but should be subject to regular and frequent checks. The frequency of these checks should be based on a structured risk assessment and modified as the client's condition changes (Shekelle et al., 2019).

Health-care providers must be vigilant for changes in behavior, affect, or verbal statements that may signify an increased risk of suicide. New or heightened expressions of hopelessness, agitation, or withdrawal should trigger an immediate reassessment of the level of monitoring required (Quinlivan et al., 2016). Thorough documentation of all observations and any changes in behavior is crucial for both ongoing care and legal considerations. Documentation should be detailed, contemporaneous, and communicated clearly during handoffs between staff members (Harmer et al., 2023). Suicide risk may change over time. Frequent reassessments help reduce risk, especially after any significant event like a familial crisis, change in medical condition, or adjustment in medication (National Action Alliance for Suicide Prevention, 2019).

Physician-Assisted Suicide

Physician-assisted suicide is a contentious issue that has implications for nursing practice. A physician provides a terminally ill client with the means, such as a prescription for lethal medication, to end their own life (Emanuel et al., 2016). The laws governing this action are different in each state. Nurses may find themselves in situations where they must navigate the ethical and legal challenges associated with this practice. The American Nurses Association (ANA) states that nurses should not participate in assisted suicide, even in jurisdictions where it is legal, because it is inconsistent with the ethical principles and standards of the nursing profession (ANA Center for Ethics and Human Rights, 2019). This statement does not mean that nurses should abandon clients who are considering or have chosen this path, however. Nurses are still obligated to provide compassionate, nonjudgmental care and respect the client's autonomy while maintaining a focus on alleviating suffering (ANA Center for Ethics and Human Rights, 2019).

Planning Nursing Care for a Suicidal Client

Planning nursing care for suicidal clients necessitates a meticulous, comprehensive, and systematic approach. The immediate priority involves ensuring the client's safety. The nurse should initiate suicide precautions. One suicide precaution includes maintaining a safe environment by removing items that could be used for self-harm or suicide, such as sharp objects, cords, and certain medications (Pinals, 2019). Regular and meticulous client monitoring is also a crucial aspect of suicide precautions, with clients being checked at frequent, unpredictable intervals to prevent any potential suicide attempts (Bowers et al., 2015). Ensuring that clients are not left alone and have someone to talk to can help alleviate feelings of isolation, which often accompany suicidal ideation.

Communication with suicidal clients also plays a critical role in nursing care planning (Falcone & Timmons-Mitchell, 2018). Develop a therapeutic relationship that encourages the client to express their feelings and thoughts openly. It is often a relief for clients to talk openly about their thoughts, and this also decreases isolation. This connection allows for a better understanding of the client's emotional state and suicidal ideation, which can guide the implementation of appropriate nursing interventions. The nurse should never be reluctant to ask the client if they are contemplating suicide or self-harm because asking a client if they are suicidal will not put the thought into their head. If the client answers that they are, then the nurse has to ask which method of harm the client is contemplating so the nurse can carry out a risk assessment of the client and initiate protective precautions as necessary.

Providing crisis information to a suicidal client in a health-care setting is a critical and sensitive task. It is crucial to ensure that the information is accurate, easily understandable, and actionable. Make sure to provide numbers for emergency services and crisis hotlines, such as the Suicide and Crisis Lifeline at 988 (988 Suicide & Crisis Lifeline, 2022). It is important to assist the client in developing a personalized safety plan that includes identifying warning signs, coping strategies, and emergency contacts. Educating family members or close friends about the signs of suicide and how to offer support is essential in reducing suicide risk. In addition, integrating family members into the care plan helps create a supportive environment for the client during their recovery. Managing suicidal clients takes a multidisciplinary team approach. A team consisting of psychiatrists, psychologists, social workers, and nursing staff can provide holistic care that addresses a client's physical and mental health needs (Moscardini et al., 2020).

REAL RN STORIES

Nurse: Alex, RN
Years in Practice: Eleven
Clinical Setting: Intensive care unit in a large city hospital
Geographic Location: Ohio

Alex's colleagues admire her for her technical skills, kindness, and empathetic nature. She has always been someone who could smile through the most challenging shifts. Yet, underneath this professional façade, Alex was silently fighting a battle, one of despair, loneliness, and mental health deterioration.

Alex had been an RN for over a decade. She was passionate about her job, but the stress, long hours, and emotionally taxing situations gradually took a toll on her mental health. Like many health-care professionals, Alex perceived her struggles as a sign of personal weakness. Unfortunately, the professional culture—where showing vulnerability looks weak—reinforced her perspective. Two years into her ICU tenure, Alex started experiencing symptoms of depression and anxiety. She felt an overwhelming sense of sadness, struggled to sleep, and lost interest in things she previously enjoyed. She started making minor mistakes at work, felt perpetually tired, and had trouble concentrating.

One night, after a particularly grueling shift where she witnessed the death of a young client, Alex felt an overwhelming sense of hopelessness. She found herself contemplating suicide, a sign that her mental health had deteriorated. She felt alone and did not know where to turn. Despite the despair, a small part of Alex recognized that she needed help. She bravely confided in a close colleague about her thoughts of suicide. The colleague immediately connected her with mental health resources, including the hospital's employee assistance program.

Alex sought professional help from a psychologist specializing in health-care worker mental health, and she was diagnosed with severe depression and burnout. She was advised to take a leave of absence from work to focus on her recovery. The psychologist recommended a multipronged treatment approach that included CBT to help change negative thinking patterns, mindfulness practices to reduce stress, and an appropriate course of medication. The psychologist also suggested group therapy sessions where Alex could connect with other health-care professionals dealing with similar issues.

The road to recovery was long for Alex, but she persevered. Her treatment helped her to regain her emotional footing, manage her depression, and create a toolbox to cope with the inherent stresses of her job. Finally, after several months, Alex could return to work, this time with a renewed spirit and an in-depth understanding of her mental health needs. She also became an advocate for mental health awareness within her hospital, helping to initiate changes in the system to recognize and address mental health concerns among staff.

Nonsuicidal Self-Injury

Self-harm, more formally referred to as **nonsuicidal self-injury (NSSI)**, is a behavior involving deliberate self-inflicted harm that is not intended to result in death. NSSI usually presents as skin cutting, burning, or severe scratching, and is often associated with a desire to cope with distressing emotions or to communicate emotional pain to others (Grandclerc et al., 2016).

The complex nature of NSSI necessitates a multifaceted approach to management and prevention. For example, interventions may focus on teaching alternative coping strategies and emotional regulation skills and facilitating supportive interpersonal relationships (Timberlake et al., 2019). NSSI is a serious concern due to its association with an increased risk of future suicide attempts. Therefore, health-care providers must be attentive and proactive in recognizing and addressing this behavior (Grandclerc et al., 2016).

Types of Self-Harm

Self-harm refers to a variety of behaviors that individuals engage in with the intent of deliberately causing harm to themselves. These behaviors can be categorized into several types based on the method of self-injury (National Alliance on Mental Illness, 2020b). Cutting or scratching the skin is the most common form of self-harm. This form of self-harm typically involves using sharp objects like knives, razors, or even the individual's fingernails to inflict

superficial to moderate injuries, primarily on the arms, legs, and torso (Mayo Clinic, 2023). Another type of self-harm is burning, which involves applying heat or friction to the skin to cause damage. For example, individuals may use lighters, matches, hot metals, or even heated objects like a hair straightener or an iron (Cipriano et al., 2017). Other forms of self-harm include self-hitting, such as punching oneself or banging one's head against a wall; self-poisoning or overdosing, which involves ingesting toxic substances or taking an excessive dose of medication; and interference with wound healing, where individuals deliberately prevent their wounds from healing normally (National Alliance on Mental Illness, 2020b).

While these types of self-harm may not be intended to result in suicide, they are often associated with severe emotional distress and mental health conditions such as depression, anxiety, and borderline personality disorder (Victor & Klonsky, 2014). These behaviors are a cry for help and indicate deep emotional pain. Individuals who self-harm often struggle with intense feelings of sadness, self-loathing, emptiness, or frustration, and they may have difficulty regulating, expressing, or understanding their feelings. Hence, health-care providers must recognize and address these behaviors promptly. Recovery is possible with professional help, and it often involves treating any underlying mental health conditions, improving emotional regulation skills, and developing healthier coping mechanisms (Mayo Clinic, 2023).

LINK TO LEARNING

The Substance Abuse and Mental Health Services Administration has provided a list of examples of self-harm (https://openstax.org/r/77selfharmexmpl) that may be used by a mental health client.

Addressing Nonsuicidal Self-Injury in Care Settings

Clients admitted for other health issues may engage in NSSI while in the health-care facility. Staff should be trained to identify signs of NSSI and assess the level of risk, including the likelihood of escalation (Cipriano et al., 2017). Once identified, immediate steps should be taken to ensure the client's safety. This may include removing objects that could be used for self-injury and considering relocation to a more closely monitored setting (Witt et al., 2021). Open, nonjudgmental communication is essential for building trust. Clients should feel understood rather than stigmatized (Witt et al., 2021). The nursing staff should continuously monitor the client's mental and emotional state because changes may require adjustments to the treatment plan. Managing NSSI in health-care settings involves a multidimensional approach that considers immediate safety concerns, long-term treatment options, and the emotional well-being of both clients and health-care providers (Zhang et al., 2023).

Relationship between NSSI and Suicide Attempts

Understanding the relationship between NSSI and suicide attempts is important for effective prevention and intervention strategies. To be clear, MSSI refers to deliberate self-harm without suicidal intent, such as cutting or burning oneself, and is primarily used as a coping mechanism for emotional distress or to feel a sense of control (Zhang et al., 2023). In contrast, suicide attempts involve self-harming behaviors undertaken with the intent to end one's life (World Health Organization, 2021). NSSI can be distinguished from suicide attempts by differences in intent, lethality, and frequency. NSSI is often repetitive and episodic, with no intention to die, whereas suicide attempts are usually less frequent but with higher lethality and intent to die (Zhang et al., 2023).

Still, individuals engaging in NSSI are at a higher risk of later suicide attempts, making NSSI a significant predictor of suicidal behavior (Chesin et al., 2017). Both NSSI and suicidal behaviors are indicators of severe emotional distress and mental health issues. Therefore, the presence of either behavior warrants immediate attention from health-care providers, who should employ a comprehensive approach to address the underlying issues contributing to these behaviors (Zhang et al., 2023).

CLINICAL JUDGMENT MEASUREMENT MODEL

Importance of Clinical Judgment in NSSI

Accurate clinical judgment is crucial in identifying and managing NSSI. It guides recognizing and analyzing cues during initial evaluation and diagnosis and shapes the treatment approach and ongoing monitoring. Conversely,

failure to exercise sound clinical judgment can result in a lack of recognition of NSSI, an incomplete understanding of the client's situation, ineffective treatment strategies, and potentially serious health consequences. Properly assessing the severity and frequency of NSSI behaviors enables clinicians to make informed decisions about immediate interventions and long-term treatment plans. It is imperative for the health-care provider to ask the client direct questions related to self-harm potential. Therefore, improving clinical judgment in this area is vital for ensuring the best possible outcomes for individuals who self-harm ("Self-Harm: Assessment, Management and Preventing Recurrence," 2022).

16.4 Bipolar Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define bipolar disorder
- Describe the symptoms of bipolar disorder
- Outline the approaches used to treat bipolar disorder

Bipolar disorder is a chronic mental health condition characterized by fluctuating periods of intense mood states, often categorized as manic, hypomanic, and depressive episodes (American Psychiatric Association, 2022). During a manic episode, an individual may exhibit heightened energy, delusions (often of grandeur), decreased need for sleep, racing thoughts, rapid speech, and impulsive or reckless behavior. Hypomanic episodes are similar but less severe and disruptive. Conversely, depressive episodes involve symptoms, such as feelings of intense sadness, hopelessness, lack of energy, difficulty concentrating, and changes in sleep and appetite. These mood shifts can occur over weeks to months and are often interspersed with periods of relatively normal mood (American Psychiatric Association, 2022).

Bipolar disorder treatment involves medication management alongside psychotherapy. Health-care providers should be aware that these individuals may also be at risk for co-occurring conditions, including substance use disorders, anxiety disorders, and suicidal ideation (American Psychiatric Association, 2022). Health-care professionals must develop skills for working with individuals with bipolar disorder, including communication strategies, empathy, and a comprehensive understanding of this condition and its treatment options.

Definition of Bipolar Disorder

Defined, bipolar disorder is a serious mental health condition characterized by extreme mood swings, including emotional highs (mania or hypomania) and lows (depression). When a person becomes depressed, they may feel sad or hopeless and lose interest or pleasure in most activities. When their mood shifts to mania or hypomania, they may feel euphoric, full of energy, or unusually irritable. These mood swings can affect sleep, energy, social and occupational activity, judgment, behavior, and the ability to think clearly. Episodes of mood swings may occur rarely or multiple times a year. While most people experience some emotional symptoms between episodes, some may not experience any (American Psychiatric Association, 2022).

Mania Versus Hypomania

Mania and hypomania are both mood states associated with bipolar disorder characterized by elevated or irritable mood, increased energy, and other specific symptoms, but they differ in their severity and impact on functioning. Mania is a severe form of elevated mood most of the time for seven days that may result in psychosis or necessitate hospitalization. Individuals experiencing mania often exhibit poor judgment, impulsivity, excessive spending, gambling, hypersexuality, and may engage in risky behaviors leading to inadvertent self-harm. On the other hand, **hypomania** is a milder form that typically does not impair social or occupational functioning to the extent that mania does and does not progress to psychosis (Jain & Mitra, 2023). While clients experiencing hypomania may show increased productivity or creativity, they are at risk for progressing to a manic episode or experiencing depressive episodes. For health-care professionals, recognizing the symptoms of mania and hypomania is crucial for timely intervention and treatment, which usually involves pharmacotherapy with mood stabilizers, such as lithium and antipsychotic medications, and may include psychotherapy (Jain & Mitra, 2023).

Causes of Bipolar Disorder

The exact causes of bipolar disorder are not understood fully, but it appears to be a complex interplay of genetic,

neurochemical, and environmental factors. Research reveals that bipolar disorder tends to run in families, which indicates a genetic predisposition to the disorder. Neurochemically, there may be imbalances in certain neurotransmitters in the brain that contribute to the mood instability seen in bipolar disorder. Environmental factors, such as high stress levels, traumatic events, or major life changes can also play a significant role in the onset of bipolar disorder (McIntyre et al., 2022). Note, however, that not everyone with these risk factors develops the disorder, and many people without these risk factors do develop bipolar disorder, which points to the complex nature of its causes.

Types of Bipolar Disorder

There are several types of bipolar disorder, each differentiated by the severity and pattern of mood fluctuations. Bipolar I disorder is characterized by manic episodes that last for at least seven days or by manic symptoms so severe that hospitalization is required, and usually includes depressive episodes as well (American Psychiatric Association, 2022). By contrast, bipolar II disorder involves a pattern of depressive and hypomanic episodes but not the full-blown manic episodes observed in bipolar I disorder (American Psychiatric Association, 2022). Cyclothymic disorder, or cyclothymia, is a milder form of bipolar disorder that involves periods of hypomanic symptoms and periods of depressive symptoms lasting for at least two years (one year in children and adolescents) (American Psychiatric Association, 2022). There is also bipolar disorder "other specified" and "unspecified," which include bipolar-like symptoms but do not meet the specific criteria for the other types (American Psychiatric Association, 2022).

CULTURAL CONTEXT

Cultural Differences Relating to Elation

Elation is a universal human emotion characterized by a sense of joy, exhilaration, and high spirits. How this emotion is experienced, expressed, and interpreted differs greatly when accounting for cultural and age-related factors. Understanding these differences is key to fostering effective cross-cultural and intergenerational communication (Lim, 2016).

Many individuals of East Asian cultures, such as Chinese, Japanese, and Korean people, experience and express elation in a subdued, controlled manner. These cultures tend to be collectivist and therefore value harmony, adjusting, and conformity. Demonstrating excessive emotion, even positive emotions like elation, can be seen as a disruption of harmony or a lack of self-control. This tends to be true across all age groups (Ip et al., 2021).

In contrast, many Western cultures (such as American and some European) tend to express elation and other emotions more openly. People in these cultures prefer emotions they can express more exuberantly than those emotions that are generally not expressed as enthusiastically (Lim, 2016). There is generally less stigma around showing strong emotions; such expressions are often associated with individualism and influencing others (Lim, 2016). Other cultures may express elation in other ways. In general, a culture's expression and feeling of elation varies according to what they value, such as communal activities or celebration.

Younger generations, who are generally more connected globally through technology and social media, may share and express their elation differently than older generations. For example, this could be through posts, pictures, or videos on social media platforms. On the other hand, older generations might prefer to express elation more personally or directly, such as sharing their joy with close friends or family members in person.

Symptoms of Bipolar Disorder

Bipolar disorder is typified by extreme shifts in mood, energy, and activity levels that interfere with day-to-day functioning. Symptoms vary across the manic and depressive phases. Manic episodes can be characterized by: feeling overly happy, energized, and restless; rapid pressured speech; impulsive behavior; experiencing delusions and a decreased need for sleep. During depressive episodes, symptoms may include feeling intensely sad or hopeless; loss of energy; difficulty concentrating; changes in eating, sleeping, or other habitual behaviors; and in severe cases, suicidal thoughts or attempts. Mixed episodes, characterized by symptoms of both mania and depression, can also occur (NIMH, 2023). It is important to note that these symptoms can be severe and differ from the normal ups and downs most people experience.

A state of extreme happiness or exhilaration called **elation** can present as a symptom in certain mood disorders, such as bipolar disorder and cyclothymic disorder. A prolonged period of elation, as described previously, is considered mania. The types of elation in these contexts can be categorized as hypomanic elation and manic elation. Hypomanic elation is a characteristic symptom of hypomania, a mood state one step down from full-blown mania. Individuals experiencing hypomanic elation may feel extremely energetic, talkative, and overly confident. Despite these intense feelings, hypomanic individuals can typically carry on with their daily activities, though they may engage in risky or impulsive behaviors due to the elevated mood.

On the other hand, **manic elation** is a symptom of a manic episode, as seen in bipolar I disorder. This form of elation is more severe and disruptive than hypomanic elation. Individuals experiencing manic elation may feel invincible or omnipotent and often engage in reckless activities without considering the consequences. This intense level of elation can impair one's ability to function normally and may necessitate hospitalization to ensure the safety of the individual and others (American Psychiatric Association, 2022).

Treatment of Bipolar Disorder

The treatment of bipolar disorder generally includes a combination of medication and psychotherapy to manage and mitigate symptoms (Mayo Clinic, 2022). Mood stabilizers, antidepressants, and atypical antipsychotics often play a role in treatment (NIMH, 2023). Psychotherapy, including CBT, family-focused therapy, and interpersonal and social rhythm therapy (IPSRT), can also be an essential part of treatment (Mayo Clinic, 2021). In some cases, ECT or other brain stimulation therapies may work when other treatments are ineffective or if the person's symptoms are severe (NIMH, 2023). Importantly, treatment plans should be tailored to the individual because what works best may differ from person to person.

Medications

Medication is a crucial part of treatment for bipolar disorder, aiming to stabilize moods and help control symptoms (NIMH, 2023). Mood stabilizers, such as lithium and valproate, are often the first line of treatment, particularly for managing manic episodes. Antidepressants can manage depressive episodes, though they are typically prescribed alongside a mood stabilizer like lithium to prevent the onset of a manic episode. Antipsychotic medications, such as olanzapine or quetiapine olanzapine, may work if other drugs fail to control the symptoms of mania or depression (Mayo Clinic, 2022). In some instances, benzodiazepines, a type of antianxiety medication, may temporarily relieve acute symptoms, such as restlessness or insomnia (NIMH, 2023). It is important to note that medication needs can change over time, so it is vital to monitor medications continually (Mayo Clinic, 2022).

Lithium, a mood stabilizer commonly used to treat bipolar disorder, comes with a number of safety concerns:

- Therapeutic range: Lithium has a narrow therapeutic range, meaning the difference between a therapeutic dose and a toxic dose is small. The therapeutic range for lithium is very narrow, typically 0.8 and 1.2 mEq/L for acute goals and 0.8 and 1.0 mEq/L for maintenance goals, with the toxicity levels beginning at 2.0 mEq/L. Regular monitoring of blood levels is required to ensure safety (Chokhawala et al., 2024).
- Kidney damage: Long-term use of lithium can lead to kidney damage or even chronic kidney disease. Regular monitoring of kidney function is essential.
- Thyroid issues: Lithium can interfere with the function of the thyroid gland, causing hypothyroidism, requiring regular thyroid function tests.
- Side effects: Common side effects of lithium can be disruptive and include thirst, frequent urination, weight gain, memory problems, hand tremors, and gastrointestinal problems.
- Drug interactions: Lithium can interact with other drugs, such as diuretics, NSAIDs, and certain antihypertensive medications, leading to increased lithium levels and potential toxicity.
- Overdose risk: Overdosing on lithium can be life-threatening. Signs of lithium overdose can include diarrhea, vomiting, drowsiness, muscle weakness, and tremor. If not treated promptly, overdose can lead to seizures, coma, or even death.

While lithium is a very effective medication, its use requires careful monitoring due to its inverse relationship with sodium, to ensure client safety. There is a need for dietary education. It is also important that clients understand the effects of dehydration with lithium knowing that increased sodium will deplete lithium, causing increased sodium presentation. It is essential to understand the signs and symptoms of lithium toxicity; early recognition and intervention can be lifesaving. Early signs of lithium toxicity include the following:

- Gastrointestinal symptoms: Nausea, metallic taste in mouth, vomiting, and diarrhea are among the early signs.
- Fine hand tremors: An increase in the tremors that many clients experience when initially starting lithium.
- Generalized weakness: Clients may complain of feeling weak or fatigued.
- Thirst and polyuria: Increased thirst and frequent urination can be indicative of beginning toxicity.

Signs of moderate lithium toxicity include the following:

- Coarse tremors: The tremors may become more severe and noticeable.
- Confusion: The client may start to become mentally disoriented.
- Muscle hyperirritability: Symptoms like twitching or hypertonia.
- Unsteady gait: Trouble with balance and coordination.

Signs of severe toxicity include the following:

- Seizures: Uncontrolled electrical activity in the brain
- Coma: Loss of consciousness
- Oliguria or Anuria: Reduced or absent urine output, potentially leading to kidney failure
- Arrhythmias: Irregularities in heart rate and rhythm

Nursing interventions for suspected lithium toxicity include immediate notification of health-care providers, cessation of lithium administration, and close monitoring of vital signs and lithium blood levels. Depending on the severity of the symptoms, hemodialysis may be required (Hedya et al., 2022).

Nurses should review all of the medications being taken by each client on lithium to ensure no contraindications and provide client education on taking lithium and the side effects and safety concerns. Adherence to the medication may be a concern, particularly with the occurrence of side effects, such as weight gain, and because clients who are entering a manic phase may deny the presence of the disorder and need for medication.

Psychotherapeutic Approaches to Dealing with Bipolar Disorder

Psychotherapeutic interventions are important in managing bipolar disorder alongside medication. CBT can help individuals understand the patterns of their thoughts and behaviors and develop strategies to manage symptoms and prevent relapses (Özdel et al., 2021). Interpersonal and social rhythm therapy (IPSRT) aims to stabilize daily rhythms, such as sleep, wake, and mealtimes, which can be particularly beneficial for individuals with bipolar disorder; disruptions in these areas can precipitate manic or depressive episodes (Mayo Clinic, 2021). Family-focused therapy involves family members and concentrates on enhancing family communication, problem-solving, and coping skills, which can be crucial for managing the disorder (Miklowitz & Chung, 2016). Psychoeducation, which involves teaching individuals with bipolar disorder and their families about the disorder, is another key psychosocial intervention. It helps improve treatment compliance and decreases the likelihood of relapses (Miklowitz & Chung, 2016). Each of these approaches can be tailored to the individual's unique needs and circumstances to optimize the management of the disorder.

Planning Nursing Care for a Client with Bipolar Disorder

Planning nursing care for a client with bipolar disorder requires an individualized, holistic approach that considers the person's unique symptoms, triggers, and needs (Hernández-Gómez et al., 2021). The first step is typically a comprehensive assessment of the client's physical and mental health and their personal and social situation to identify specific areas of need. Next, developing a care plan should include elements of psychoeducation, helping the client understand their condition, treatment options, and strategies for self-management. Nursing care also involves monitoring the client's mood, behavior, and response to medication and communicating this information to the health-care team.

In acute phases, the focus may be on maintaining safety, providing support, managing symptoms, and stabilizing mood. In the maintenance phase, nursing care should emphasize recovery and the prevention of future episodes, which can include lifestyle counseling, promoting medication adherence, encouraging participation in therapy, and coordinating care with other health-care providers (Hernández-Gómez et al., 2021). Throughout this process, it is essential to involve the client in decision-making, support their autonomy, and respect their dignity.

Interacting with clients who have a bipolar disorder can be both rewarding and challenging. These individuals often go through phases of manic and depressive episodes, and knowing how to effectively communicate during these

different stages is crucial (SAMHSA, 2016). During manic phases, the client may exhibit elevated mood, increased activity, hostility, and grandiose thoughts. It is essential for the nurse to maintain a calm demeanor, provide concise and clear directions, and avoid challenging the client's grandiosity to prevent escalation. In contrast, during depressive phases, the client may be withdrawn, exhibit low energy, and may even have suicidal thoughts. It is vital to employ empathetic and active listening, and to consult the mental health team for additional evaluation and treatment, if necessary (SAMHSA, 2020b). Understanding the specific needs and symptoms of clients' bipolar disorder can lead to more effective nursing care and better outcomes (Novick & Swartz, 2019).

REAL RN STORIES

Nurse: Joan, RN
Years in Practice: Four
Clinical Setting: Crisis intervention unit in a regional hospital
Geographic Location: Oregon

Joan is looking after Sarah who is a thirty-five-year-old client diagnosed with bipolar disorder. She was in a manic phase upon admission, extremely talkative and agitated. Her medical chart indicated a history of medication noncompliance, which often exacerbated her symptoms. The challenge was to keep her safe while her medication was adjusted. She was so full of energy and grandiose plans that she wanted to leave the hospital immediately to "change the world." By using a calm, clear, and firm approach, health-care providers managed to convince her to stay for observation. During the manic phase, clients like Sarah often feel invincible, which can lead to risky behaviors. It is crucial for health-care providers to ensure a safe environment and encourage medication compliance to stabilize their mood (SAMHSA, 2023a).

A week later, Sarah began displaying depressive behaviors. She became withdrawn and started expressing feelings of worthlessness. She also began to discuss suicidal thoughts. The nurse's role transitioned from setting firm boundaries to providing emotional support and vigilant monitoring for suicidal ideation (Twivy et al., 2023).

With medication adjustments and a multidisciplinary approach involving psychiatrists, social workers, and mental health nurses, Sarah began to stabilize. With proper care she was able to transition from extreme behaviors to a more balanced state. This transition emphasizes the importance of holistic care and teamwork in managing complex conditions like bipolar disorder (Skjærpe et al., 2022).

Summary

16.1 Depressive Disorders

The etiology of mood disorders involves genetic, biological, environmental, and psychological factors. These disorders are often now looked at as a spectrum of symptoms rather than as discrete categories of symptoms. Diagnosis is based on detailed clinical evaluation and symptomatology, guided by criteria from diagnostic manuals, such as the *DSM-5*. Managing mood disorders typically involves a combination of pharmacological and psychotherapeutic interventions. Antidepressants and mood stabilizers are considered the gold standards of medication treatment, while cognitive behavioral, interpersonal, dialectical, and family-focused therapies are common forms of psychotherapy. Early detection and appropriate management are critical to improving outcomes and enhancing the quality of life for individuals with mood disorders (Sekhon & Gupta, 2020).

16.2 The Spectrum of Mood Disorders

Depressive disorders, a category of mood disorders, are characterized by persistent feelings of sadness, loss of interest or pleasure in activities, and various physical and cognitive symptoms that cause significant distress or impairment in daily life. Major depressive disorder, the most severe form, and dysthymia, a chronic but milder form, are the primary types. These disorders result from a complex interplay of genetic, biological, environmental, and psychosocial factors. Accurate diagnosis is crucial and involves a thorough clinical evaluation, often using diagnostic criteria from the *DSM-5*.

Management typically involves a combination of pharmacological and psychotherapeutic interventions. Nurses play a pivotal role in managing care for individuals with depressive disorders. They protect the safety of the client, monitor clients' responses to treatment, manage medication side effects, provide client and family education, and offer emotional support.

16.3 Self-Harm and Suicide

Understanding and effectively managing suicide and NSSI is critical for nursing professionals. Early identification of signs is pivotal, and this is where clinical judgment comes into play. Recognize that suicide and NSSI are distinct phenomena, requiring different intervention approaches. For suicide, risk assessment tools like the SAD PERSONS scale can be valuable, but should be supplemented with clinical insights. Clients at high risk for suicide may require continuous monitoring and potentially immediate intervention. In the case of NSSI, the role of the family, ethical dilemmas, resource allocation, and cultural considerations all require nuanced clinical judgment. Health-care providers must synthesize clinical data and contextual factors to make informed decisions regarding risk assessment, intervention strategies, and long-term care plans for both conditions. By integrating evidence-based practice with individual client needs, nurses can contribute significantly to improving client outcomes (National Action Alliance for Suicide Prevention, 2018).

16.4 Bipolar Disorders

Bipolar disorders are chronic mental health conditions characterized by severe mood swings that include episodes of depression and mania. Bipolar disorders are categorized into bipolar I, bipolar II, and cyclothymic disorder, each varying in the intensity and frequency of these mood episodes. Symptoms of these disorders fluctuate based on the phase of the disorder: manic episodes may involve high energy, euphoria, and hyperactivity, while depressive episodes may result in feelings of sadness, hopelessness, and lethargy.

The treatment approach for bipolar disorder typically comprises a combination of medication and psychotherapy. Common medications include mood stabilizers, such as lithium, antidepressants, and atypical antipsychotics. In addition, CBT, family-focused therapy, interpersonal and social rhythm therapy, and psychoeducation have proven effective in managing the disorder and preventing relapses.

Key Terms

bipolar disorder recurrent illness that involves changes in mood and energy that may be severe and involves both depression and mania, or hypomania

depression feelings of sadness and/or loss of interest in once enjoyable activities

depressive disorders mental health conditions characterized by persistent feelings of sadness, loss of interest in

activities, and difficulties in carrying out daily activities

elation exhilarating state of pride and optimism without feelings of depression

hypomania energized activity level of behavior

lethality assessment structured evaluation of the risk factors associated with a person's potential for engaging in a life-threatening behavior, such as suicide

mania when a person's mood is abnormally elevated and accompanied by high energy or activity

manic elation symptom of a manic episode, as seen in bipolar I disorder, that is more severe and disruptive than hypomanic elation

mood disorder disturbances in a person's emotional state that are intense, long-lasting, and not necessarily tied to any specific event or situation

nonsuicidal self-injury (NSSI) (also, **self-harm**) behavior involving deliberate self-inflicted harm that is not intended to result in suicide

persistent depressive disorder (formerly called *dysthymia*) type of depression less severe than major depression but chronic, lasting for at least two years

self-harm (also, **nonsuicidal self-injury**) behavior that involves deliberately causing harm to one's own body as a way to cope with emotional distress or regain a sense of control

spectrum model of mood disorders acknowledges the variability in symptom presentations and offers a framework for individualized care

suicidal ideation thoughts, fantasies, or preoccupations with committing suicide

Assessments

Review Questions

1. What condition is considered a mood disorder? Select all that apply.

a. major depressive disorder
b. bipolar disorder
c. schizophrenia
d. dysthymia

2. What is the primary characteristic of persistent depressive disorder?

a. extreme mania
b. extreme depression
c. milder form of depression
d. absence of mood

3. What type of medication is commonly prescribed for bipolar disorder?

a. SSRIs
b. mood stabilizers
c. antipsychotics
d. benzodiazepines

4. What is a psychosocial treatment used for major depressive disorder?

a. antipsychotic medication
b. electroconvulsive therapy
c. cognitive behavioral therapy
d. narcotics

5. What factor is typically associated with the onset of depression? Select all that apply.

a. genetics
b. environmental stressors
c. high levels of physical activity
d. neurochemical imbalances

6. What neurotransmitter is most commonly associated with depression?
   a. dopamine
   b. serotonin
   c. norepinephrine
   d. GABA

7. What does anhedonia refer to?
   a. excessive sleeping
   b. loss of interest or pleasure in activities
   c. overeating
   d. agitation

8. What is a clinical symptom of depression? Select all that apply.

   a. persistent sadness
   b. impaired concentration
   c. elevated self-esteem
   d. feelings of worthlessness

9. What therapy focuses on identifying and changing negative thought patterns and behaviors?
   a. psychodynamic therapy
   b. cognitive behavioral therapy
   c. interpersonal therapy
   d. family therapy

10. How is self-harm often used as a coping mechanism?
   a. to get back at someone
   b. to cope with overwhelming emotions
   c. to manipulate others
   d. to enhance physical well-being

11. What is the first priority in nursing care for a client contemplating suicide?
   a. medication administration
   b. establishing a therapeutic alliance
   c. physical restraints
   d. safety measures

12. What is an approach for caring for clients who self-injure? Select all that apply.
   a. emotional validation
   b. physical restraints
   c. harm-reduction techniques
   d. cognitive behavioral therapy

13. What is a common warning sign of suicide? Select all that apply.

   a. withdrawal from social activities
   b. increased energy and enthusiasm
   c. verbalizing thoughts of death
   d. giving away personal belongings

14. What is nonsuicidal self-injury?
   a. the act of deliberately harming the surface of one's body, such as cutting or burning, with the intent of committing suicide
   b. the act of deliberately harming one's body, such as cutting or burning, to express emotional distress or

cope with emotional pain and without suicidal intent
c. an act of revenge toward someone else
d. an unconscious action where the person is not aware they are causing harm to themselves

15. What is the primary difference between NSSI and suicidal behavior?
a. Both NSSI and suicidal behavior are carried out with the intention of ending one's life.
b. NSSI involves harming others, while suicidal behavior involves self-harm.
c. While both NSSI and suicidal behavior involve self-inflicted harm, the key difference lies in intent.
d. There is no significant difference between NSSI and suicidal behavior; they are the same thing.

16. What therapeutic interventions may be beneficial for clients who engage in NSSI?
a. aromatherapy and acupuncture only
b. cognitive behavioral therapy, mindfulness-based interventions, group therapy, family therapy, and certain medications as directed by a psychiatrist
c. sedation until the client's behavior improves
d. physical restraint as the primary treatment method

17. What is bipolar disorder?
a. a disorder characterized by persistent depressive episodes only
b. a disorder characterized by both depressive and manic episodes
c. a disorder characterized by persistent manic episodes only
d. a disorder characterized by fluctuating levels of anxiety

18. During a manic episode, what behavior is a client likely to exhibit?
a. excessive sleeping
b. elevated self-esteem
c. social withdrawal
d. anhedonia

19. What symptom is characteristic of a depressive episode in bipolar disorder?
a. racing thoughts
b. impaired concentration
c. grandiosity
d. increased energy

20. What medication class is commonly prescribed for managing manic episodes in bipolar disorder?
a. SSRIs
b. SNRIs
c. benzodiazepines
d. mood stabilizers

21. How should a nurse manage the potential side effects of lithium?
a. Adjust the medication dosage without consulting the health-care provider.
b. Educate clients about these potential side effects, monitor their occurrence, and work with the health-care team to manage them.
c. Discontinue the medication immediately.
d. Ignore these symptoms as they are not related to the medication.

22. How can a nurse support the mental well-being of a client and reduce the stigma associated with bipolar disorder?
a. by ignoring the emotional concerns of the client and focusing solely on medication management; discouraging any discussions about the disorder to avoid drawing attention
b. by suggesting that clients should keep their diagnosis a secret to avoid societal judgment, focusing

solely on physical symptoms rather than emotional well-being

c. by providing emotional support, listening empathetically to clients' concerns, and encouraging self-care activities and therapies; educating clients, families, and the public about the disorder to reduce stigma and advocating for client rights and dignity
d. by providing only pharmacological interventions without addressing emotional and psychosocial needs; disregarding the importance of client advocacy and education

Check Your Understanding Questions

1. What are the key characteristics of a depressive disorder?
2. What is the role of psychosocial approaches in managing mood disorders?
3. How might the presentation of mood disorders vary across different age groups? Provide examples to support your answer.
4. List two possible environmental factors that could contribute to depression.
5. What is the role of pharmacotherapy in the treatment of depression?
6. How can self-harm serve as an emotional outlet for some individuals?
7. What elements should be considered when planning care for a suicidal client?
8. What distinguishes nonsuicidal self-injury from suicidal behaviors?
9. What are some immediate steps you should take if a client expresses suicidal ideation?
10. What are some common forms of NSSI?
11. How does bipolar I differ from bipolar II?
12. Describe one characteristic symptom of a manic episode.
13. What role do antipsychotic medications play in treating bipolar disorder?

Reflection Questions

1. Consider how understanding the spectrum of mood disorders and their treatment options could be valuable in your nursing practice.
2. How would you summarize issues relating to depression to a person who is not a nurse?
3. What role does genetics play in the etiology of depression?
4. How might the symptoms of depression manifest differently in older adults compared with younger individuals?
5. Reflect on the complexities of nursing care for clients who self-harm or contemplate suicide and consider how you can provide compassionate and effective care.
6. How would you approach a conversation with a client who expresses suicidal ideation?
7. What role can nurses play in addressing NSSI?
8. How would you manage and prioritize interventions when caring for a client experiencing a manic episode in a psychiatric setting?
9. How does bipolar disorder differ from depressive disorders in terms of symptoms, mood fluctuations, and treatment options?

Critical-Thinking Questions about Case Studies

1. Refer to Depression: Part 3.
   Depression is often associated with loss in a person's life circumstances. What are the losses that this nurse

can identify that this client has experienced?

2. Refer to Depression: Part 3.
   What are the indications that the nurse needs to prioritize safety as the main issue in care planning for this client?

3. Refer to Depression: Part 3.
   The client reports that he plans to suffocate himself with his bedsheets. If setting the ideal environment for the client, how would the nurse go about ensuring that this does not happen?

Competency-Based Assessments

1. Describe some scenarios in which a combination of pharmacological and psychosocial interventions might be effective. Provide rationale for your answer.
2. As a clinical nurse, how would you compare the role of psychotherapy in the treatment of depression with pharmacotherapy?
3. You're working in the emergency department, and a client with a history of mental illness presents with superficial cuts on their wrists. How would you approach the assessment and initial care for this client?
4. You're a nurse in the psychiatric unit. A client expresses contemplation of suicide during your assessment. Outline your plan of nursing care for this client.
5. Create a multimodal treatment approach for an individual with bipolar disorder.

References

988 Suicide & Crisis Lifeline. (2022). 988lifeline.org. https://988lifeline.org/

Adamiak, S., & Dohnalik, J. (2023, August 29). The prohibition of suicide and its theological rationale in Catholic moral and canonical tradition: Origins and development. *Journal of Religion & Health, 62*, 3820–3833. https://doi.org/10.1007/s10943-023-01900-w

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychiatric Nurses Association. (2021, July). *APNA position: Electroconvulsive therapy*. https://www.apna.org/news/electroconvulsive-therapy.

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2019). APA offers new guidance for treating depression. *Monitor on Psychology, 50*(8). https://www.apa.org/monitor/2019/09/ce-corner-depression

American Psychological Association. (2020, March 4). *Working out boosts brain health*. https://www.apa.org/topics/exercise-fitness/stresshttps://www.apa.org/topics/exercise-fitness/stress

ANA Center for Ethics and Human Rights. (2019). ANA position statement: The nurse's role when a patient requests medical aid in dying. *OJIN: The Online Journal of Issues in Nursing, 24*(3). https://doi.org/10.3912/ojin.vol24no03poscol02

Andreotti, E. T., Ipuchima, J. R., Cazella, S. C., Beria, P., Bortoncello, C. F., Silveira, R. C., & Ferrão, Y. A. (2020). Instruments to assess suicide risk: A systematic review. *Trends in Psychiatry and Psychotherapy, 42*(3), 276–281. https://doi.org/10.1590/2237-6089-2019-009

Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research, 88*, 113–120. https://doi.org/10.1016/j.jpsychires.2017.01.017

Ariapooran, S., Heidari, S., Asgari, M., Ashtarian, H., & Khezeli, M. (2018). Individualism-collectivism, social support,

resilience and suicidal ideation among women with the experience of the death of a young person. *International Journal of Community Based Nursing and Midwifery, 6*(3), 250–259.

Baldessarini, R. J., Lau, W. K., Sim, J., Sum, M. Y., & Sim, K. (2017). Suicidal risks in reports of long-term controlled trials of antidepressants for major depressive disorder II. *The International Journal of Neuropsychopharmacology, 20*(3), 281–284. https://doi.org/10.1093/ijnp/pyw092

Banerjee, D., Varshney, P., & Vajawat, B. (2020). "Guarding the gatekeepers": Suicides among mental health professionals and scope of prevention, a review. *Psychiatry Research, 294*, 113501. https://doi.org/10.1016/j.psychres.2020.113501

Beebe, C. (2018). Ligature-risk requirements: Separating fact from fiction in suicide prevention. https://www.aha.org/system/files/2019-01/2018-dec-hfm-ligature-risk.pdf

Bjureberg, J., Dahlin, M., Carlborg, A., Edberg, H., Haglund, A., & Runeson, B. (2022). Columbia-suicide severity rating scale screen version: Initial screening for suicide risk in a psychiatric emergency department. *Psychological Medicine, 52*(16), 3904–3912. https://doi.org/10.1017/S0033291721000751

Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies, 52*(9), 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.05.001

Cabrera, L. Y., Gilbert, M. M. C., McCright, A. M., Achtyes, E. D., & Bluhm, R. (2021). Beyond the cuckoo's nest: Patient and public attitudes about psychiatric electroceutical interventions. *The Psychiatric Quarterly, 92*(4), 1425–1438. https://doi.org/10.1007/s11126-021-09916-9

Carpenter, J. E., Lee, T., Greene, E., & Holovac, E. (2021). A stepwise approach for preventing suicide by lethal poisoning. *Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS, 38*(2), 62–67. https://doi.org/10.12788/fp.0087

Centers for Disease Control and Prevention. (2020). *Suicide rising across the US*. https://www.cdc.gov/vitalsigns/suicide/index.html

Centers for Disease Control and Prevention. (2021). *Prevention strategies*. https://www.cdc.gov/suicide/prevention/index.html

Centers for Disease Control and Prevention. (2023, November 29). *Suicide data and statistics.* https://www.cdc.gov/suicide/suicide-data-statistics.html

Chammas, F., Januel, D., & Bouaziz, N. (2022). Inpatient suicide in psychiatric settings: Evaluation of current prevention measures. *Frontiers in Psychiatry, 13*, 997974. https://doi.org/10.3389/fpsyt.2022.997974

Chatterton, M., Stockings, E., Berk, M., Barendregt, J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *The British Journal of Psychiatry, 210*(5), 333–341. https://www.doi.org/10.1192/bjp.bp.116.195321

Chesin, M. S., Galfavy, H., Sonmez, C. C., Wong, A., Oquendo, M. A., Mann, J. J., & Stanley, B. (2017). Nonsuicidal self-injury is predictive of suicide attempts among individuals with mood disorders. *Suicide & Life-Threatening Behavior, 47*(5), 567–579. https://doi.org/10.1111/sltb.12331

Chokhawala, K., Lee, S., & Saadabadi, A. (2024). *Lithium*. StatPearls (Internet), National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK519062.

Chu, A., & Wadhwa, R. (2021). *Selective serotonin reuptake inhibitors*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK554406/

Cipriani, A., Furukawa, T. A., Salanti, G., Chaimani, A., Atkinson, L. Z., Ogawa, Y., Leucht, S., Ruhe, H. G., Turner, E. H., Higgins, J. P. T., Egger, M., Takeshima, N., Hayasaka, Y., Imai, H., Shinohara, K., Tajika, A., Ioannidis, J. P. A., & Geddes, J. R. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: A systematic review and network meta-analysis. *Lancet, 391*(10128), 1357–1366. https://doi.org/10.1016/S0140-6736(17)32802-7

Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology, 8*. https://doi.org/10.3389/fpsyg.2017.01946

Clarke, S., Allerhand, L. A., & Berk, M. S. (2019). Recent advances in understanding and managing self-harm in adolescents. *F1000Research, 8*, F1000 Faculty Rev-1794. https://doi.org/10.12688/f1000research.19868.1

Clay, R. (2018). The cultural distinctions in whether, when and how people engage in suicidal behavior. *Monitor on Psychology, 49*(6), 28. American Psychological Association.

Cleare, A., Pariante, C. M., Young, A. H., Anderson, I. M., Christmas, D., Cowen, P. J., Dickens, C., Ferrier, I. N., Geddes, J., Gilbody, S., Haddad, P. M., Katona, C., Lewis, G., Malizia, A., McAllister-Williams, R. H., Ramchandani, P., Scott, J., Taylor, D., Uher, R., & Members of the Consensus Meeting. (2015). Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2008 British Association for Psychopharmacology guidelines. *Journal of Psychopharmacology*, *29*(5), 459–525. https://doi.org/10.1177/0269881115581093

Cleveland Clinic. (2018, July 16). *Mood disorders*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/17843-mood-disorders

Cleveland Clinic. (2022, April 19). *Dialectical behavior therapy (DBT)*. Cleveland Clinic. https://my.clevelandclinic.org/health/treatments/22838-dialectical-behavior-therapy-dbt

Connors, E. (2021, June 20). *Indigenous people, trauma, and suicide prevention*. Centre for Suicide Prevention. https://www.suicideinfo.ca/local_resource/trauma-and-suicide-in-indigenous-people/

Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. *Journal of Affective Disorders, 159*, 118–126. https://doi.org/10.1016/j.jad.2014.02.026

de Abreu Costa, M., & Moreira-Almeida, A. (2022). Religion-adapted cognitive behavioral therapy: A review and description of techniques. *Journal of Religion and Health, 61*(1), 443–466. https://doi.org/10.1007/s10943-021-01345-z

Devita, M., De Salvo, R., Ravelli, A., De Rui, M., Coin, A., Sergi, G., & Mapelli, D. (2022). Recognizing depression in the elderly: Practical guidance and challenges for clinical management. *Neuropsychiatric Disease and Treatment, 18*, 2867–2880. https://doi.org/10.2147/NDT.S347356

Ee, C., Lake, J., Firth, J., Hargraves, F., de Manincor, M., Meade, T., Marx, W., & Sarris, J. (2020). An integrative collaborative care model for people with mental illness and physical comorbidities. *International Journal of Mental Health Systems, 14*(1). https://doi.org/10.1186/s13033-020-00410-6

Elena-Rodica, P., Bianca Augusta, O., Vasile, C., & Roxana, C. (2023). Assessment of self-injurious behavior in major depressive disorder: A case report. *Archives of Psychiatry and Mental Health, 7*(1), 004–009. https://doi.org/10.29328/journal.apmh.1001046

Emanuel, E. J., Onwuteaka-Philipsen, B. D., Urwin, J. W., & Cohen, J. (2016). Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA, 316*(1), 79–90. https://doi.org/10.1001/jama.2016.8499

Falcone, T., & Timmons-Mitchell, J. (2018). *Suicide prevention: A practical guide for the practitioner*. Springer.

Fanelli, D., Weller, G., & Liu, H. (2021). New serotonin-norepinephrine reuptake inhibitors and their anesthetic and analgesic considerations. *Neurology International, 13*(4), 497–509. https://doi.org/10.3390/neurolint13040049

Gearing, R., & Alonzo, D. (2018). Religion and suicide: New findings. *J Relig Health, 57*, 2478–2499. https://doi.org/10.1007/s10943-018-0629-8

Gómez-Pinilla F. (2008). Brain foods: The effects of nutrients on brain function. Nature reviews. *Neuroscience, 9*(7), 568–578. https://doi.org/10.1038/nrn2421https://doi.org/10.1038/nrn2421

Grandclerc, S., De Labrouhe, D., Spodenkiewicz, M., Lachal, J., & Moro, M. R. (2016). Relations between nonsuicidal self-injury and suicidal behavior in adolescence: A systematic review. *PloS One, 11*(4), e0153760.

https://doi.org/10.1371/journal.pone.0153760

Guarnotta, E. (2023). *Functional family therapy: What it is, cost, & what to expect*. https://www.choosingtherapy.com/functional-family-therapy/

Halaris, A., & Cook, J. (2023). The glutamatergic system in treatment-resistant depression and comparative effectiveness of ketamine and esketamine: Role of inflammation? *Advances in Experimental Medicine and Biology, 1411*, 487–512. https://doi.org/10.1007/978-981-19-7376-5_21

Harmer, B., Lee, S., Duong, T. V. H., & Saadabadi, A. (2023). *Suicidal ideation*. In StatPearls. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK565877/

Harris, I., Beese, S., & Moore, D. (2019). Predicting future self-harm or suicide in adolescents: A systematic review of risk assessment scales/tools. *BMJ Open 9*: e029311. https://doi.org/10.1136/bmjopen-2019-02931

Hawton, K., Bergen, H., Simkin, S., Cooper, J., Waters, K., Gunnell, D., Kapur, N. (2010). Toxicity of antidepressants: Rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry, 196*(5), 354–358. https://doi.org/10.1192/bjp.bp.109.070219

Hedya, S. A., Avula, A., & Swoboda, H. D. (2022). *Lithium toxicity*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK499992/

Hernández-Gómez, A., Andrade-González, N., Lahera, G., & Vieta, E. (2021). Recommendations for the care of patients with bipolar disorder during the COVID-19 pandemic. *Journal of Affective Disorders, 279*, 117–121. https://doi.org/10.1016/j.jad.2020.09.105

Hollon, S., DeRubeis, R., Fawcett, J., Amsterdam, J., Shelton, R., Zajecka, J., Young, P., & Gallop, R. (2014). Effect of cognitive therapy with antidepressant medications vs antidepressants alone on the rate of recovery in major depressive disorder: A randomized clinical trial. *JAMA Psychiatry, 71*(10), 1157–1164. https://doi.org/10.1001/jamapsychiatry.2014.1054 (Retraction published *JAMA Psychiatry*. 2016 Jun 1;*73*(6), 639–40)

Howland, M., & El Sehamy, A. (2021, January). *What are bipolar disorders?* Psychiatry.org; American Psychiatric Association. https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders

Informed Health. (2020, June 18). *Depression: How effective are antidepressants?* National Library of Medicine; Institute for Quality and Efficiency in Health Care (IQWiG). https://www.ncbi.nlm.nih.gov/books/NBK361016/

Ip, K. I., Miller, A. L., Karasawa, M., Hirabayashi, H., Kazama, M., Wang, L., Olson, S. L., Kessler, D., & Tardif, T. (2021). Emotion expression and regulation in three cultures: Chinese, Japanese, and American preschoolers' reactions to disappointment. *Journal of Experimental Child Psychology, 201*, 104972. https://doi.org/10.1016/j.jecp.2020.104972

Jain, A., & Mitra, P. (2023, February 20). *Bipolar disorder*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK558998/

John Hopkins Medicine. (2019). Dysthymia. Johns Hopkins Medicine. https://www.hopkinsmedicine.org/health/conditions-and-diseases/dysthymia

Karl, J. P., Hatch, A. M., Arcidiacono, S. M., Pearce, S. C., Pantoja-Feliciano, I. G., Doherty, L. A., & Soares, J. W. (2018). Effects of psychological, environmental and physical stressors on the gut microbiota. *Frontiers in Microbiology, 9*, 2013. https://doi.org/10.3389/fmicb.2018.02013

Katz, C., Randall, J. R., Sareen, J., Chateau, D., Walld, R., Leslie, W. D., Wang, J., & Bolton, J. M. (2017). Predicting suicide with the SAD PERSONS scale. *Depression and Anxiety, 34*(9), 809–816. https://doi.org/10.1002/da.22632

King, C. A., Horwitz, A., Czyz, E., & Lindsay, R. (2017). Suicide risk screening in healthcare settings: Identifying males and females at risk. *Journal of Clinical Psychology in Medical Settings, 24*(1), 8–20. https://doi.org/10.1007/s10880-017-9486-y

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: What we know, and what we need to know. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 59*(11), 565–568. https://doi.org/10.1177/

070674371405901101

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum, 30*(2), 111–116. https://doi.org/10.1177/0840470416679413

Lim N. (2016). Cultural differences in emotion: Differences in emotional arousal level between the East and the West. *Integrative Medicine Research, 5*(2), 105–109. https://doi.org/10.1016/j.imr.2016.03.004

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid systematic review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child and Adolescent Psychiatry, 59*(11), 1218–1239.e3. https://doi.org/10.1016/j.jaac.2020.05.009

Mason, B. L., Brown, E. S., & Croarkin, P. E. (2016). Historical underpinnings of bipolar disorder diagnostic criteria. *Behavioral Sciences, 6*(3), 14. https://doi.org/10.3390/bs6030014

Mayo Clinic. (2018, October 12). *Electroconvulsive therapy (ECT)*. https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894

Mayo Clinic. (2021, December 14). *Seasonal affective disorder (SAD)*. https://www.mayoclinic.org/diseases-conditions/seasonal-affective-disorder/symptoms-causes/syc-20364651

Mayo Clinic. (2022, December 13). *Bipolar disorder*. https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/diagnosis-treatment/drc-20355961

Mayo Clinic. (2023, April 6). *Self-injury/cutting*. https://www.mayoclinic.org/diseases-conditions/self-injury/symptoms-causes/syc-20350950

McIntyre, R. S., Alda, M., Baldessarini, R. J., Bauer, M., Berk, M., Correll, C. U., Fagiolini, A., Fountoulakis, K., Frye, M. A., Grunze, H., Kessing, L. V., Miklowitz, D. J., Parker, G., Post, R. M., Swann, A. C., Suppes, T., Vieta, E., Young, A., & Maj, M. (2022). The clinical characterization of the adult patient with bipolar disorder aimed at personalization of management. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 21*(3), 364–387. https://doi.org/10.1002/wps.20997

McIntyre, R., Young, A., & Haddad, P. (2018). Rethinking the spectrum of mood disorders: Implications for diagnosis and management - Proceedings of a symposium presented at the 30th Annual European College of Neuropsychopharmacology Congress, 4 September 2017, Paris, France. *Therapeutic Advances in Psychopharmacology, 8*(1 Suppl), 1–16. https://doi.org/10.1177/2045125318762911

MDCalc. (2024). *DSM-5 criteria for major depressive disorder*. https://www.mdcalc.com/calc/10195/dsm-5-criteria-major-depressive-disorder

Mental Health First Aid. (2019, July 11). *Four ways culture impacts mental health*. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health

Miklowitz, D., & Chung, B. (2016). Family-focused therapy for bipolar disorder: Reflections on 30 years of research. *Family Process, 55*(3), 483–499. https://doi.org/10.1111/famp.12237

Minnesota Department of Health. (2019). *Suicidal ideation risk assessment steps and resources for exploring thoughts of suicide*. https://www.health.state.mn.us/people/syringe/suicide.pdf

Minot, D. (2023, April 18). *How faith communities can help reduce mental health stigma*. Behavioral Health News. https://behavioralhealthnews.org/how-faith-communities-can-help-reduce-mental-health-stigma/

Moraczewski, J., & Aedma, K. K. (2020). *Tricyclic antidepressants*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK557791/

Moscardini, E. H., Hill, R. M., Dodd, C. G., Do, C., Kaplow, J. B., & Tucker, R. P. (2020). Suicide safety planning: Clinician training, comfort, and safety plan utilization. *International Journal of Environmental Research and Public Health, 17*(18), 6444. https://doi.org/10.3390/ijerph17186444

National Action Alliance for Suicide Prevention. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe*. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care*. https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf

National Alliance on Mental Illness. (2020a). *Mental health by the numbers*. https://www.nami.org/mhstats

National Alliance on Mental Illness. (2020b). *Self-harm*. https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Self-harm

National Alliance on Mental Illness. (n.d.) *Suicide prevention.* https://nami.org/Your-Journey/Frontline-Professionals/Suicide-Prevention

National Council of State Boards of Nursing. (2019). *Clinical Judgment Measurement Model [Review of Clinical Judgment Measurement Model]*. Next Generation NCLEX News; NCSBN. https://www.ncsbn.org/public-files/NGN_Winter19.pdf

National Institute of Mental Health. (2016, June). *Brain stimulation therapies*. https://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies

National Institute of Mental Health. (2020a). *Major depression*. https://www.nimh.nih.gov/health/statistics/major-depression.shtml

National Institute of Mental Health. (2020b). *Suicide*. https://www.nimh.nih.gov/health/statistics/suicide.shtml

National Institute of Mental Health. (2021). *Perinatal depression*. https://www.nimh.nih.gov/health/publications/perinatal-depression

National Institute of Mental Health. (2023, February). *Bipolar disorder*. https://www.nimh.nih.gov/health/topics/bipolar-disorder

Novick, D. M., & Swartz, H. A. (2019). Evidence-based psychotherapies for bipolar disorder. *Focus (American Psychiatric Publishing), 17*(3), 238–248. https://doi.org/10.1176/appi.focus.20190004

Ong, H. S., Fernandez, P. A., & Lim, H. K. (2021). Family engagement as part of managing patients with mental illness in primary care. *Singapore Medical Journal, 62*(5), 213–219. https://doi.org/10.11622/smedj.2021057

Özdel, K., Kart, A., & Türkçapar, M. H. (2021). Cognitive behavioral therapy in treatment of bipolar disorder. *Noro Psikiyatri Arsivi, 58*(Suppl 1), S66–S76. https://doi.org/10.29399/npa.27419

Paris, J. (2014). The mistreatment of major depressive disorder. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 59*(3), 148–151. https://doi.org/10.1177/070674371405900306

Pinals, D. A. (2019). Liability and patient suicide. *Focus (American Psychiatric Publishing), 17*(4), 349–354. https://doi.org/10.1176/appi.focus.20190023

Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: A systematic review of the literature. *Borderline Personality Disorder and Emotion Dysregulation, 2*, 2. https://doi.org/10.1186/s40479-014-0024-3

Popova, V., Daly, E. J., Trivedi, M., Cooper, K., Lane, R., Lim, P., Mazzucco, C., Hough, D., Thase, M. E., Shelton, R. C., Molero, P., Vieta, E., Bajbouj, M., Manji, H., Drevets, W. C., & Singh, J. B. (2019). Efficacy and safety of flexibly dosed esketamine nasal spray combined with a newly initiated oral antidepressant in treatment-resistant depression: A randomized double-blind active-controlled study. *The American Journal of Psychiatry, 176*(6), 428–438. https://doi.org/10.1176/appi.ajp.2019.19020172

Pradhan, B., Parikh, T., Makani, R., & Sahoo, M. (2015). Ketamine, transcranial magnetic stimulation, and depression specific yoga and mindfulness based cognitive therapy in management of treatment resistant depression: Review and some data on efficacy. *Depression Research and Treatment*, 2015, 842817. https://doi.org/10.1155/2015/

842817

QSEN Institute. (2020). Pre-Licensure KSAs. https://qsen.org/competencies/pre-licensure-ksas/

Quinlivan, L., Cooper, J., Davies, L., Hawton, K., Gunnell, D., & Kapur, N. (2016). Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating risk scales using measures of diagnostic accuracy. *BMJ Open, 6*(2), e009297. https://doi.org/10.1136/bmjopen-2015-009297

Rajhans, P., Hans, G., Kumar, V., & Chadda, R. K. (2020). Interpersonal psychotherapy for patients with mental disorders. *Indian Journal of Psychiatry, 62*(Suppl 2), S201–S212. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_771_19

Remes, O., Mendes, J. F., & Templeton, P. (2021). *Biological, psychological, and social determinants of depression: A review of recent literature.* Brain Sciences. https://doi.org/10.3390%2Fbrainsci11121633

Robinson, C., Dalal, S., Chitneni, A., Patil, A., Berger, A. A., Mahmood, S., Orhurhu, V., Kaye, A. D., & Hasoon, J. (2022). A look at commonly utilized serotonin noradrenaline reuptake inhibitors (SNRIs) in chronic pain. *Health Psychology Research, 10*(3), 32309. https://doi.org/10.52965/001c.32309

Rönnqvist, I., Nilsson, F. K., & Nordenskjöld, A. (2021). Electroconvulsive therapy and the risk of suicide in hospitalized patients with major depressive disorder. *JAMA Network Open, 4*(7), e2116589. https://doi.org/10.1001/jamanetworkopen.2021.16589

Rost, N., Binder, E. B., & Brückl, T. M. (2023). Predicting treatment outcome in depression: An introduction into current concepts and challenges. *European Archives of Psychiatry and Clinical Neuroscience, 273*(1), 113–127. https://doi.org/10.1007/s00406-022-01418-4

Rush, A. J. (2024, March 21). Unipolor major depression in adults: Choosing initial treatment. https://www.uptodate.com/contents/unipolar-major-depression-in-adults-choosing-initial-treatment

Rush, A. J., South, C., Jain, S., Agha, R., Zhang, M., Shrestha, S., Khan, Z., Hassan, M., & Trivedi, M. H. (2021). Clinically significant changes in the 17- and 6-item Hamilton Rating Scales for Depression: A STAR*D Report. *Neuropsychiatric Disease and Treatment, 17*, 2333–2345. https://doi.org/10.2147/NDT.S305331

Rybakowski, J. K. (2023). Application of antipsychotic drugs in mood disorders. *Brain Sciences, 13*(3), 414. https://doi.org/10.3390/brainsci13030414

Saghir, Z., Syeda, J. N., Muhammad, A. S., & Balla Abdalla, T. H. (2018). The amygdala, sleep debt, sleep deprivation, and the emotion of anger: A possible connection? *Cureus, 10*(7), e2912. https://doi.org/10.7759/cureus.2912

Salchi, H. (2022, November 10). *Expressing depression differs across cultures*. Baylor College of Medicine. https://blogs.bcm.edu/2022/11/10/expressing-depression-differs-across-cultures/

Salik, I., & Marwaha, R. (2020). *Electroconvulsive therapy*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK538266/

Sanacora, G., Frye, M. A., McDonald, W., Mathew, S. J., Turner, M. S., Schatzberg, A. F., Summergrad, P., Nemeroff, C. B., & American Psychiatric Association (APA) Council of Research Task Force on Novel Biomarkers and Treatments. (2017). A consensus statement on the use of ketamine in the treatment of mood disorders. *JAMA Psychiatry, 74*(4), 399–405. https://doi.org/10.1001/jamapsychiatry.2017.0080

Scotton, W. J., Hill, L. J., Williams, A. C., & Barnes, N. M. (2019). Serotonin syndrome: Pathophysiology, clinical features, management, and potential future directions. *International Journal of Tryptophan Research, 12*, 1178646919873925. https://doi.org/10.1177/1178646919873925

Sekhon, S., & Gupta, V. (2020). *Mood disorder*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK558911/

Self-harm: Assessment, management and preventing recurrence. (2022). National Institute for Health and Care Excellence (NICE). NICE Guideline, No. 225. https://www.ncbi.nlm.nih.gov/books/NBK588208/

Sheffler, Z. M., & Abdijadid, S. (2020). *Antidepressants*. PubMed; StatPearls Publishing.

https://www.ncbi.nlm.nih.gov/books/NBK538182/

Shekelle, P. G., Greeley, A. M., Tanner, E. P., Mak, S. S., Begashaw, M. M., Miake-Lye, I. M., & Beroes-Severin, J. M. (2019). One-to-one observation: A systematic review. In www.ncbi.nlm.nih.gov. Department of Veterans Affairs (US). https://www.ncbi.nlm.nih.gov/books/NBK553686/

Sidwell, A., Mayor, S., Wheeler, R., & Mitchell, A. (2023). Suicide risk mitigation. *BMJ Best Practice*. https://bestpractice.bmj.com/topics/en-gb/3000095

Skjærpe, J. N., Joa, I., Willumsen, E., Hegelstad, W. T. V., Iakovleva, T. A., & Storm, M. (2022). Perspectives on coordinating health services for individuals with serious mental illness - A qualitative study. *Journal of Multidisciplinary Healthcare, 15*, 2735–2750. https://doi.org/10.2147/JMDH.S384072

Slade, S., & Sergent, S. R. (2020). *Interview techniques*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK526083/

Smith, S. (2018, January). *Creating S.M.A.R.T. goals*. University of Rochester Medical Center. https://www.urmc.rochester.edu/behavioral-health-partners/bhp-blog/january-2018/creating-s-m-a-r-t-goals.aspx.

Steele, I. H., Thrower, N., Noroian, P., & Saleh, F. M. (2018). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment & management. *Journal of Forensic Sciences, 63*(1), 162–171. https://doi.org/10.1111/1556-4029.13519

Stone, D., Simon, T., Fowler, K., Kegler, S., Yuan, K., Holland, K., Ivey-Stephenson, A., & Crosby, A. (2018). Vital signs: Trends in state suicide rates — United States, 1999–2016 and circumstances contributing to suicide — 27 states. *Morbidity and Mortality Weekly Report, 67*, 617–624. https://doi.org/10.15585/mmwr.mm6722a1

Stroup, T. S., & Gray, N. (2018). Management of common adverse effects of antipsychotic medications. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 17*(3), 341–356. https://doi.org/10.1002/wps.20567

Sub Laban, T., & Saadabadi, A. (2019). *Monoamine oxidase inhibitors (MAOI)*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK539848/

Substance Abuse and Mental Health Services Administration. (2016). An introduction to bipolar disorder and co-occurring substance use disorders. *SAMHSA Advisory, 15*(2), 1–12.

Substance Abuse and Mental Health Services Administration. (2020a). *Evidence-based resource guide series treatment for suicidal ideation, self-harm, and suicide attempts among youth*. Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth. https://store.samhsa.gov/sites/default/files/pep20-06-01-002.pdf

Substance Abuse and Mental Health Services Administration. (2020b). *National guidelines for behavioral health crisis care -A best practice toolkit knowledge informing transformation*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Substance Abuse and Mental Health Services Administration. (2021, July 23). *Compassion fatigue and self-care for crisis counselors*. https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors

Substance Abuse and Mental Health Services Administration. (2022, March 31). *Living well with serious mental illness*. https://www.samhsa.gov/serious-mental-illness

Substance Abuse and Mental Health Services Administration. (2023a, February 7). *Bipolar disorder*. https://www.samhsa.gov/mental-health/bipolar

Substance Abuse and Mental Health Services Administration. (2023b, April 24). *Self-harm*. https://www.samhsa.gov/mental-health/self-harm

The Editors of Encyclopaedia Britannica. (2019). *Seppuku*. https://www.britannica.com/topic/seppuku

Timberlake, L. M., Beeber, L. S., Hubbard, G. (2019). Nonsuicidal self-injury: Management on the inpatient

psychiatric unit. *Journal of the American Psychiatric Nurses Association, 26*(1), 10–26. https://doi.org/10.1177/1078390319878878

Torres, F. (2020). *What is depression?* American Psychiatric Association. https://www.psychiatry.org/patients-families/depression/what-is-depression

Tundo, A., de Filippis, R., & Proietti, L. (2015). Pharmacologic approaches to treatment resistant depression: Evidences and personal experience. *World Journal of Psychiatry, 5*(3), 330–341. https://doi.org/10.5498/wjp.v5.i3.330

Twivy, E., Kirkham, M., & Cooper, M. (2023). The lived experience of adolescent depression: A systematic review and meta-aggregation. *Clinical Psychology & Psychotherapy, 30*(4), 754–766. https://doi.org/10.1002/cpp.2834

Victor, S. E., & Klonsky, E. D. (2014). Correlates of suicide attempts among self-injurers: A meta-analysis. *Clinical Psychology Review, 34*(4), 282–297. https://doi.org/10.1016/j.cpr.2014.03.005

Weber, A. N., Michail, M., Thompson, A., & Fiedorowicz, J. G. (2017). Psychiatric emergencies: Assessing and managing suicidal ideation. *The Medical Clinics of North America, 101*(3), 553–571. https://doi.org/10.1016/j.mcna.2016.12.006

White, N. (2015). Mindfulness-based cognitive therapy for depression, current episodes, and prevention of relapse. *American Journal of Lifestyle Medicine, 9*(3), 227–229. https://doi.org/10.1177/1559827615569677

Witt, K. G., Hetrick, S. E., Rajaram, G., Hazell, P., Taylor Salisbury, T. L., Townsend, E., & Hawton, K. (2021). Psychosocial interventions for self-harm in adults. *The Cochrane Database of Systematic Reviews, 4*(4), CD013668. https://doi.org/10.1002/14651858.CD013668.pub2

World Health Organization. (2021). *Suicide*. https://www.who.int/news-room/fact-sheets/detail/suicide

World Health Organization. (2023, March 31). *Depressive disorder (Depression)*. https://www.who.int/news-room/fact-sheets/detail/depression

Yatham, L., Kennedy, S., Parikh, S., Schaffer, A., Bond, D., Frey, B., Sharma, V., Goldstein, B., Rej, S., Beaulieu, S., Alda, M., MacQueen, G., Milev, R., Ravindran, A., O'Donovan, C., McIntosh, D., Lam, R., Vazquez, G., Kapczinski, F., McIntyre, R. S., … Berk, M. (2018). Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders, 20*(2), 97–170. https://doi.org/10.1111/bdi.12609

Yin, H., Wardenaar, K. J., Xu, G., Tian, H., & Schoevers, R. A. (2020). Mental health stigma and mental health knowledge in Chinese population: A cross-sectional study. *BMC Psychiatry, 20*(1), 323. https://doi.org/10.1186/s12888-020-02705-x

Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. The lancet. *Psychiatry, 3*(7), 646–659. https://doi.org/10.1016/S2215-0366(16)30030-X

Zhang, R., Lai, J., & Wang, H. (2023). An integrative model of in-hospital and out-of-hospital nursing care for non-suicidal self-injury: A narrative review. *Brain Sciences, 13*(3), 466. https://doi.org/10.3390/brainsci13030466

Zimmerman, M., Ellison, W., Young, D., Chelminski, I., & Dalrymple, K. (2015). How many different ways do patients meet the diagnostic criteria for major depressive disorder? *Comprehensive Psychiatry, 56*, 29–34. https://doi.org/10.1016/j.comppsych.2014.09.007

CHAPTER 17
Anxiety, OCD, and Trauma-Stressor Disorders

FIGURE 17.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Stress is commonly understood as a physical, mental, or emotional strain or tension that results from challenges or adverse situations. It can emerge from external pressures, such as work demands or interpersonal conflicts, and internal pressures, such as personal expectations or chronic health conditions. While short-term stress can be beneficial for alertness, motivation, and performance, chronic stress, when left unmanaged, can negatively affect physical and psychological well-being (American Psychological Association, 2020).

Anxiety, OCD, and trauma-stressor disorders are a group of mental health conditions prevalent in society and can significantly affect individuals' lives. These disorders can cause distress, dysfunction, and disability in individuals, making it important for nurses to understand their underlying causes, symptoms, and treatment options. The causes of anxiety, OCD, and trauma-stressor disorders are complex and multifactorial, involving genetic, environmental, and biological factors. Effective treatments for these disorders include medication, psychotherapy, and lifestyle changes.

17.1 Stress and Anxiety

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define stress and explain how the body reacts to stress
- Describe coping strategies for stress
- Discuss the prevalence and impact of anxiety
- Outline approaches for managing and treating anxiety

Stress is a normal part of life. Everyone experiences it in one form or another, though individual reactions to stress can vary depending on a person's personality, coping skills, and support systems. Some individuals may be able to handle stress effectively, while others may struggle to cope with stress and experience negative outcomes. Stress and anxiety, while closely related, are distinct concepts in psychological research and practice. The body's response to external pressures or threats, often resulting in physiological and emotional reactions is called **stress**. It can be either short-lived (acute) or long-term (chronic) (American Psychological Association, 2022). On the other hand, **anxiety** is a heightened state of arousal and worry that may not always have a clear external cause. It can manifest as general apprehension about the future or, in more severe cases, as clinically recognized anxiety disorders. While everyone experiences stress and anxiety to some degree, excessive or chronic experiences of these states can affect overall health and well-being (American Psychological Association, 2022) (Figure 17.2).

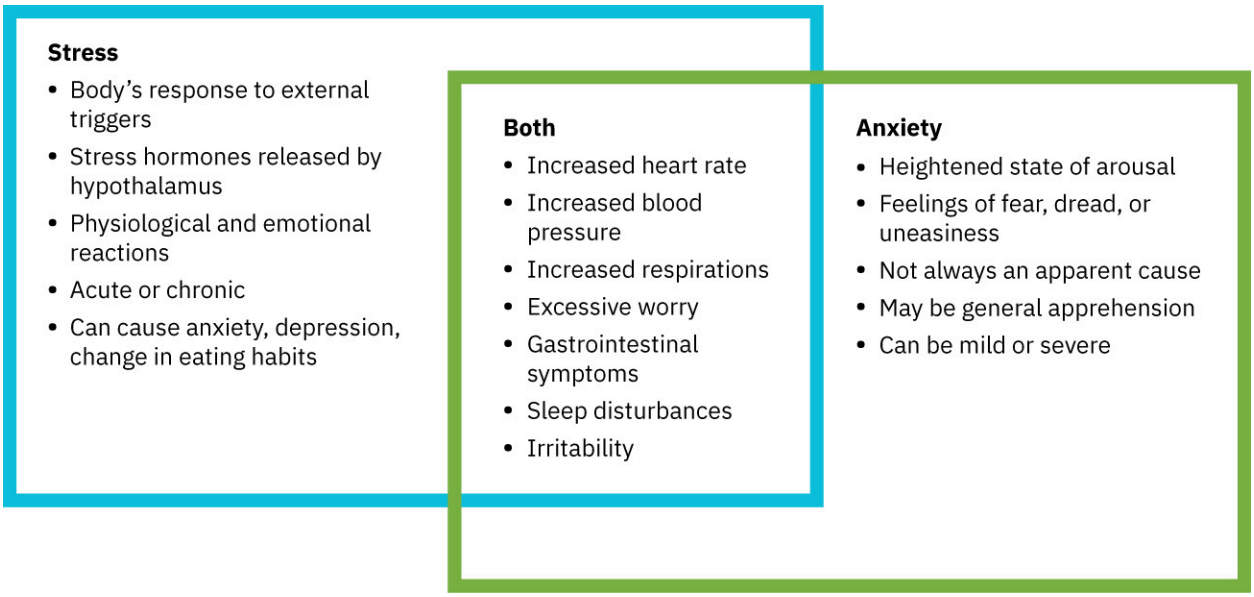


FIGURE 17.2 Stress and anxiety are similar in many ways, but there are also key differences between them. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Definition of Stress

Many factors, including work, relationships, finances, and health problems, can cause stress. Stress is the brain's initial response to a demand or challenge. When confronted with a situation requiring attention or action, the brain's hypothalamus initiates a series of chemical releases, activating the sympathetic nervous and adrenal-cortical systems. This activation releases stress hormones, particularly cortisol and adrenaline, which prepare the body for the "fight-or-flight" response. The fight-or-flight response allows individuals to respond rapidly to environmental threats. While this acute stress response can be adaptive in the short term, helping individuals react swiftly to imminent threats, chronic activation due to repeated or sustained stressors can negatively affect physical and mental health (Chu et al., 2022). This response can result in physical symptoms, such as increased heart rate, blood pressure, and breathing rate. In addition to physical symptoms, stress can cause emotional and behavioral reactions, such as anxiety, depression, irritability, and changes in eating and sleeping patterns.

LINK TO LEARNING

One approach to measuring stress uses Life Change Units (https://openstax.org/r/77lifechgunit) which involve calculating level of stress. Note that the same event may affect adults differently than it affects youths.

Reactions to stress vary from person to person and can be influenced by factors, such as genetics, personality, coping skills, support systems, and past experiences. Identifying and understanding individual reactions is crucial for developing effective stress management strategies (Fink, 2016). Generally, stress reactions can be classified into three main categories: physiological, emotional, and behavioral. These responses are the body's way of adapting to a perceived threat or challenge (Figure 17.3).

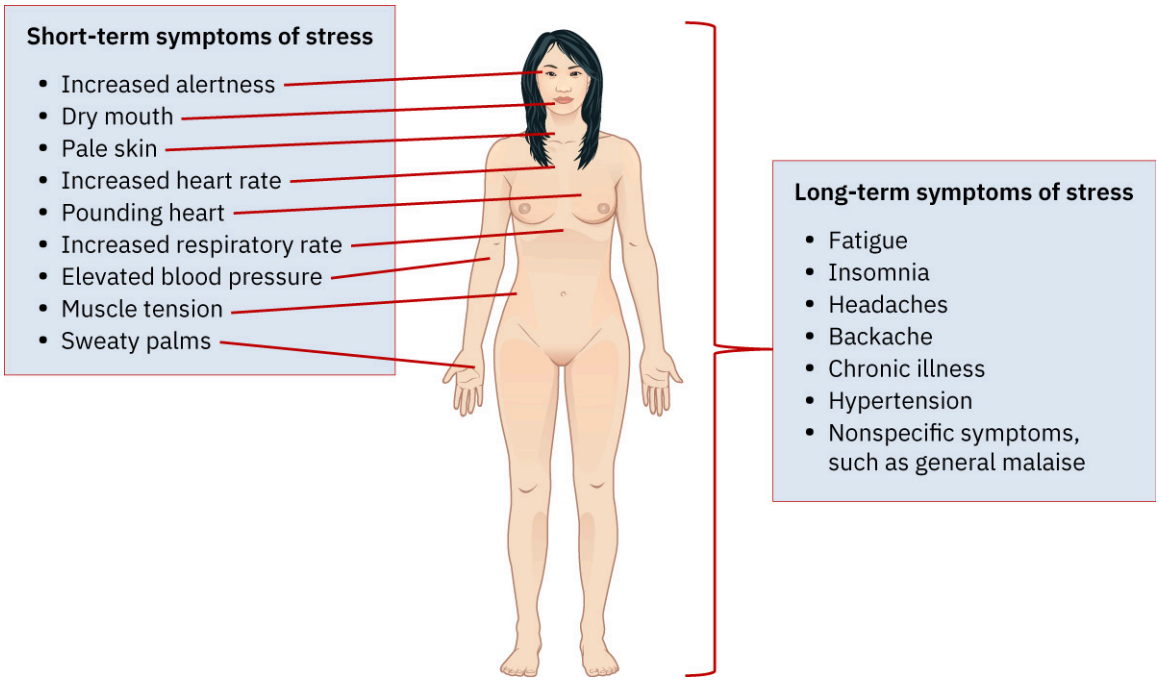


FIGURE 17.3 Stress can have numerous effects on the body. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Physiological Reactions to Stress

Physiological reactions are the body's physical responses to stress. These reactions are primarily driven by the activation of the sympathetic nervous system and the release of stress hormones, such as cortisol and adrenaline. Some common physiological stress reactions include increased heart rate, elevated blood pressure, rapid breathing, tensed muscles, sweating, digestive issues (nausea, diarrhea, or constipation), weakened immune system, and insomnia or sleep disturbances (Figure 17.4).

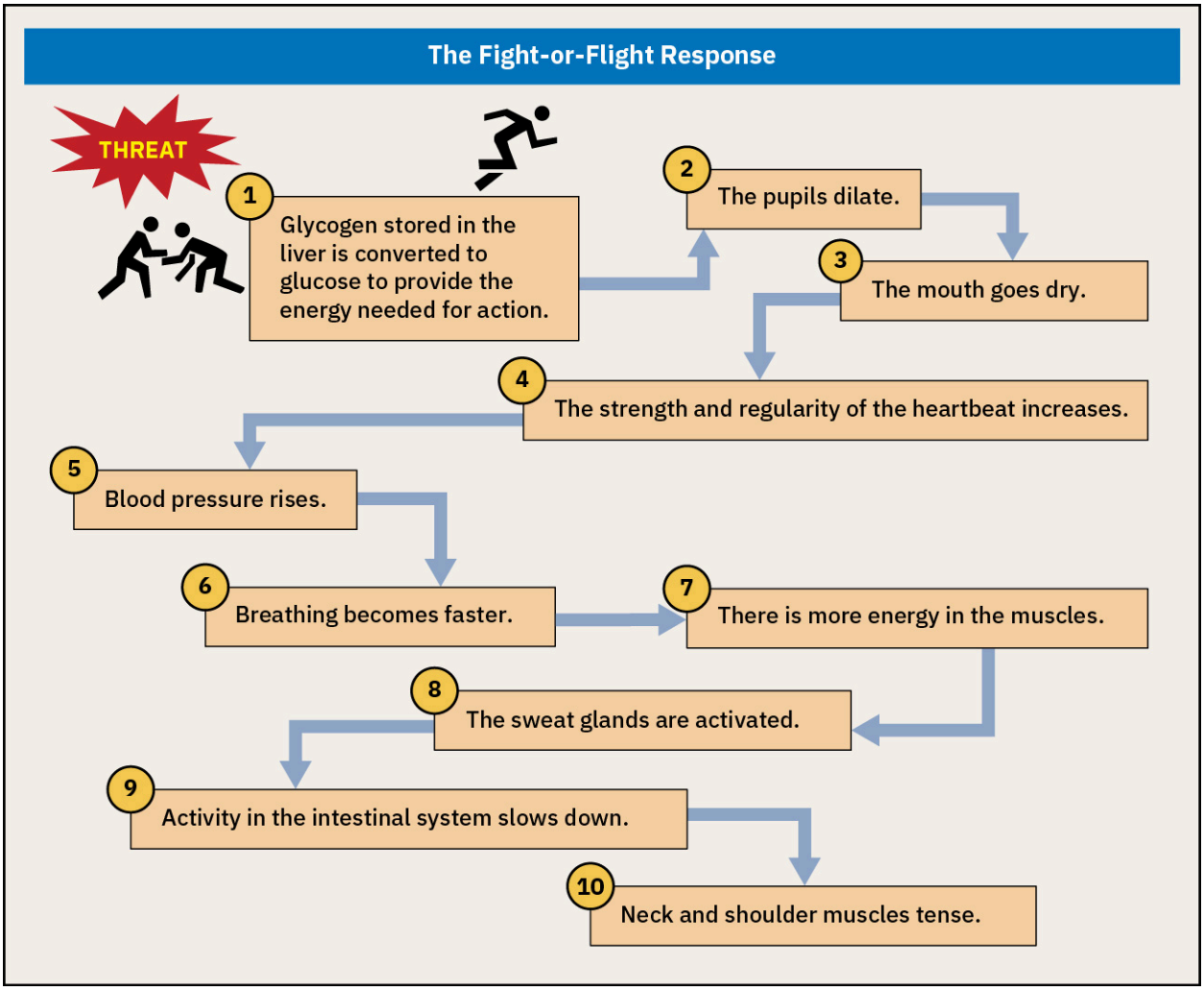


FIGURE 17.4 The fight-or-flight response is a physiological reaction that can cause a number of physical effects. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The fight-or-flight response, also known as the acute stress response, is a physiological reaction that occurs when an individual perceives a threat or a challenging situation. This response is an evolutionary adaptation that helps prepare the body to either confront the threat (fight) or escape it (flight). When the response is triggered, several physiological changes occur in the body:

- The heart pumps faster to increase blood flow and oxygen supply to the muscles and vital organs.
- Arteries constrict, raising blood pressure to deliver more oxygen and nutrients to the muscles.
- Breathing becomes faster and shallower to take in more oxygen.
- The liver releases stored glucose and fat to provide the body with additional energy.
- Pupils dilate to improve vision and awareness of the environment.
- Blood is redirected from less critical systems (like digestion) to essential muscles and organs (brain, heart, and skeletal muscles) to enhance physical performance.
- Muscles tense up to prepare for action, improving reaction time and strength.
- Senses become sharper, enhancing the body's ability to detect potential threats and respond accordingly.

These physiological changes enable the body to respond quickly and effectively to the perceived threat. However, the fight-or-flight response is designed for short-term situations, and prolonged activation can negatively affect physical and mental health, leading to chronic stress, anxiety, or other stress-related disorders (Fink, 2016).

Stress affects the body physically in various ways, and its effects can be classified into short-term and long-term consequences. Short-term effects of stress include increased heart rate and blood pressure, rapid breathing, tensed muscles, pupil dilation, temporary digestive issues, and increased blood glucose levels.

Short-term stress can be beneficial in some situations by enhancing performance and helping individuals cope with immediate challenges or threats. In contrast, long-term stress—also called chronic or prolonged stress—can have detrimental effects on physical and mental health (Fink, 2016):

- Long-term stress can weaken the immune system.
- It can lead to cardiovascular issues, such as persistently elevated blood pressure and heart rate, which can contribute to the development of hypertension, heart disease, and stroke.
- It increases the risk of developing anxiety, depression, and other mental health issues.
- If not resolved, it can lead to insomnia or other sleep-related problems, which affect overall health and well-being.
- It can cause changes in appetite, leading to overeating or undereating and, subsequently, weight gain or loss.
- It can lead to long-term digestive issues, such as irritable bowel syndrome, ulcers, or gastroesophageal reflux disease.
- It can disrupt the menstrual cycle in women, cause erectile dysfunction in men, and reduce fertility in both sexes.
- It can exacerbate conditions like acne, eczema, and psoriasis.

Emotional Reactions to Stress

Stress can also manifest in emotional responses. Different individuals may experience different emotional reactions to stress. Some common emotional responses include anxiety or worry, irritability or anger, feelings of sadness or helplessness, mood swings, difficulty concentrating or making decisions, and emotional exhaustion or burnout (Zhaoyang et al., 2020).

Behavioral Reactions to Stress

Stress can also lead to changes in behavior as individuals try to cope with or adapt to their stressors. Some common behavioral reactions to stress are changes in eating habits (overeating or undereating), sleep disturbances (insomnia or oversleeping), substance misuse (alcohol, drugs, or medications), social withdrawal or isolation, procrastination or avoidance of tasks, aggression or irritability toward others, and decreased work performance or productivity (Attia et al., 2022).

Coping with Stress

Coping with stress is essential for maintaining physical, mental, and emotional well-being. There are numerous strategies and techniques that can help individuals manage stress more effectively that nurses need to promote with clients. Some focus on the source of stress, while others focus on the emotional or physiological response. Other coping methods involve engaging in a healthy lifestyle with adequate social support and limiting exposure to known stressors (Greenberg, 2017).

Coping with stress and fostering resilience are critical for navigating life's challenges. An individual's ability to bounce back from adversity, trauma, or significant stress represents their **resilience**. It does not mean avoiding stress or hardship but developing the skills and attributes necessary to adapt and recover. Factors contributing to resilience include positive relationships, optimism, the ability to make realistic plans and carry them out, and effective communication. By combining effective coping strategies with resilience-building practices, individuals can not only navigate challenges, but also thrive in the face of them (American Psychological Association, 2022).

Problem-Focused Strategies

Problem-focused coping strategies—removing oneself from a stressful situation, practicing time management—involve directly addressing the source of stress by taking action to change, manage, or eliminate the stressor. Problem-focused coping strategies can be effective in managing stress when the stressor is within one's control but less effective for stressors that are outside one's control. In such cases, emotion-focused coping strategies, which involve managing emotional reactions to stress, may be more appropriate (Schoenmakers et al., 2015).

Emotion-Focused Strategies

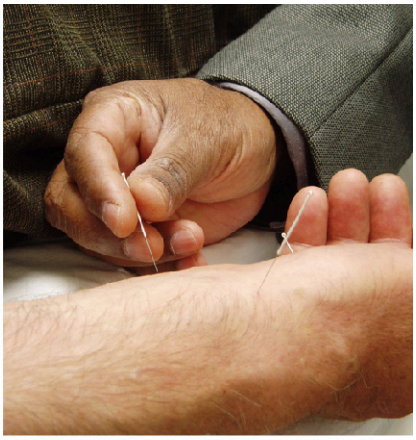
Emotion-focused coping strategies aim to help individuals manage and regulate their emotional responses to stressors. Examples of these strategies include seeking social support, where individuals may confide in trusted friends or family members to gain understanding or emotional solace. Distraction techniques redirect one's

attention away from distressing emotions. Meditation and mindfulness practices can help individuals remain anchored in the present moment, reducing feelings of stress. These strategies can be especially beneficial when stressors are beyond one's control. Different strategies work for different individuals, and a combination of problem-focused and emotion-focused methods may be most effective in managing stress (Schoenmakers et al., 2015).

A wide range of techniques can help reduce the effects of stress on the body and mind and improve one's overall well-being. Incorporating one or more of the following techniques into daily life can significantly benefit personal and professional well-being (Davis et al., 2019).

- Deep breathing exercises: Slow, deep breaths can activate the body's relaxation response, counteracting stress and promoting calm.
- Progressive muscle relaxation: This technique involves systematically tensing and relaxing different muscle groups to release physical tension and promote relaxation.
- Visualization or guided imagery: Imagining a peaceful, calming scene or environment can help reduce stress and promote relaxation.
- Mindfulness and meditation: Practicing mindfulness or meditation can help individuals become more aware of their emotions, thoughts, and bodily sensations, allowing them to manage stress more effectively.
- Cognitive restructuring: Reevaluating and reframing negative thoughts or beliefs can help change one's perspective and reduce emotional stress.
- Assertiveness training: Developing assertive communication skills can help individuals express their needs and preferences effectively, improving relationships and reducing stress.
- Time management: Prioritizing tasks, setting realistic goals, and creating schedules can help manage time more effectively and reduce stress related to workload or deadlines.
- Problem-solving: These techniques involve analyzing the stressor and identifying potential solutions, breaking the problem into smaller, manageable tasks, and creating an action plan to tackle each task systematically.
- Exercise: Regular physical activity can help reduce stress, improve mood, and promote overall well-being.
- Seeking social support: Connecting with friends, family, or support groups can provide emotional support, encouragement, and a sense of belonging during stressful times.
- Techniques, such as mindfulness meditation, yoga (Figure 17.5), tai chi, and qigong, combine physical movement with breath work and mental focus to promote relaxation and reduce stress.
- The traditional Chinese medicine practice of acupuncture involves inserting thin needles into specific points on the body to promote balance and reduce stress.
- Massage therapy can help release physical tension, improve circulation, and promote relaxation.
- The use of essential oils can help reduce stress and promote relaxation. Lavender, bergamot, and chamomile are some examples of essential oils with calming properties.
- Some dietary supplements, such as omega-3 fatty acids, magnesium, and ashwagandha, may have stress-reducing properties.
- Cognitive behavioral therapy involves changing negative thought patterns and behaviors to reduce stress and improve coping skills.
- In some cases, prescription medications, such as antidepressants, anxiolytics, or beta-blockers, may help manage stress.

(a)



(b)

FIGURE 17.5 Both (a) yoga and (b) acupuncture can be effective techniques for managing and relieving stress. (credit (a): "Yoga Instructor Stretches JBA Members' Resiliency" by Airman 1st Class Valentina Lopez/U.S. Air Force, Public Domain; credit (b): "Basic Acupuncture" by Kyle Hunter/Wikimedia Commons, Public Domain)

Additionally, dietary choices play a role in stress management. A balanced diet rich in nutrient-dense foods can enhance brain function and provide sustained energy, potentially moderating stress-related mood fluctuations (Hepsomali & Groeger, 2021). Sleep is also foundational to cognitive and emotional functioning and coping with stress; research indicates that adults who regularly obtain adequate hours of restorative sleep are better equipped to handle daily stressors and exhibit improved mood regulation (Vandekerckhove & Wang, 2017). With its capacity to evoke emotions, music has been identified as a powerful therapeutic tool, offering listeners an avenue for emotional release and relaxation (de Witte et al., 2022). The presence of pets, especially dogs and cats, has been linked to reduced stress levels due to their ability to provide unconditional love, tactile comfort, and companionship (Grajfoner et al., 2021). Spiritual involvement, whether through organized religion or personal practices, can offer individuals a sense of purpose and community, providing a broader perspective on life's challenges and a reservoir of strength (Yan et al., 2019).

LINK TO LEARNING

The National Council for Mental Wellbeing provides a Mental Health "First Aid Kit" that includes five practical tips (https://openstax.org/r/77mentalhlttips) for coping with stress.

Defense Mechanisms

Defense mechanisms are unconscious psychological processes that protect individuals from feelings of anxiety, guilt, or shame, often resulting from stress (Freud, 1966). Table 17.1 lists some common defense mechanisms related to stress.

Defense Mechanism	Definition	Example
Denial	Refusing to accept the reality of a situation or experience, because acknowledging it would be too emotionally painful or overwhelming.	A person who drinks alcohol daily insists they do not have a drinking problem. Despite negative consequences due to their drinking, they refuse to accept that their alcohol consumption is problematic.
Repression	Pushing uncomfortable thoughts or memories into the unconscious mind to avoid dealing with them consciously.	A child who was abused by a family member might have no recollection of the abuse as an adult. The memory is too painful, so the mind buries it deep within the unconscious.
Projection	Attributing one's unwanted thoughts, feelings, or impulses to another person, often as a way of avoiding personal responsibility or guilt.	A person feeling guilty about lying might accuse someone else of being dishonest. They project their feelings of dishonesty onto another person.
Displacement	Redirecting negative emotions or impulses from their original source to a less threatening target, often to cope with anger or frustration.	After a stressful day at work, a husband comes home and yells at his wife. Instead of addressing his anger toward his boss, he displaces it onto a less threatening target.
Rationalization	Creating justifications or excuses for one's behavior or emotions to avoid confronting the real reasons.	After not getting promoted, a person might say they did not want the higher responsibility anyway, even if they were previously excited about the possibility.
Intellectualization	Focusing on the intellectual aspects of a situation rather than the emotional ones, often as a way of avoiding painful feelings.	Instead of expressing the emotional pain of a recent breakup, someone might study the psychological processes of grief and heartbreak, distancing themselves from their feelings by examining the situation purely intellectually.
Reaction formation	Behaving in a manner opposite to one's true feelings to conceal or deny them.	A person who harbors feelings of prejudice might go out of their way to be overly kind and generous to individuals from the group they have prejudiced feelings toward. They overcompensate in the opposite direction of their actual feelings.
Sublimation	Channeling negative emotions or impulses into socially acceptable behaviors or activities, such as engaging in artistic pursuits or exercise to cope with stress.	A person with aggressive tendencies might channel those feelings into contact sports, like boxing or football. This way, they convert their unacceptable urges into a more acceptable form.

TABLE 17.1 Common Defense Mechanisms (Bailey & Pico, 2020)

Defense Mechanism	Definition	Example
Regression	Reverting to earlier stages of development or behaviors typically associated with childhood to cope with stress or difficult emotions.	An adult, when facing marital problems, might start to act childishly, throwing tantrums or sulking, reverting to an earlier stage of development.
Undoing	Attempting to "undo" or compensate for an undesirable thought, feeling, or action by engaging in behaviors that symbolically negate it.	After saying something hurtful to a friend, a person might be excessively kind or generous to them in an attempt to "undo" the harm they caused.
Identification	Adopting the characteristics, beliefs, or behaviors of another person or group, often as a way of managing feelings of insecurity or inadequacy.	A bullied child might start emulating the behavior of his bully, trying to feel powerful by identifying with the aggressor.

TABLE 17.1 Common Defense Mechanisms (Bailey & Pico, 2020)

Defense mechanisms are not inherently harmful, as they can temporarily help individuals navigate stressful situations. If an individual overuses or only relies on defense mechanisms, however, it may adversely affect personal growth and self-awareness (Sekowski, 2022). When addressing the use of defense mechanisms by clients, nurses should employ active listening and nonjudgmental communication rather than confronting the defense mechanism directly, which may exacerbate the client's stress or anxiety. Create a safe and trusting environment where clients feel understood and respected. Open-ended questions encourage clients to explore and express their feelings. Client education might be helpful when appropriate, but it is essential to approach this with sensitivity, ensuring it does not invalidate the client's feelings or experiences. Through empathy, patience, and self-awareness, nurses can support clients in navigating their defense mechanisms to benefit their overall well-being (Bailey & Pico, 2020).

Prevalence and Impact of Anxiety

Anxiety, or feelings of fear, dread, or uneasiness, is a natural and normal emotional response to stress or threat. When anxiety becomes excessive or persistent, however, it can interfere with daily activities and impact an individual's quality of life. Anxiety can range from mild to severe and can present differently in each individual. If left untreated, it can significantly affect an individual's mental and physical health (American Psychiatric Association, 2013).

PSYCHOSOCIAL CONSIDERATIONS

Stress and Anxiety in Nursing Students

Stress and anxiety in nursing students can arise from academic pressures, clinical experiences, or the impending responsibility of client care.

Common triggers of stress and anxiety in nursing students include:

- clinical mistakes or perceived errors
- fear of harming clients
- high academic workload
- balancing personal, work, and academic lives
- peer and instructor evaluations

Manifestations of stress and anxiety include:

- reduced cognitive function and focus
- impaired clinical decision-making
- decrease in academic performance
- physical symptoms, such as insomnia, headaches, or palpitations
- emotional symptoms, such as feelings of inadequacy and depression

Coping strategies for stress and anxiety include:

- peer support and mentorship
- stress management and relaxation techniques
- professional counseling services
- adequate preparation and training for clinical settings
- feedback and positive reinforcement from instructors

Anxiety among nursing students is a significant concern that can influence their academic performance, clinical experiences, and overall well-being (Comparcini et al., 2022).

Causes of Anxiety

Anxiety disorder is a complex mental health condition stemming from, and exacerbated by, various genetic, biological, and environmental factors. Scientists believe genetic factors play a role in the development of anxiety: Studies have shown that individuals with a family history of anxiety disorders are more likely to develop the condition (Bandelow & Michaelis, 2015). Brain development is another crucial factor in the development of anxiety. The amygdala, responsible for processing emotional responses, has been shown to be hyperactive in individuals with anxiety disorders (Bandelow & Michaelis, 2015). Additionally, the prefrontal cortex, responsible for regulating emotional responses, may not function properly in individuals with anxiety.

Environmental factors, such as parenting style, life events, and social influences, can also contribute to the development of anxiety. For example, parental overprotection, criticism, and rejection have been linked to increased anxiety in children. Traumatic life events, such as abuse or neglect, can also increase the risk of developing anxiety disorders. Social influences, such as peer pressure and exposure to stressful environments, can also contribute to the development of anxiety (Bandelow & Michaelis, 2015).

Anxiety has been examined and interpreted from various theoretical perspectives over the years. The cognitive perspective emphasizes the role of maladaptive thoughts and beliefs in the development of anxiety disorders, while the behavioral perspective focuses on the role of learning and conditioning. The psychodynamic perspective suggests that anxiety arises from unresolved conflicts and repressed impulses. In contrast, the humanistic perspective emphasizes the importance of self-actualization and personal growth in preventing and treating anxiety disorders. The biological perspective examines the role of neurotransmitters and brain structures in the development of anxiety disorders. This perspective emphasizes the interaction between genetic and environmental factors, as research has shown that anxiety disorders can be inherited (Barlow & Durand, 2015).

Incidence of Anxiety

Anxiety is a prevalent mental health condition affecting millions of individuals worldwide. In the United States alone, an estimated 19.1 percent of adults had an anxiety disorder in the past year. The prevalence of any anxiety disorder was higher for females (23.4 percent) than for males (14.3 percent) but was similar across age groups. An estimated 31.1 percent of U.S. adults experience an anxiety disorder at some time in their lives (National Institute of Mental Health, 2023).

Among anxiety disorders, generalized anxiety disorder (GAD) is one of the most commonly diagnosed conditions, affecting 6.8 million adults or 3.1 percent of the U.S. population (Anxiety and Depression Association of America, 2022). Panic disorder and social anxiety disorder (SAD) are also prevalent, with reported twelve-month prevalence rates of 2.7 percent and 7.1 percent, respectively (Anxiety and Depression Association of America, 2022). Specific phobias affect 19.3 million adults, or 9.1 percent of the U.S. population (Anxiety and Depression Association of America, 2022).

Signs and Symptoms of Anxiety

Anxiety is characterized by feelings of fear, apprehension, and unease, often accompanied by physical symptoms, such as sweating, palpitations, and shortness of breath. According to the American Psychiatric Association (APA), the signs and symptoms of anxiety can include excessive worry or fear about a specific situation or object, avoidance of certain situations, panic attacks, restlessness, irritability, muscle tension, and difficulty sleeping. In addition, individuals with anxiety may experience gastrointestinal symptoms, such as nausea or diarrhea, and difficulty concentrating or completing daily tasks (2013). Specific signs and symptoms are listed in Table 17.2.

Type	Sign or Symptom	Description
Physical	Palpitations	A feeling that the heart is pounding or racing
	Tremors or shaking	Especially noticeable in the hands
	Sweating	Excessive sweating even in cool environments
	Shortness of breath	Feeling unable to take a deep breath
	Gastrointestinal Issues	Nausea, stomach cramps, or diarrhea
	Fatigue	Feeling unusually tired or drained
	Sleep disturbances	Difficulty falling or staying asleep or nightmares
Cognitive	Excessive worry	Constant concern about grades, clinical performance, or other issues
	Difficulty concentrating	Struggling to focus on lectures, readings, or practical tasks
	Indecisiveness	Difficulty making decisions
	Memory issues	Forgetting learned material, misplacing items, or struggling with recall
Behavioral	Avoidance	Evading certain situations or tasks due to fear of failure or judgment
	Procrastination	Continually postponing tasks
	Restlessness	Unable to sit still, constantly fidgeting or moving
	Isolation	Pulling away from friends, family, or fellow students
Emotional	Feeling overwhelmed	A sensation that everything is too much to handle
	Mood swings	Rapid shifts in mood from high to low
	Irritability	Easily annoyed or angered
	Sense of impending doom	A constant feeling that something terrible is about to happen

TABLE 17.2 Signs and Symptoms of Anxiety

Techniques to Measure Anxiety

Because anxiety is a subjective experience, it can be challenging to measure objectively. Several techniques are available to assess anxiety levels in individuals (Rose & Devine, 2014). One commonly used method is for individuals to self-report information about their subjective experiences of anxiety, for example, through interviews

or questionnaires. These measures can include the State-Trait Anxiety Inventory (STAI) and the Beck Anxiety Inventory (BAI), which assess general and specific anxiety symptoms, respectively (Julian, 2011).

Another technique is to monitor changes in the body's physiological responses to anxiety, such as heart rate, blood pressure, and respiration rate. These measures can be obtained using instruments like electrocardiograms (ECGs), electroencephalograms (EEGs), and skin conductance response (SCR) devices (Kyriakou et al., 2019).

Additionally, behavioral measures can provide insight into an individual's level of anxiety. For example, the approach-avoidance task is a common measure of anxiety that assesses how individuals respond to threatening or anxiety-provoking stimuli (Rose & Devine, 2014).

There are different levels of anxiety that a person can experience. Some levels can be regularly handled, whereas other levels can cause functional impairment.

Mild

Mild anxiety is a normal and expected response to stressors and does not typically interfere with daily activities. Individuals may experience feelings of nervousness or apprehension, but they can manage their symptoms and continue to function normally (American Psychiatric Association, 2013).

Though often viewed negatively, mild anxiety can have several positive aspects and adaptive functions. Mild anxiety can make individuals more alert and ready to face upcoming challenges by sharpening their senses and attention. Mild anxiety can sometimes push individuals into an optimal zone of arousal, enhancing performance, especially in situations that require focus, like exams or presentations. The slight unease from mild anxiety can act as a motivating force, pushing individuals to prepare, study, or practice. Mild anxiety can sometimes act as a signal that there is a problem to address, prompting individuals to think creatively and come up with solutions. Experiencing and coping with mild anxiety can help individuals develop resilience and better adapt to future stressors. Experiencing anxiety can increase one's empathy and understanding toward others who face mental health challenges (American Psychiatric Association, 2013).

Moderate

Increased feelings of worry or fear characterize moderate anxiety, which may be accompanied by physical signs, such as sweating, trembling, or rapid heart rate. Individuals may also experience difficulty concentrating and avoid situations that trigger their anxiety (American Psychiatric Association, 2013).

Severe

Severe anxiety is an intense level of anxiety in which individuals may experience overwhelming feelings of panic, terror, or dread. Physical symptoms, such as chest pain or difficulty breathing, may be severe and require medical attention. Individuals with severe anxiety may also have difficulty functioning in daily life and may require professional treatment (American Psychiatric Association, 2013).

Severe anxiety profoundly impacts an individual's behaviors, thought processes, and problem-solving capacities. Individuals experiencing severe anxiety may avoid situations or locations associated with anxiety, limiting their daily activities (Robinson et al., 2013). They might also exhibit restlessness or procrastination due to anticipatory stress or resort to substance misuse as a coping mechanism (FHE Health, 2016). Cognitively, individuals with severe anxiety commonly display catastrophic thinking, visualizing the worst possible scenarios (Kishikawa et al., 2022). They are prone to rumination, repeatedly reflecting on distressing events without resolution, and might also demonstrate perfectionism, viewing any shortcoming as a personal failure (American Psychiatric Association, 2020).

Panic

Panic is a specific level of anxiety characterized by sudden and intense feelings of fear or terror, often accompanied by physical symptoms, such as chest pain, sweating, trembling, and a rapid heartbeat. Panic attacks can occur unexpectedly, or specific situations or stimuli can trigger them. Treatment for panic often involves cognitive behavioral therapy or medication, and a proper diagnosis is essential to develop an effective treatment plan (American Psychiatric Association, 2013).

PSYCHOSOCIAL CONSIDERATIONS

Panic in a Nursing Student

Panic involves sudden and intense feelings of fear or terror, often accompanied by physical symptoms. These episodes can be overwhelming and disruptive.

Physical symptoms can include:

- Palpitations: rapid heart rate or skipped beats
- Trembling: shaking or shivering without an apparent cause
- Shortness of breath: a sensation of being unable to breathe
- Chest pain: feeling pressure or discomfort in the chest
- Dizziness: feeling lightheaded or faint
- Nausea: upset stomach or urge to vomit
- Chills or hot flashes: sudden temperature changes without environmental reasons

Cognitive and emotional symptoms can include:

- Fear of losing control: an overwhelming belief that everything is out of their control
- Fear of dying: intense concern that death is imminent
- Detachment: feeling disconnected from oneself or the environment, also known as derealization or depersonalization

Potential triggers in nursing students can include:

- Clinical stress: encountering real-life medical scenarios, especially emergencies
- Academic pressure: anxiety over grades, exams, and performance evaluations
- Lack of sleep: irregular hours or night shifts can disrupt sleep patterns
- Caffeine overconsumption: relying heavily on caffeinated drinks to stay awake

Coping strategies can include:

- Deep breathing: Slowing down and focusing on breathing can help reduce panic symptoms.
- Grounding techniques: Tactics like the "5-4-3-2-1" sensory method can help reconnect individuals to the present moment (Smith, 2018) (Figure 17.6).
- Seek support: Talking to a trusted friend, mentor, or professional can help process and manage the episode.

5-4-3-2-1 Grounding Technique	
5	What are 5 things you see?
4	What are 4 things you feel?
3	What are 3 things you hear?
2	What are 2 things you smell?
1	What is 1 thing you taste?

FIGURE 17.6 Grounding using the five senses is an effective way to cope with panic. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Cognitive Distortions and Anxiety

Cognitive distortions are patterns of negative thinking often associated with higher anxiety levels. According to the cognitive model, anxious individuals tend to interpret ambiguous or uncertain situations negatively, leading to increased fear and anxiety. One common cognitive distortion related to anxiety is catastrophizing, which involves

imagining the worst possible outcome of a situation and exaggerating its potential negative consequences. An example would be a student making a small mistake on a project. The distortion of catastrophizing might lead the student to believe they would fail the course and, as a result, ruin their entire life. Another distortion is all-or-nothing thinking, which involves viewing situations as completely good or completely bad without any shades of gray. All-or-nothing thinking might lead an individual to see their ability as an artist as either perfect or entirely flawed, based on the reception of a single piece. This thinking can lead to anxiety because it creates unrealistic expectations and increases the likelihood of disappointment or failure. Other anxiety-related cognitive distortions include overgeneralization, jumping to conclusions, and personalization. These distortions can be targeted by cognitive behavioral therapy, which aims to help individuals identify and challenge their negative thought patterns to reduce anxiety symptoms (Rnic et al., 2016).

Treating Anxiety

Anxiety can significantly impair an individual's quality of life. Fortunately, several effective treatments are available to help manage and alleviate anxiety symptoms. The choice of treatment depends on the severity of symptoms, individual preferences, and other factors. Still, some of the most commonly used treatments for anxiety include psychotherapy, self-help strategies, and medications (American Psychiatric Association, 2013).

Psychotherapy

Psychotherapy is a widely used treatment approach for anxiety. One of the most effective forms of psychotherapy is cognitive behavioral therapy, which helps individuals identify and change negative patterns of thought and behavior contributing to their anxiety. CBT is based on the idea that thoughts, feelings, and behaviors are interconnected. If an individual changes one, the other two can also change. For example, by changing negative thought patterns, people can influence their feelings and behaviors (Nakao et al., 2021). Other types of psychotherapy may also be effective for managing anxiety symptoms. Some examples of these methods are cognitive restructuring, which involves identifying and challenging negative thoughts and replacing them with more balanced and positive ones, and acceptance and commitment therapy (ACT), which is an approach that combines aspects of acceptance and mindfulness strategies with commitment and behavior-change strategies. The primary aim is to promote psychological flexibility, which is the ability to be open, adaptable, and effective in the presence of difficult emotions or thoughts (Schuman-Olivier et al., 2020).

Excessive and persistent fear, worry, and avoidance behaviors characterize anxiety. One commonly used treatment for anxiety is **desensitization**, an exposure therapy that involves gradually exposing the individual to the feared stimulus or situation until they no longer experience anxiety in response to it (Nash, 2022). For example, if someone fears needles, they might first be instructed to imagine a needle. Then, the individual might look at a picture of a needle. Once the individual can successfully do these things, they might progress to holding a syringe without a needle, then on to watching someone receive an injection, then to receiving a mock injection with the needle cap, and finally receiving a real injection. Research has shown that desensitization effectively treats anxiety, including specific phobias. It allows individuals to confront and overcome their fears in a safe and controlled environment, leading to long-term improvements in their mental health and quality of life (Craske et al., 2014).

Nonpharmacological and Self-Help Approaches

Relaxation techniques, such as progressive muscle relaxation and deep breathing exercises, can help reduce physical symptoms of anxiety and promote feelings of calm and relaxation. Exercise and physical activity have also been shown to be effective in reducing anxiety symptoms. Other nonpharmacological approaches that may be helpful for anxiety include dietary changes, such as reducing caffeine and alcohol intake, and complementary or alternative therapies, such as acupuncture and massage therapy. Overall, nonpharmacological approaches can be effective in treating anxiety and may be particularly beneficial for individuals who prefer not to take medication or who have had limited success with medication (Bandelow et al., 2015).

Biofeedback

A technique, **biofeedback** (Figure 17.7) involves monitoring and controlling physiological responses to improve physical and mental health. The technique can be useful in treating anxiety, as it can help individuals learn how to manage their physiological responses to stress and anxiety. Biofeedback can measure various physiological responses, including heart rate, blood pressure, muscle tension, and skin conductance. In addition, biofeedback can be used with other anxiety disorder treatments, such as CBT. Combining biofeedback and CBT has been shown to

reduce anxiety symptoms and improve overall mental health effectively (Gevirtz, 2013).

FIGURE 17.7 During a biofeedback session, a therapist uses computers to monitor a client's physiological responses to stressors and stimuli related to anxiety. (credit: "Biofeedback training program for post-traumatic stress symptoms" by Army Medicine/Wikimedia Commons, CC BY 2.0)

Hypnosis

Hypnosis is a noninvasive and nonpharmacological approach to treating anxiety that aims to alter an individual's thoughts, feelings, and behaviors (Hasbi & Effendy, 2019). Hypnotherapy involves inducing a trancelike state in the client and providing suggestions to modify their thoughts and behaviors. This treatment can help individuals with anxiety learn how to manage their symptoms and improve their coping strategies (Hasbi & Effendy, 2019).

Pharmacological Treatments

Medication therapy is commonly used to treat anxiety. The most commonly prescribed medications for anxiety are benzodiazepines, buspirone, and antidepressants, specifically SSRIs and SNRIs (Strawn et al., 2018).

Benzodiazepines

Benzodiazepines work by enhancing the effects of the neurotransmitter gamma-aminobutyric acid (GABA), which has a calming effect on the brain. Benzodiazepines can quickly relieve acute anxiety symptoms, making them especially useful for immediate or short-term relief. Chronic use, even over a short period (a few weeks), however, can lead to physical and psychological dependence. Withdrawal symptoms can be severe and include insomnia, increased anxiety, tremors, and, in extreme cases, seizures (Rosenbaum, 2020) (Table 17.3).

Drug Name	Use	Duration of Action
Diazepam (Valium)	Anxiety, muscle relaxant, alcohol withdrawal, seizures	Long acting
Alprazolam (clonazepam (Klonopin))	Anxiety, panic disorder	Intermediate acting
Lorazepam (Ativan)	Anxiety, insomnia due to anxiety, status epilepticus, alcohol withdrawal	Intermediate acting
Clonazepam (Klonopin)	Panic disorder, seizures	Long acting
Chlordiazepoxide (Librium)	Alcohol withdrawal, anxiety	Long acting
Oxazepam (Serax)	Anxiety, alcohol withdrawal	Short to intermediate acting

TABLE 17.3 Most Commonly Prescribed Benzodiazepines (Dubovsky & Marshall, 2022)

Buspirone

Buspirone is a medication commonly used to treat anxiety. It is classified as an anxiolytic, which means that it works to reduce feelings of anxiety and tension. Buspirone works by binding to certain receptors in the brain that are involved in the regulation of mood and anxiety, specifically the serotonin 5-HT1A receptors. Unlike benzodiazepines, buspirone is not associated with the risk of dependence or withdrawal symptoms. It also does not have sedative effects, so it can be taken during the day without interfering with everyday activities. Buspirone can take several weeks to start working and may cause side effects, such as nausea, dizziness, and headaches. It may also be less effective than other medications for some individuals with anxiety disorders (Melaragno, 2021).

Antidepressants

Antidepressants are commonly used to treat anxiety, particularly SSRIs and SNRIs (Mayo Clinic, 2019). These medications work by increasing the availability of serotonin and norepinephrine in the brain, which can help regulate mood and reduce anxiety symptoms (Bandelow et al., 2015). Studies have shown that antidepressants can effectively treat anxiety, but the response to antidepressants can vary widely among individuals, and it may take several weeks or months to reduce anxiety symptoms significantly. Additionally, some individuals may experience side effects, such as nausea, dizziness, and sexual dysfunction. Antidepressants are often used with psychotherapy, such as cognitive behavioral therapy, to achieve optimal treatment outcomes (National Institute of Mental Health, 2023) (Table 17.4).

Drug Name	Class	Use
Fluoxetine (Prozac)	SSRI	Generalized anxiety disorder, panic disorder, OCD, depression
Sertraline (Zoloft)	SSRI	Generalized anxiety disorder, panic disorder, OCD, social anxiety disorder, PTSD, depression
Paroxetine (Paxil)	SSRI	Generalized anxiety disorder, panic disorder, social anxiety disorder, OCD, PTSD, depression
Citalopram (Celexa)	SSRI	Generalized anxiety disorder, depression

TABLE 17.4 Most Commonly Prescribed Antidepressants for Anxiety (Mayo Clinic, 2019)
Abbreviations: OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor

Drug Name	Class	Use
Escitalopram (Lexapro)	SSRI	Generalized anxiety disorder, depression
Venlafaxine (Effexor XR)	SNRI	Generalized anxiety disorder, panic disorder, social anxiety disorder, depression
Duloxetine (Cymbalta)	SNRI	Generalized anxiety disorder, depression, neuropathic pain

TABLE 17.4 Most Commonly Prescribed Antidepressants for Anxiety (Mayo Clinic, 2019)
Abbreviations: OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor

Other Medications

Beta-blockers, such as propranolol, can be used to treat anxiety disorders. These medications target the physical symptoms of anxiety, such as tachycardia, flushing, and shaking (National Institute of Mental Health, 2023). Gabapentin, a medication commonly used to treat seizures and nerve pain, has also been studied for its potential effectiveness in treating anxiety disorders. Although the exact mechanism of action is unclear, gabapentin is thought to increase the release of the inhibitory neurotransmitter GABA, which can help reduce feelings of anxiety. Several small studies have suggested that gabapentin may effectively treat anxiety disorders, such as generalized anxiety disorder, social anxiety disorder, and panic disorder. It requires more research, however, and it has side effects, such as dizziness, drowsiness, and confusion, and it can also be habit-forming if used for extended periods (Berlin et al., 2015).

Nursing Care for Clients with Anxiety

Nursing interventions for anxiety should be tailored to the specific needs of the individual, and any treatment plan should be developed in collaboration with all members of the health-care team (American Nurses Association, 2022). Some of the most common interventions involve assessing the client's level of anxiety, including the severity and duration of symptoms; creating a quiet and soothing environment, which can help reduce the client's anxiety and promote relaxation; and encouraging relaxation techniques, such as deep breathing exercises, progressive muscle relaxation, and guided imagery. There is a need to assist the client in the development of coping strategies, such as positive self-talk, distraction techniques, and problem-solving skills. It is also important to educate the client and their family or caregivers about anxiety, its symptoms, and available treatments. People who understand their condition often feel more in control. Nurses may also administer and manage prescribed medications, such as benzodiazepines or SSRIs, or refer the client to other health-care professionals, support groups, or community resources that can provide additional support and assistance.

17.2 Anxiety-Related Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe causes and treatment approaches for generalized anxiety disorder
- Understand and plan the nursing interventions for a person with a phobia
- Outline the attributes of, and approaches to care for, a person suffering from a panic attack

Anxiety disorders encompass a wide range of mental health conditions characterized by persistent and excessive fear or anxiety. These emotions are typically disproportionate to the situation and can interfere with daily activities, relationships, and overall quality of life. Anxiety disorders are among the most common psychiatric disorders in the United States (American Psychiatric Association, 2013).

Generalized Anxiety Disorder

Anxiety becomes classified as a disorder when it exceeds expected levels of worry or fear and begins to interfere with daily functioning. While it is normal to experience anxiety in response to stressful situations or challenges, anxiety disorders are characterized by persistent, excessive, and often irrational fears disproportionate to the

triggering event or situation (American Psychiatric Association, 2013). Anxiety becomes problematic when it persists for extended periods, often six months or more, without a specific or rational cause. Sometimes anxiety is so severe that it leads to physical symptoms, such as heart palpitations, sweating, or shaking. Also, if anxiety hinders a person's ability to function normally, it will likely be considered a disorder (National Institute of Mental Health, 2023). When it is characterized by persistent and excessive worry about everyday events and activities, it is considered **generalized anxiety disorder (GAD)** and can develop in children or adults.

Causes of Generalized Anxiety Disorder

The exact causes of GAD are not fully understood, but several factors are believed to contribute to the development of this disorder (National Institute of Mental Health, 2023). One of the leading causes of GAD is believed to be genetics. Studies have shown that individuals with a family history of anxiety disorders are more likely to develop GAD. Another potential cause of GAD is environmental factors, such as stress and trauma. Traumatic experiences, such as physical or emotional abuse, can lead to GAD in some individuals. Chronic stress due to professional or financial challenges can contribute to the development of GAD, and so can a medical diagnosis, particularly one with a poor prognosis (National Institute of Mental Health, 2023).

Additionally, brain chemistry and function may play a role in the development of GAD. People with GAD have been found to have imbalances in neurotransmitters, such as serotonin and norepinephrine, that regulate mood and anxiety. These imbalances can lead to persistent anxiety and worry (Nuss, 2015).

Signs and Symptoms of Generalized Anxiety Disorder

GAD can manifest in various ways, including physical, cognitive, and behavioral symptoms. Physical symptoms of GAD can include muscle tension, headaches, nausea, sweating, trembling, fatigue, and difficulty sleeping. Cognitive symptoms of GAD can include persistent and excessive worrying about everyday events, difficulty controlling or stopping worrying, overthinking or ruminating, and feeling on edge or restless. Behavioral symptoms of GAD can include avoiding situations or activities that might trigger worry or anxiety, seeking reassurance from others, and engaging in compulsive or repetitive behaviors to reduce anxiety (National Institute of Mental Health, 2023).

Symptoms of GAD vary between adults and children. Symptoms associated with GAD in adults include:

- restlessness
- feeling on edge or irritable
- fatigue
- shortness of breath
- heart palpitations
- difficulty concentrating
- muscle tension
- sleep problems
- unexplained pains, such as headaches, muscle aches, and stomachaches

GAD in children and adolescents may be seen as excessive anxiety and worry about events or activities, such as school. The child or adolescent may have difficulty controlling worries. There may also be restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep difficulties (American Academy of Child and Adolescent Psychiatry, 2022). Symptoms associated with GAD in children include:

- excessive worry
- increased muscle aches
- impaired concentration
- fatigue
- irritability
- restlessness
- difficulty sleeping

Diagnosing Generalized Anxiety Disorder

An in-depth interview conducted by a mental health professional is crucial to understanding the client's symptoms, history, and anxiety's impact on daily life. Questions should focus on the nature of the anxiety, its duration and severity, potential triggers, and coping strategies.

Because anxiety may have physical manifestations or be linked to other medical conditions, a physical examination should rule out underlying medical issues. Continuous observation of symptoms, such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances, helps form a diagnosis. A comprehensive medical and psychiatric history can provide essential insights into the individual's overall health and potential factors contributing to anxiety. An evaluation of how anxiety affects daily functioning, relationships, and occupational performance is essential (Cleveland Clinic, 2022).

Treatment of Generalized Anxiety Disorder

Psychotherapy is a common treatment for GAD. CBT has been shown to be effective for GAD. CBT helps individuals identify and change negative thought patterns and behaviors contributing to anxiety (Nakao et al., 2021). An example of a use for CBT in GAD would be when a client constantly worries about failing at work, even though they are performing well. A therapist might help them identify this as an irrational fear and work on understanding why this thought pattern occurs. Another client may believe that any mistake will lead to catastrophe. CBT teaches them to challenge this belief, considering alternative outcomes, and replacing the thought with something more positive and realistic. Other types of therapy, such as acceptance and commitment therapy (ACT) and interpersonal therapy (IPT), may also be helpful. ACT focuses on accepting thoughts and feelings rather than attempting to eliminate or control them. It emphasizes mindfulness and commitment to personal values. During ACT, clients may learn to observe their anxiety as a passing experience rather than a constant problem. IPT focuses on interpersonal relationships and how they impact mental health. A client with GAD may struggle with conflict in their relationship with a sibling, contributing to their anxiety. IPT helps clients understand and address conflict, improving their relationships and reducing anxiety (Bright et al., 2019).

Medications, such as antidepressants and benzodiazepines, may also be used to treat GAD. Antidepressants can help regulate brain chemistry and improve mood. Benzodiazepines can quickly relieve anxiety symptoms but can also be habit-forming and have other potential side effects. Table 17.5 lists the medications used for GAD.

Medication	Classification	Use
Sertraline	SSRI	Often used for GAD and other anxiety disorders
Escitalopram	SSRI	Commonly prescribed for GAD
Venlafaxine	SNRI	Used to treat GAD, may have fewer side effects
Buspirone	Azapirone	A non-benzodiazepine option for chronic anxiety
Alprazolam	Benzodiazepine	Short-term relief, risk of dependence
Diazepam	Benzodiazepine	Used for acute anxiety, not typically long-term

TABLE 17.5 Medication Treatment for GAD (Bandelow, Michaelis, et al., 2017)

Self-help strategies, such as exercise, relaxation techniques, and stress management, can also help manage symptoms of GAD. Regular exercise can help to reduce anxiety and improve mood. Relaxation techniques, such as deep breathing and progressive muscle relaxation, can help to reduce muscle tension and promote relaxation. Stress management techniques, such as time management and problem-solving, can help individuals cope better with stressors (Gautam et al., 2017).

LINK TO LEARNING

Clients can use the acronym STOP (https://openstax.org/r/77STOPanxiety) to help de-escalate from moments of anxiety.

Client education and counseling are essential components of the treatment of GAD. Clients with GAD often have

misconceptions about their symptoms and may benefit from learning more about the nature of anxiety and effective coping strategies. Some individuals may dismiss their symptoms of GAD as normal stress or everyday worry, failing to recognize that the persistent and excessive anxiety they experience is a treatable medical condition (National Institute of Mental Health, 2022a). There may also be an expectation that treatment, whether medication or therapy, will provide immediate relief. In truth, treatment for GAD often requires time and consistent effort, and progress may be gradual (Mayo Clinic, 2017).

Educating clients involves informing them about the nature of GAD, including common symptoms, such as persistent worry, restlessness, and physical symptoms like fatigue and muscle tension (American Psychiatric Association, 2013). Clients should be aware that treatment may include a combination of medication and psychotherapy tailored to their unique needs and symptoms (Bandelow, Michaelis, et al., 2017). During education sessions, encouraging self-help strategies, such as mindfulness practices, stress management, and maintaining a healthy lifestyle can also be important. Engaging clients in shared decision-making and facilitating open communication with health-care providers can foster a sense of empowerment and active participation in their care, leading to better outcomes (Bandelow, Michaelis, et al., 2017). In addition, clients can benefit from learning problem-solving and communication skills to improve their relationships and reduce stress in their daily lives. Client education and counseling can be delivered in individual or group settings and supplemented with self-help books and online resources (Bandelow, Michaelis, et al., 2017).

PSYCHOSOCIAL CONSIDERATIONS

Generalized Anxiety Disorder and Aggravating Factors

The following psychosocial factors may contribute to the degree, development, and maintenance of GAD:

- Early life experiences: Traumatic or stressful experiences in childhood or adolescence, such as abuse, neglect, or loss, can increase the risk of developing GAD in adulthood.
- Family and social environment: Family and social factors, including familial stress, cultural background, and social support networks, can contribute to the development and maintenance of GAD.
- Personality traits: Individuals with certain personality traits, such as perfectionism, difficulty with uncertainty, and a high need for control, may be more prone to developing GAD.
- Cognitive and behavioral patterns: Cognitive patterns, including negative thinking and catastrophizing, as well as avoidance behaviors, can contribute to the persistence of anxiety symptoms in GAD.
- Interpersonal relationships: Difficulty with assertiveness, conflict resolution, and social skills can impact the individual's ability to manage stress and cope with anxiety symptoms.
- Work and academic stress: High levels of stress in the workplace or academic setting can trigger or exacerbate anxiety symptoms in individuals with GAD.

(National Institute of Mental Health, 2022a)

Nursing Interventions

Nurses will encounter clients suffering from GAD in all settings and at all stages of life. Nursing interventions for GAD may include assessing and monitoring the client's anxiety level and related physical symptoms, such as increased heart rate or muscle tension. Nurses can also encourage clients to express their feelings and concerns, provide active listening and support, and teach the client relaxation techniques, such as deep breathing, progressive muscle relaxation, and mindfulness. Nurses will also assist the client with identifying and challenging negative thought patterns and developing coping skills. They can educate the client and their family members on the nature of GAD, the importance of self-care, and the benefits of seeking professional help. Collaborating with the client's health-care team to develop and implement an individualized treatment plan is part of the nurse's responsibility as is administering medications as prescribed and monitoring for potential side effects. Nurses will also refer clients to community resources, such as support groups or counseling services (American Nurses Association, 2022).

CULTURAL CONTEXT

Anxiety and Culture

Culture plays an important role in the manifestation, expression, and treatment of anxiety disorders. Different cultures may have different ways of describing and experiencing anxiety symptoms, which can impact the identification and diagnosis of anxiety disorders. For example, some cultures may express anxiety symptoms primarily through somatic complaints, such as headaches or gastrointestinal problems, rather than through psychological symptoms. In addition, cultural factors, such as stigma, religious beliefs, and social support can influence an individual's willingness to seek help for anxiety symptoms and their preference for certain treatments. Some cultures may prefer traditional healing practices, such as herbal remedies or acupuncture, over Western-style psychotherapy or medication. Mental health professionals must be aware of these cultural considerations and tailor their assessment and treatment approach to provide effective care for individuals of different cultures with anxiety disorders (Tse & Haslam, 2021).

Phobias

A **phobia** is an excessive and irrational fear of a specific object, situation, or activity that is typically harmless. Unlike general fear or discomfort, a phobia is characterized by intense anxiety that can lead to avoidance behavior, severely impacting a person's daily life and functioning (American Psychiatric Association, 2013). Phobias are categorized into different types, such as specific phobias, which focus on particular objects or situations (e.g., spiders, flying); social phobias; and agoraphobia, the fear of being in places or situations where escape might be difficult (Mayo Clinic, 2023a).

Causes of Phobia

The development of phobias is thought to be influenced by a combination of genetic, environmental, and cognitive factors. One theory proposes that individuals may be genetically predisposed to developing phobias. Certain phobias (such as a fear of heights or spiders) appear more common across cultures and may have an evolutionary basis. Environmental factors, such as experiencing a traumatic event or being repeatedly exposed to a phobic stimulus, can also contribute to the development of phobias. Cognitive factors, such as a tendency to catastrophize or engage in negative self-talk, can amplify feelings of fear and anxiety in response to phobic stimuli. Additionally, social learning theory suggests that individuals may learn phobic responses through observation or the influence of significant others (Choy et al., 2007).

Several risk factors have been identified as potentially contributing to the development of phobias. One risk factor is a family history of anxiety disorders or phobias, which suggests a genetic predisposition to these conditions. Other risk factors may include exposure to traumatic events, such as physical or sexual abuse, or a history of childhood adversity. Social factors, such as being raised in an overprotective or controlling environment, may also increase the likelihood of developing phobias. In addition, temperament and personality traits, such as neuroticism or behavioral inhibition, have been associated with an increased risk of anxiety disorders and phobias. Finally, life stressors, such as job loss or relationship difficulties, may trigger the onset of phobias in susceptible individuals (Bandelow, Michaelis, et al., 2017).

Signs and Symptoms of Phobias

Phobias can manifest in both physical and psychological ways. Physical symptoms may include increased heart rate, sweating, trembling, nausea, and hyperventilation. Physical symptoms may sometimes be severe enough to cause a panic attack. Psychological/behavioral symptoms may include intense fear or anxiety, a sense of impending doom or danger, and avoidance behavior. Individuals with phobias may go to great lengths to avoid the phobic stimulus, which can interfere with daily functioning and lead to social isolation. In addition, the fear associated with phobias is often disproportionate to the actual level of danger posed by the phobic stimulus. Some individuals with phobias may also experience feelings of guilt, shame, or embarrassment about their symptoms, which can exacerbate their anxiety (Choy et al., 2007).

Types of Phobias

Phobias can be broadly categorized into specific phobias, social phobias, and agoraphobia. Intense and irrational

fear of a specific object or situation, such as heights, spiders, or flying, characterizes specific phobias. Social phobia, or social anxiety disorder, is characterized by an intense and persistent fear of social or performance situations in which others may observe or evaluate the individual. Agoraphobia is characterized by an intense fear of situations or places where escape might be difficult, or help might not be available. This fear may lead individuals to avoid situations, such as public transportation or crowded places, and make them anxious about being outside of the home. While each type of phobia has unique features, they all share a common element of fear or anxiety that interferes with daily functioning (American Psychiatric Association, 2013). Table 17.6 lists some common phobias.

Phobia	Description
Arachnophobia	Fear of spiders
Acrophobia	Fear of heights
Agoraphobia	Fear of open or crowded spaces or situations where escape might be difficult
Claustrophobia	Fear of enclosed or tight spaces
Social phobia	Fear of social or performance situations that may lead to embarrassment
Aerophobia	Fear of flying
Trypanophobia	Fear of needles or injections
Ophidiophobia	Fear of snakes

TABLE 17.6 Common Phobias (American Psychiatric Association, 2013)

LIFE-STAGE CONTEXT

Phobias in Children, Adolescents, and Older Adults

Phobias can affect individuals of any age, but age-related concerns may impact the diagnosis and treatment of phobias. In older adults, phobias may be more likely to co-occur with other medical or psychiatric conditions, complicating treatment. Older adults may also be more likely to have mobility or health problems that make it difficult to access treatment. In addition, phobias may be underdiagnosed or misdiagnosed in children and adolescents due to their unique developmental needs and concerns. For example, children may express fear or anxiety through physical symptoms or have difficulty articulating their fears. Children may be more likely to express fear or anxiety through crying, clinging to caregivers, or freezing in place. They may also have difficulty articulating their fears and may not fully understand the implications of their phobia. Adolescents may experience symptoms similar to those of adults but may have additional concerns about their social identity, such as fear of embarrassment or humiliation (Choy et al., 2007). The prevalence and specific types of phobias may vary by age group. For example, specific phobias, such as fear of animals or the dark, are more common in children, while social phobia becomes more prevalent in adolescence and young adulthood (Davis et al., 2009).

Treatment Options for Phobias

Treatment for phobias in children and adolescents may involve play therapy, parent-child interaction therapy, other age-appropriate interventions, and cognitive behavioral therapy (Davis et al., 2009). Treatment for phobias in adults may involve cognitive behavioral therapy, exposure therapy, or medication, depending on the severity of the symptoms and the individual's preferences and needs (American Psychiatric Association, 2013).

Cognitive Behavioral Therapy

Treatment for phobias typically involves a combination of psychotherapy and medication. CBT is a commonly used approach that involves cognitive restructuring techniques to assist individuals in recognizing and challenging their

irrational thoughts related to the phobia, promoting healthier thinking patterns (Choy et al., 2007).

Exposure Therapy

Exposure therapy is a widely used treatment for phobias, particularly specific phobias. This therapy involves gradually exposing the individual to the phobic stimulus in a controlled setting to reduce their fear response. Exposure therapy can be conducted in vivo, in which the individual is exposed to the actual phobic stimulus, or imaginal, in which the individual is asked to imagine the phobic stimulus. Virtual reality exposure therapy (VRET) uses technology to create controlled and safe virtual environments for exposure, proving useful for specific phobias like acrophobia or fear of flying (Donnelly et al., 2021). Exposure therapy is thought to work by allowing the individual to experience the phobic stimulus and develop new, less fearful associations with it. While exposure therapy can be challenging and uncomfortable for some individuals, it has been shown to be an effective treatment for phobias, with long-lasting benefits even after treatment has ended (Choy et al., 2007).

Psychopharmacology

Medications, such as SSRIs and benzodiazepines, may also be used to treat phobias alone or in combination with psychotherapy. Medication is typically not a first-line treatment option, however, and is usually reserved for individuals with more severe symptoms or who have not responded to psychotherapy alone (Choy et al., 2007). While medications like benzodiazepines or SSRIs may reduce anxiety symptoms, they often do not address the underlying cognitive and behavioral patterns contributing to the phobia (Mayo Clinic, 2023a). As a result, discontinuation of medication might lead to a return of symptoms, whereas the skills learned in CBT can provide ongoing management (Choy et al., 2007). Additionally, medication may come with potential side effects and risks, such as dependency on benzodiazepines, which could outweigh the benefits (Baldwin et al., 2014).

Alternative Treatments

In addition to CBT and medications, individuals with phobias may benefit from self-help techniques, such as mindfulness and relaxation techniques, that teach individuals to manage anxiety through deep breathing and focusing on the present moment, as well as lifestyle modifications, such as regular exercise and healthy sleep habits (Choy et al., 2007). Additionally, methods such as eye movement desensitization and reprocessing (EMDR) are often employed for trauma-related disorders but have been adapted to treat phobias (De Jongh et al., 2013). The effectiveness of these alternative approaches varies and might depend on individual factors, including the type and severity of the phobia, previous treatment experiences, and personal preferences.

Nursing Interventions

Nursing interventions for phobias may involve a combination of client education, counseling, and medication management. Client education can help individuals with phobias understand the nature of their symptoms and how they can effectively manage them. In addition, nurses can support clients in medication management, for example, by monitoring for potential side effects and ensuring adherence to medication regimens. Nurses may also work with individuals to develop personalized treatment plans, including exposure therapy or other forms of psychotherapy. Nurses play a crucial role in providing emotional support and helping individuals build self-confidence and self-efficacy in managing their symptoms (Yamamoto-Mitani et al., 2016).

Panic Disorders

A **panic disorder** is an anxiety reaction to stress that results in a panic attack. This can be an upsetting experience for the person having the panic attack and the people they are with. Treatment aims to reduce the number of panic attacks a person might suffer and focuses on psychological therapies and psychopharmacology (National Institute of Mental Health, 2023).

Anxiety and Panic

Anxiety and panic are common emotional responses but differ in several important ways. Anxiety is a general feeling of apprehension or worry, often about future events or uncertain situations. Panic is a sudden and intense feeling of fear or terror, often accompanied by physical symptoms, such as sweating, heart palpitations, and shortness of breath. Panic is a sudden and unexpected response to a perceived threat and is often experienced as a feeling of loss of control. Panic attacks can be triggered by a specific situation or occur spontaneously, leading to avoidance behaviors or the development of panic disorder (National Institute of Mental Health, 2023). Table 17.7 contrasts characteristics of anxiety and panic.

	Anxiety	Panic
Duration	May be short or long	Typically short
Onset	Typically gradual	Typically sudden
Symptoms	Typically mild and may include: • restlessness • irritability • muscle tension • difficulty sleeping • fatigue	Typically intense and may include: • rapid heart rate • shortness of breath • nausea • dizziness • numbness

TABLE 17.7 **Anxiety vs. Panic** (Catchings, 2019)

Panic Attack

A **panic attack** is a sudden episode of intense fear or discomfort lasting several minutes or longer. During a panic attack, an individual may experience physical symptoms, such as sweating, trembling, heart palpitations, shortness of breath, and chest pain. They may also experience psychological symptoms, such as a feeling of impending doom or a sense of losing control. Panic attacks can be triggered by a specific situation, such as public speaking or flying, or can occur spontaneously. They are a hallmark symptom of panic disorder. Panic attack symptoms can resemble symptoms of other serious health problems, so it is essential to rule out a medical reason for the physical symptoms, such as an allergic reaction, asthma attack, or myocardial infarction (National Institute of Mental Health, 2016).

According to Craske and Barlow (2008), there are two types of panic attacks: expected and unexpected. Expected panic attacks are triggered by a specific situation or object, such as public speaking or flying. The fear of having a panic attack in these situations can lead individuals to avoid them altogether, interfering with daily life. On the other hand, unexpected panic attacks occur without a clear trigger or warning. They can happen at any time, including during sleep, and can be distressing and disruptive to daily life. While the type of panic attack may differ, the symptoms and severity are similar. Panic attacks can be very intense and overwhelming and can lead to feelings of fear and loss of control.

Causes of Panic Disorder

The underlying causes of panic disorder are complex and multifactorial, often involving a combination of genetic, neurobiological, psychological, and environmental factors (Cleveland Clinic, 2023). Research has revealed a familial aggregation of panic disorder, suggesting a genetic predisposition (Na et al., 2011). Neurobiological studies have found abnormalities in certain brain structures that regulate fear and anxiety, such as the amygdala (Goddard, 2017). Psychological factors include cognitive processes that may influence the development of panic attacks, such as heightened sensitivity to bodily sensations and misinterpretation of these sensations as life-threatening (Cleveland Clinic, 2023). Additionally, exposure to stressful life events and chronic stress can contribute to the onset of panic disorder. Individuals with panic disorders have been found to have imbalances in neurotransmitters, such as serotonin and norepinephrine, which regulate mood and anxiety. These imbalances can lead to sudden and intense feelings of fear and panic (National Institute of Mental Health, 2022a).

Management of Panic Disorder

Managing panic disorder, and panic attacks specifically, requires tailoring treatment to specific clients and their triggers and symptoms. Exposure therapy and medication are common interventions, as are alternative therapies like breathing and meditation.

Exposure Therapy

Exposure therapy is a common CBT method that focuses on confronting the fears and beliefs associated with panic disorder to help individuals engage in activities they have avoided. Exposure therapy is sometimes used along with relaxation exercises. In the context of treating panic attacks, exposure therapy might include both interoceptive and situational exposures. Interoceptive exposure involves simulating bodily sensations associated with panic, such as

rapid breathing or heart palpitations, to help clients confront and become accustomed to these sensations without panic. Situational exposure, on the other hand, would involve confronting feared situations or places that might trigger a panic attack (American Psychological Association, 2017).

Exposure therapy aims to reduce the exaggerated fear response by allowing the individual to experience the feared stimulus in a safe environment. Through repeated exposures, the individual can learn to tolerate the anxiety, reevaluate the threat posed by the feared situation, and build confidence in their ability to cope (Knowles & Olatunji, 2019). Research has shown that exposure therapy can be an effective treatment for panic disorder, often leading to significant reductions in the frequency and severity of panic attacks (Kaplan & Tolin, 2011).

Medication

Medications for panic attacks typically fall into two categories: antidepressants and benzodiazepines. Antidepressants such as SSRIs and SNRIs are commonly used to treat panic attacks. These medications work by regulating levels of neurotransmitters in the brain that are associated with mood and anxiety. Antidepressants may take several weeks to start working and cause side effects, such as nausea, dry mouth, and sexual dysfunction.

Benzodiazepines are another class of medications commonly used to treat panic attacks. These medications work by enhancing the effects of a neurotransmitter called GABA, which has a calming effect on the brain. Benzodiazepines work quickly to reduce symptoms of panic but can be habit-forming and may cause drowsiness, dizziness, and impaired coordination. Medications may be combined with psychotherapy and self-help strategies to provide the most effective treatment for panic attacks (Mayo Clinic, 2018b).

Nursing Strategies and Interventions

When managing a panic attack, it is crucial for the nurse to remain calm and focused and to encourage the individual experiencing the panic attack to do the same. Rapid breathing can exacerbate the symptoms of a panic attack, so encouraging slow, deep breathing can help to reduce symptoms and promote relaxation. The nurse can coach the individual to breathe in slowly through their nose, hold for a few seconds, and then exhale slowly through their mouth.

Offering reassurance to the client can be another useful strategy. The nurse should let the individual know they are not alone and that panic attacks are a common experience. Offering encouragement and support and reminding the individual that the panic attack will pass will assist in lessening the length and severity of the attack. Grounding techniques can help the individual to stay present and focused in the moment. The nurse can encourage the individual to focus on their senses, such as the feeling of their feet on the ground or the sound of their breathing. If possible, the nurse should move the individual to a quiet, calm environment free from distractions and stimuli that may exacerbate their symptoms. The nurse may also encourage the individual to engage in self-care practices, such as exercise, healthy eating, and getting enough rest. These practices can help to reduce the frequency and intensity of panic attacks over time (Department of Respiratory Medicine, 2022).

Specific nursing interventions for panic attacks may include:

- Assessing and monitoring the client's history of panic, anxiety level, and related physical symptoms. Perform a rapid assessment of vital signs, including heart rate, blood pressure, and respiratory rate. Note any chest pain, difficulty breathing, or other symptoms.
- Encouraging clients to express their feelings and concerns and providing active listening and support.
- Using therapeutic communication techniques, such as offering reassurance and exploring coping strategies.
- Teaching the client relaxation techniques, such as deep breathing, progressive muscle relaxation, and mindfulness.
- Assisting the client with identifying and challenging negative thought patterns and developing coping skills.
- Educating the client and their family members on the nature of panic attacks, the importance of self-care, and the benefits of seeking professional help.
- Collaborating with the client's health-care team to develop and implement an individualized treatment plan.
- Administering medications as prescribed and monitoring for potential side effects.
- Documenting thoroughly by keeping detailed notes of the client's presentation, the nursing assessment, interventions, and the client's response for proper continuity of care.
- Referring the client to community resources, such as support groups or counseling services (American Nurses Association, 2022).

It is also critical to understand how to assist clients in coping after they have experienced a panic attack.

Coping after a Panic Attack

After a panic attack, it is important to encourage the client to practice self-care. Encourage the client to engage in relaxation techniques, such as deep breathing, progressive muscle relaxation, or guided imagery to help reduce stress and anxiety. Mindfulness can help the client stay present in the moment and reduce worry about future panic attacks. Encourage the client to focus on their breathing, body sensations, or surroundings to ground themselves in the present moment. Exercise can also help to reduce anxiety and promote overall physical and mental well-being. Identifying support systems is another important step in coping after a panic attack. Clients should be encouraged to reach out to family and friends for support or consider joining a support group for individuals with similar disorders. Clients should be encouraged to be kind and compassionate to themselves and avoid self-criticism or negative self-talk. Also, clients who stick to a regular routine often report reduced stress and a sense of stability and predictability (National Institute of Mental Health, 2023).

It is important to teach individuals strategies to help prevent future panic attacks. Individuals should first be educated about panic attacks, explaining the physiological and psychological components that can help reduce fear and stigma. Assisting individuals to identify and challenge irrational thoughts that may contribute to panic and replacing them with more balanced perspectives is also a good strategy. Breathing retraining exercises can also teach clients to control hyperventilation and other panic-related physical symptoms.

17.3 Obsessive–Compulsive and Related Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the causes of obsessive-compulsive disorder
- Describe the signs and symptoms of obsessive-compulsive disorder
- Give examples of treatment approaches for obsessive-compulsive disorder
- Outline considerations when planning nursing care for a person who has obsessive-compulsive disorder

One common form of anxiety-related mental disorder wherein a person has recurring thoughts and ideas that make them uncomfortable and anxious is called **obsessive-compulsive disorder (OCD)**. To relieve their anxiety, they carry out ritualistic behavior that provides some relief, but the person will usually become anxious again later. Obsessive thoughts and ritualistic behavior can restrict the person's lifestyle, causing problems at work or with relationships. The person has insight into their problem but often feels powerless to do anything. Treatment involves psychological approaches, to help people face their fears, and medication (National Institute of Mental Health, 2022b).

Causes of Obsessive-Compulsive Disorder

OCD is characterized by obsessions, recurrent, unwanted thoughts that cause anxiety. In response to these obsessions, an individual feels driven to perform repetitive behaviors or mental acts, called compulsions. Researchers believe that a complex interplay of genetic, neurobiological, and environmental factors contributes to the development of OCD (Pauls, 2008). Specifically, alterations in the brain's serotonin system and abnormalities in the brain's circuitry have been implicated in the pathophysiology of the disorder (Saxena & Rauch, 2000). Additionally, stressful life events or childhood trauma can exacerbate the onset or severity of OCD symptoms (Pauls, 2008).

REAL RN STORIES

Nurse: Jane, RN
Years in Practice: Seven
Clinical Setting: Mental Health Unit, Regional Hospital
Geographic Location: Louisiana

Jane, an experienced RN in a mental health unit, was assigned to care for a thirty-five-year-old client named Mark, who had been diagnosed with severe OCD. Mark's condition was characterized by an intense fear of contamination

and a compulsive need to perform cleaning rituals. He would wash his hands almost continuously, causing his skin to become raw and chapped. The need to clean his hands and surroundings was disrupting his ability to lead a normal life, severely impacting his interpersonal relationships.

In addition to the standard care plan for OCD, Jane tailored her approach to Mark's specific symptoms. Recognizing that his fear of contamination was the central issue, she worked with the treatment team to design a care plan that included exposure therapy. The therapy involved gradually exposing Mark to objects he considered contaminated while supporting him in resisting the urge to perform his compulsive cleaning rituals.

Jane maintained an empathetic and client-centered approach throughout this process, allowing Mark to express his feelings and concerns. She made a point of involving him in the decision-making process, setting attainable goals, and praising his efforts and progress.

The therapeutic relationship between Jane and Mark was essential in creating a safe environment for Mark to challenge his compulsive behaviors. Jane's understanding of the nature of OCD, combined with her compassionate and individualized approach, facilitated Mark's progress in therapy. Over time, Mark reduced his compulsive behaviors and improved his overall quality of life. The success of this case emphasizes the crucial role that nurses play in the care and recovery of clients with mental health conditions, such as OCD.

Signs and Symptoms of OCD

Manifestations of OCD can vary widely, but common obsessions include fears of germs or other kinds of contamination; unwanted intrusive thoughts, especially of a sexual or religious nature; thoughts of harm to self or others; and an **obsession** with symmetry, order, or routine (National Institute of Mental Health, 2022b). Some of the most commonly reported compulsions are excessive handwashing, excessive cleaning or organizing, compulsive counting, and repeatedly checking and rechecking the condition of objects, such as door locks, light switches, or electrical appliances (National Institute of Mental Health, 2022b). These obsessions and compulsions can cause significant distress and impairment in an individual's daily functioning, relationships, and overall quality of life (American Psychiatric Association, 2013).

The OCD cycle (Figure 17.8) is a continuous loop consisting of four stages: obsession, anxiety, **compulsion**, and temporary relief. In the first stage, an individual experiences an intrusive and unwanted thought, image, or urge (obsession) that elicits feelings of distress or anxiety. To alleviate this distress, the individual engages in a repetitive behavior or mental act (compulsion). The compulsion provides a temporary sense of relief from the anxiety, but the obsession soon returns, perpetuating the cycle. The repeating nature of the OCD cycle can make it difficult for individuals to break free from the pattern and can lead to a significant impairment in their daily lives (Foa et al., 1995).

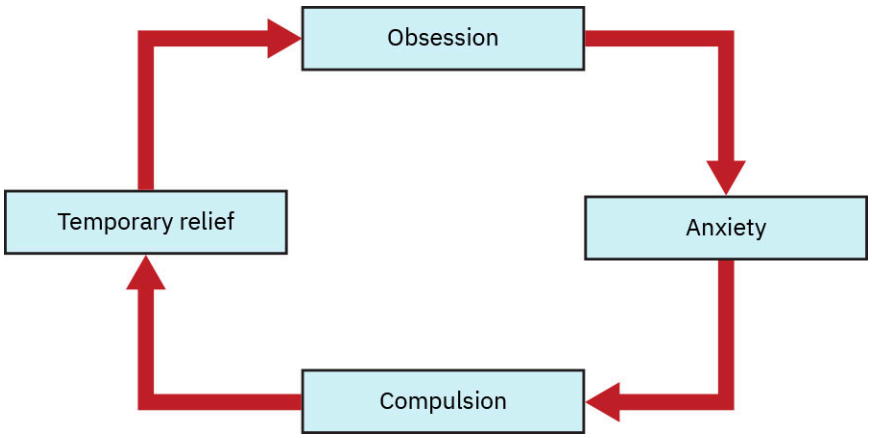


FIGURE 17.8 In the OCD cycle, obsessive thoughts and anxiety lead to compulsive behavior that brings only temporary relief before the cycle restarts. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Treatment of OCD

Various evidence-based treatment options are available for individuals with OCD to reduce symptoms and improve the overall quality of life. CBT—particularly a specialized form called **exposure and response prevention (ERP)**—has

been found to be highly effective in treating OCD (Hezel & Simpson, 2019; National Institute of Mental Health, 2022b). ERP involves gradually exposing oneself to anxiety-provoking stimuli while simultaneously refraining from engaging in compulsions, leading to a reduction of anxiety over time (National Institute of Mental Health, 2022b). Pharmacological treatments, particularly SSRIs, have also demonstrated efficacy in alleviating OCD symptoms (National Institute of Mental Health, 2022b). Commonly prescribed SSRIs include fluoxetine, sertraline, and fluvoxamine (American Psychiatric Association, 2013) (Table 17.8).

Medication	Class
Fluoxetine (Prozac)	Selective serotonin reuptake inhibitor
Fluvoxamine (Luvox)	Selective serotonin reuptake inhibitor
Sertraline (Zoloft)	Selective serotonin reuptake inhibitor
Clomipramine (Anafranil)	Tricyclic antidepressant

TABLE 17.8 Medications Commonly Used for Treatment of OCD (Mayo Clinic, 2023b)

Imaginal Exposure

Another CBT technique commonly used to treat OCD is called **imaginal exposure**, which involves mentally confronting and engaging with a feared situation, traumatic memory, or anxiety-provoking thought in a safe and controlled environment. This technique aims to help individuals process their fears, reduce anxiety, and learn effective coping strategies. For example, suppose a client with OCD has an intense fear of contamination from germs that she believes will cause a deadly illness to her family members. Her compulsions involve excessive washing and avoiding physical contact with her children. Direct exposure might be too overwhelming for her at the beginning of treatment.

In an imaginal exposure session, the therapist asks the client to imagine touching a doorknob without washing her hands and then hugging her children. They create a vivid description of the scene, involving all sensory details, and the therapist guides the client to visualize it repeatedly. The therapist encourages the client to experience anxiety and discomfort without engaging in compulsive washing behavior. They repeat the exposure several times during and in subsequent sessions until the anxiety associated with the imagined scenario diminishes. This technique allows the client to confront and gradually habituate to the fear in a controlled setting, thereby reducing the anxiety associated with the feared contamination (Peterson et al., 2019).

Habit Reversal Training

A behavioral therapy technique primarily used for treating tic disorders and body-focused repetitive behaviors (BFRBs), such as hair pulling (trichotillomania) and skin picking (excoriation disorder), is **habit reversal training (HRT)**. Although HRT is not specifically designed for OCD, it can be adapted and used with other therapeutic approaches to manage some OCD symptoms, particularly those involving compulsive behaviors (Lee et al., 2019). HRT consists of several steps:

- Awareness training: This step involves helping the individual become more aware of their compulsive behavior, the triggers, and the situations in which they are most likely to engage. For example, a client with OCD who has a compulsive habit of repeatedly checking the stove to ensure it is off may be assisted to recognize the specific circumstances, feelings, and thoughts that trigger the compulsive stove checking.
- Competing response training: The individual learns a new, healthier behavior to replace the compulsive one. This competing response should be incompatible with the compulsive behavior and should be practiced whenever the urge to engage in the compulsive behavior arises. Together, the client and therapist develop a healthier response to the identified triggers. For instance, they might decide that the client will check the stove once, take a photograph with his phone, and then leave the house, using the photograph to reassure himself if he feels the urge to check again.
- Social support: It can be beneficial to enlist the help of friends, family, or a support group to provide encouragement and reinforcement for practicing the competing response. A family member or friend may be

involved to support the client and remind them to use the new coping strategy if they notice them engaging in compulsive behavior.
- Motivation enhancement: Techniques to increase motivation for change, such as identifying the personal benefits of stopping the compulsive behavior, can help the individual stay committed to the habit reversal process. The therapist helps the client understand the negative impact of the compulsive checking and the benefits of the new behavior, reinforcing motivation to change.
- Generalization: The individual is encouraged to apply the competing response in different situations and environments to generalize their new behavior and reduce the likelihood of relapse (Azrin & Nunn, 1973). Strategies are discussed to prevent a return to the compulsive behavior, and the client is encouraged to use the newly learned techniques if the urge returns.

Traditional treatments for OCD usually involve a combination of medication and psychotherapy, with ERP being the most effective therapeutic approach. In cases where ERP is not entirely effective or when the compulsive behaviors are more habit-like, HRT may be an effective adjunctive intervention to help manage compulsive behaviors in OCD (Lee et al., 2019).

Medication

Medications are often used alongside psychotherapy for OCD. The most common medications for OCD are SSRIs, which are considered the first-line pharmacological treatment due to their efficacy and tolerability. Some common SSRIs used for OCD include:

- fluoxetine (Prozac)
- sertraline (Zoloft)
- fluvoxamine (Luvox)
- paroxetine (Paxil)
- citalopram (Celexa)
- escitalopram (Lexapro)

Benzodiazepines, such as diazepam (Valium) and lorazepam (Ativan), are sometimes used for short-term relief of anxiety associated with OCD. Tricyclic antidepressants (TCAs) are an older class of antidepressants that affect multiple neurotransmitters, including serotonin and norepinephrine. The TCA clomipramine (Anafranil) has been specifically approved for treating OCD and is often used when SSRIs are ineffective or not tolerated. TCAs do have more side effects than SSRIs, so they are not considered first-line treatment (International OCD Foundation, 2023).

Gamma Knife

Gamma knife treatment is a noninvasive surgical procedure that uses radiation to destroy targeted brain tissue. While it is typically used to treat tumors and other abnormalities, it has also been used as a treatment for severe cases of OCD that have not responded to other forms of treatment. The procedure involves using multiple beams of gamma radiation to precisely target the area of the brain that is responsible for OCD symptoms. It is thought to disrupt the abnormal neural circuitry contributing to OCD symptoms. While gamma knife treatment may be effective for some individuals with severe OCD, it is not a first-line treatment option and is typically reserved for cases that have not responded to other forms of treatment (International OCD Foundation, 2023).

Deep Brain Stimulation and Transcranial Magnetic Stimulation

Researchers are studying both deep brain stimulation (DBS) and transcranial magnetic stimulation (TMS) as potential treatments for OCD. DBS involves the surgical implantation of electrodes in specific areas of the brain that are believed to be involved in OCD, followed by electrical stimulation of those areas. Studies have shown that DBS can effectively reduce OCD symptoms in some clients. DBS is invasive though and there are many risks associated with brain surgery.

TMS is a noninvasive procedure that uses magnetic fields to stimulate specific brain areas; it is approved for treating conditions like depression and certain anxiety disorders (Perera et al., 2016). While results in treating OCD have been mixed, some studies have found TMS effective in reducing symptoms (Rapinesi et al., 2019). TMS has become more accessible and is available in various settings, including a physician's office. Conducting TMS in a physician's office allows for more convenient access to treatment for clients. It may also promote collaboration between the client's existing health-care providers, fostering a more integrated approach to care (Dunner et al., 2014). The treatment involves multiple sessions, often over four to six weeks. TMS provides an additional option for clients who

have not responded to traditional therapies (Maslenikov et al., 2017).

Self-Help for OCD

Regardless of their treatment, nurses should encourage clients to educate themselves about OCD to understand the disorder and how it affects daily life. Keeping a journal to identify situations or thoughts that trigger OCD symptoms is a helpful way to deal with the disorder by challenging negative thoughts with positive, realistic thoughts. Clients should also get adequate rest, a balanced diet, and adequate physical activity. Setting small goals and recognizing that the recovery process may be slow is important for the client to consider to prevent further negative thoughts about themselves (Jassi et al., 2020).

Nursing Interventions for OCD

Nurses can help monitor medication side effects and provide education about medication use. The nurse can also educate the client on relaxation techniques, such as deep breathing, progressive muscle relaxation, or meditation to help reduce anxiety and stress. Time management strategies can help establish a daily routine that reduces anxiety and increases control. The nurse can also assist the client in locating a support group for people with OCD that will allow them to connect with others with similar experiences and provide emotional support (El et al., 2023).

17.4 Trauma-Induced and Stress-Related Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the causes, symptoms, and interventions for a person with body dysmorphic disorder
- Outline the causes, symptoms, and interventions for a person with hoarding disorder
- Outline the causes, symptoms, and treatment approaches for a person with trichotillomania
- Outline the causes, symptoms, and treatment approaches for a person with excoriation
- Outline the causes, symptoms, and treatment approaches for a person with post-traumatic stress disorder
- Outline the causes, symptoms, and treatment approaches for a person with acute stress disorder
- Outline the causes, symptoms, and treatment approaches for a person with attachment disorder

There are a range of disorders that are induced by trauma and stress. Post-traumatic stress disorder (PTSD), for instance, has gained attention because of veterans of wars who suffer from it. Hoarding has also captured media attention. Other disorders remain somewhat less known and private in that they do not attract national attention, including body dysmorphic disorder, trichotillomania, excoriation, acute stress disorder, and attachment disorder.

Body Dysmorphic Disorder

The mental disorder in which a person is preoccupied with perceived defects or flaws in their appearance is called **body dysmorphic disorder (BDD)**. For example, people with BDD may believe they look unattractive, their skin is too oily, or their nose is too big or crooked. They often obsess over these perceived flaws and attempt to disguise them with clothing or makeup. People with BDD are often highly self-critical and may fear being judged by others. BDD can cause significant distress and interfere with daily functioning. It can also lead to social withdrawal, occupational difficulties, and suicidal thoughts (Jaroszewski & Wilheim, 2022).

BDD is thought to be related to low self-esteem, anxiety, and depression. Treatment for BDD typically involves a combination of psychotherapy, medications, and lifestyle changes. CBT is the most commonly used type of psychotherapy for BDD. It helps people to identify and challenge unhelpful thoughts and behaviors related to their appearance. Medications like Selective serotonin reuptake inhibitors (SSRIs) may also reduce anxiety and associated depression (Jaroszewski & Wilheim, 2022).

Causes of Body Dysmorphic Disorder

BDD is not simply a case of being self-conscious. It is a mental health disorder that can cause significant distress and impairment in daily functioning. The causes of BDD are not entirely understood, but the disorder is likely due to a combination of biological, psychological, and environmental factors. Brain imaging studies suggest that people with BDD may have differences in how their brains process information (Buchanan et al., 2013). Psychological factors may also play a role, as people with BDD often fear negative evaluations from others. Environmental factors, such as having experienced teasing or bullying, may also influence the onset of BDD (Jaroszewski & Wilheim, 2022).

Onset and Course of BDD

The onset of BDD typically occurs in late adolescence or early adulthood. It is estimated that up to 2.4 percent of the population may be affected by BDD, with higher rates in higher socioeconomic groups (Jaroszewski & Wilheim, 2022). The course of the disorder can be chronic and often coexists with other mental health conditions, such as depression and anxiety disorders (Phillips et al., 2005).

Prevalence

BDD is more commonly found in young adults, with a mean age of onset of fifteen to sixteen. In addition, BDD is more commonly seen in women, although signs and symptoms may be seen more frequently in men as they age (Jaroszewski & Wilheim, 2022). The exact prevalence of BDD is challenging to estimate due to the shame and secrecy surrounding this condition. As a result, BDD often goes undiagnosed or misdiagnosed. Individuals with BDD may be reluctant to seek help or they present with other symptoms consistent with other mental health conditions, such as depression, social anxiety, or eating disorders (Enander et al., 2018).

Signs and Symptoms of BDD

Signs and symptoms of BDD include preoccupation with an imagined or exaggerated physical flaw, such as a blemish, scar, or other perceived defect; engaging in repetitive behaviors, such as checking mirrors multiple times a day, excessive grooming, or skin picking; avoiding social activities, such as going to the beach, because of embarrassment over perceived flaws; spending excessive amounts of time comparing oneself to others; wearing heavy makeup, hats, or clothing to hide perceived flaws; engaging in cosmetic surgery or other medical treatments in an attempt to fix perceived flaws; seeking reassurance from friends and family about perceived flaws; and experiencing anxiety, depression, or suicidal thoughts related to perceived flaws (Jaroszewski & Wilheim, 2022).

LINK TO LEARNING

The video titled *Because I'm Ugly: Body Dysmorphic Disorder and Me* (https://openstax.org/r/77dysmorphia) explores the challenges of living with BDD through the real-life testimony of Elias, a seventeen-year-old boy with the disorder.

Diagnosing BDD

BDD can be complex and requires a comprehensive assessment by a mental health professional. It is crucial to assess the client's emotional response to their perceived flaws, the time spent focusing on them, and the impact on daily functioning. Treatment history, family history, and comorbidity with other disorders, such as anxiety and depression, should also come up during the diagnostic process (Thanveer & Khunger, 2016).

Treating BDD

There are several treatments for BDD, ranging from psychotherapy to medication. CBT, especially when tailored specifically to BDD, has been found to be highly effective in reducing symptoms (Veale et al., 2014). Alongside CBT, SSRIs have proven beneficial for some individuals (Castle et al., 2021). An integrative approach that involves collaboration between therapists, psychiatrists, and other health-care providers, such as nurses, can result in more effective care (Harrison et al., 2016).

Cognitive Behavioral Therapy

CBT is a talk therapy that helps people identify and change negative thoughts and behaviors. It is often used to treat BDD, as it can help people learn to challenge distorted thoughts about their appearance and replace them with more realistic ones. CBT also helps people learn to manage their anxiety, practice healthy self-care, and reframe their relationship with their bodies (Harrison et al., 2016).

Exposure/Response Prevention

Body dysmorphia exposure and response prevention (BD ERP) is a form of CBT used to treat BDD by exposing the client to their feared body image so they can learn how to manage their reactions to it. The first step in BD ERP is for the individual to identify and then confront their fears around their body image. The therapist will then help the individual gradually face these fears by exposing themselves to the feared body image. Next, the individual will learn how to manage their anxiety and distress when exposed to the feared body image, such as by using relaxation

techniques. During treatment, the individual will engage in activities and behaviors that challenge their negative beliefs about their appearance. These could include participating in activities they have previously avoided due to their body image concerns, such as looking in the mirror, going to the beach, or wearing certain clothing. The ultimate goal of BD ERP is for the individual to accept and manage their body image without feeling extreme distress or anxiety (Reid et al., 2021).

Medications

Medications can help treat BDD, but they are typically used in conjunction with therapy, such as CBT or other forms of psychotherapy. Some medications that may be used to treat BDD include SSRIs, which can help alleviate the symptoms of depression and anxiety often associated with BDD; they may also help reduce obsessive-compulsive symptoms common in BDD (Mayo Clinic, 2021b). SSRIs are not a cure for BDD. They can only help reduce the severity of some symptoms.

Antipsychotic medications can help manage symptoms of delusions or paranoia that may be present in some individuals with BDD. They may also help reduce obsessive-compulsive symptoms. There is no antipsychotic medication specifically designed to treat body dysmorphia, though certain antipsychotic medications, such as olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), clozapine (Clozaril), and aripiprazole (Abilify), have been used (Castle et al., 2021).

Self-Help Resources for BDD

Self-help strategies can be helpful in the treatment of BDD. Online self-help programs, incorporating psychoeducational materials and interactive exercises, can help individuals with mild to moderate symptoms (Enander et al., 2014). Additional self-help resources include:

- Body Dysmorphic Disorder Foundation: Visit the BDD Foundation website (https://openstax.org/r/77BDDwebsite) for information, resources, and support.
- Distraction techniques: Develop strategies to help focus attention away from perceived flaws and on other activities, such as exercise, hobbies, or spending time with friends and family.
- Support groups: Connect with others with body dysmorphia or similar mental health concerns. Support groups can provide a safe and nonjudgmental environment to share experiences and learn from others.
- Healthy coping skills: Find healthy ways to cope with body dysmorphia, such as journaling, yoga, mindfulness, art, and music.

Nursing Interventions

Nurses can assess the client's perception of their body image, assist the client with associated distress or impairment, and help with the condition's impact on their daily lives. Nurses can also educate clients on the nature of BDD, its symptoms, and its effect on their mental health, which can alleviate feelings of shame or guilt. Nurses may assist the client to develop healthy coping mechanisms to manage negative feelings associated with body dysmorphia. Nurses can monitor the client's progress, manage any medications, evaluate the effectiveness of interventions, and adjust the treatment plan as needed to help clients achieve their treatment goals and improve their overall quality of life (Perkins, 2019).

The concept of offering self is important for clients dealing with BDD. A nurse offers self by spending time with the client and building a relationship to ensure the client becomes comfortable discussing sensitive issues. Therapeutic communication with a client with BDD is a critical skill for nurses, as it forms the foundation of effective care for individuals struggling with this complex condition. Effective communication requires a nonjudgmental and empathetic approach, recognizing that the client's concerns about appearance are intensely real and distressing to them. Open-ended questions and reflective listening can facilitate understanding of the client's feelings and thoughts without reinforcing the distortions associated with BDD. Encouraging and supporting clients in expressing their feelings about their appearance without agreeing with their distorted self-image helps in building trust (Perkins, 2019). Nurses can encourage clients to develop a positive body image by focusing on their strengths and abilities, engaging in positive self-talk, and engaging in activities that promote self-care and well-being. Nurses may also encourage the client's engagement in social support networks, such as family, friends, or support groups. These types of engagement can help the individual feel less isolated and provide a safe space to discuss their concerns (Perkins, 2019).

Hoarding

The mental health condition characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value is **hoarding disorder**. Hoarding behavior can lead to cluttered living spaces that can be hazardous or unsanitary and can interfere with daily activities, such as cooking, cleaning, and sleeping (American Psychiatric Association, 2021).

Causes and Incidence of Hoarding Disorder

The incidence of hoarding disorder in the general population is not well established, but it is believed to affect between 1.5 percent and 6 percent of adults. Hoarding disorder is more common in older adults, with prevalence rates increasing in those over sixty-five. Women are also more likely than men to develop hoarding disorder (Postlethwaite et al., 2019). While the exact cause of hoarding disorder is unknown, it is thought to be associated with various factors, such as genetics, brain structure and function, and life experiences. Individuals with a hoarding disorder tend to have a history of traumatic or stressful events, such as the loss of a loved one, divorce, or physical abuse, which may contribute to the onset or exacerbation of hoarding behaviors (Fontenelle et al., 2021). A family history of hoarding and underlying genetic factors may also play a role in the development of this disorder (Dozier & Ayers, 2017). Traumatic early life experiences can shape attachment to possessions and difficulty discarding items. Individuals who grew up in a cluttered home or experienced parental deprivation have been shown to form unhealthy attachments to items (Kehoe & Egan, 2019). Interpersonal difficulties and social isolation are often both a cause and consequence of hoarding, leading to a vicious cycle that reinforces the behavior. In addition, individuals with hoarding disorder may also be more likely to have other psychiatric conditions, such as anxiety, depression, or obsessive-compulsive disorder (American Psychiatric Association, 2013).

Signs and Symptoms of Hoarding Disorder

Individuals with hoarding disorder experience distress or anxiety at the thought of discarding possessions. They feel a sense of attachment or emotional significance to the items they hoard. Hoarding behavior can lead to social isolation, because individuals may be embarrassed or ashamed of their living conditions and avoid inviting others into their homes (Mayo Clinic, 2018a). Physical symptoms of hoarding disorder may include respiratory problems and evidence of falls or other injuries. The accumulation of items and neglect of household maintenance can lead to dust accumulation, mold growth, and poor air quality, all of which can exacerbate or cause respiratory problems. Difficulty maneuvering through cluttered spaces may lead to falls and other injuries (American Lung Association, 2021). There is also an increased risk of fire or other hazards due to the cluttered living environment (Mayo Clinic, 2018a).

Diagnosing Hoarding Disorder

The diagnosis of hoarding disorder is based on a thorough clinical assessment of the individual's symptoms and behaviors. Diagnostic criteria for hoarding disorder include persistent difficulty discarding or parting with possessions, regardless of their actual value, and cluttered living spaces that interfere with daily activities. To be diagnosed with hoarding disorder, an individual must experience significant distress or impairment due to hoarding behavior. Diagnosis may also involve ruling out other conditions contributing to the individual's symptoms, such as obsessive-compulsive disorder or major depressive disorder. Diagnostic assessments for hoarding disorder may include interviews with the individual and their family members and observation of their living environment. The diagnosis of hoarding disorder can be complex and may require a multidisciplinary approach involving mental health providers, primary care physicians, and other specialists as needed (American Psychiatric Association, 2013).

Several assessment scales evaluate the severity of hoarding disorder and track symptom changes over time:

- Saving Inventory-Revised (SI-R): The SI-R is a self-report measure that assesses the severity of hoarding symptoms and related features, such as indecisiveness, clutter, and excessive acquisition.
- Hoarding Rating Scale (HRS): The HRS is a clinician-administered tool that assesses the severity of hoarding symptoms and associated features, such as functional impairment and distress.
- Clutter Image Rating (CIR): The CIR is a visual rating scale that assesses the severity of clutter in the individual's living environment.
- Home Environment and Living Inventory (HEAL): The HEAL is a comprehensive assessment tool that evaluates the individual's living environment and functional ability, including mobility and social support.

These assessment scales can be used to inform treatment planning and evaluate the effectiveness of interventions over time. No single assessment scale is definitive, however, and it is essential to perform a thorough clinical assessment that considers the individual's unique circumstances and needs (International OCD Foundation, 2023).

Treating Hoarding Disorder

Treatment for hoarding disorder typically involves a combination of medication and psychotherapy, such as cognitive behavioral therapy or exposure therapy. In addition, environmental interventions, such as professional organizing or cleaning services, may also help address the physical aspects of hoarding behavior (American Psychiatric Association, 2013).

Cognitive Behavioral Therapy

CBT is a commonly used treatment approach for hoarding disorder. CBT for hoarding disorder typically involves a combination of individual and group therapy sessions and aims to address the underlying beliefs and thought patterns that contribute to hoarding behavior. In CBT, individuals learn to identify and challenge negative thoughts and beliefs about possessions and develop new, more adaptive ways of thinking. CBT may also involve exposure therapy, in which individuals are gradually exposed to the anxiety-provoking situations associated with discarding possessions. In addition, CBT may incorporate skills training in areas, such as organization, decision-making, and time management, to improve the individual's ability to manage their living environment and daily activities. While CBT is generally considered an effective treatment for hoarding disorder, it may not be effective for all individuals (International OCD Foundation, 2023).

The Effectiveness of Medication

Medication treatment for hoarding disorder often accompanies psychotherapy. The Food and Drug Administration (FDA) has not approved any specific medication for the treatment of hoarding disorder, but medications commonly used to treat other psychiatric conditions may effectively reduce the symptoms of anxiety and depression that are often associated with hoarding disorder. These medications may also help to reduce urges to acquire possessions and may improve decision-making around discarding possessions. Other off-label medications to treat hoarding disorder include atypical antipsychotics and mood stabilizers, although there exists limited evidence for their effectiveness (International OCD Foundation, 2023).

Interventions Involving the Family

Hoarding disorder can significantly impact the afflicted individual's family and loved ones. Family members may experience distress or frustration due to the individual's hoarding behavior and may feel overwhelmed or helpless in their efforts to intervene. Thus, family involvement in treatment can be an important component of hoarding disorder management. Family may participate in education about the disorder and its impact on the family, training in communication and problem-solving skills, and involvement in the individual's treatment planning and decision-making. Family members may also play a role in the practical aspects of hoarding disorder treatment, such as assisting with decluttering or organizing the individual's living space. It is important to approach family involvement in hoarding disorder treatment in a collaborative and nonjudgmental manner and to consider each individual and family's unique needs and circumstances (International OCD Foundation, 2023).

Nursing Interventions

The nurse's role in assessing and managing hoarding disorder may involve client education, counseling, and referral to specialized mental health providers as needed. A nurse must perform a thorough assessment of mental and physical health, including evaluating the living environment and its potential impact on physical health, and educate the client about the disorder (Millen et al., 2017). Educating clients about the disorder, including symptoms, causes, and treatment options, can reduce stigma and promote engagement in treatment. Building trust through empathetic and nonjudgmental communication is vital. Nurses can reinforce therapeutic strategies taught in CBT and manage medications (Bodryzlova et al., 2019). Nurses can work with clients to create a safe living environment (Rodriguez et al., 2016). Linking clients with community resources, support groups, or specialized hoarding interventions can further support treatment (Weir, 2020). Nurses must recognize the complexity of the disorder and approach care with dignity, empathy, and an understanding of the unique challenges faced by individuals with this disorder.

Trichotillomania

The mental health disorder **trichotillomania** is characterized by a chronic need to pull out one's hair. This disorder

falls under obsessive-compulsive and related disorders and can lead to distressing physical and emotional symptoms (American Psychiatric Association, 2013). Understanding trichotillomania is essential as clients may present with noticeable hair loss, skin damage, and related complications, such as infection.

Causes and Risk Factors for Trichotillomania

Trichotillomania occurs in 1.7 percent of the population, equally in males and females (Grant et al., 2020). The causes of trichotillomania are believed to be genetic, environmental, and psychological factors. Research suggests that trichotillomania may be associated with abnormalities in brain structure and function, including alterations in neurotransmitters, such as dopamine, serotonin, and glutamate. Trauma, stress, and other life events may also contribute to the development of trichotillomania. A family history of trichotillomania or other psychiatric conditions may increase an individual's risk of developing the disorder, suggesting a genetic component to the disorder. Age is also a potential risk factor for trichotillomania, with onset typically occurring in childhood or adolescence, although the disorder may also develop in adulthood. Stress and other environmental factors may trigger or exacerbate symptoms of trichotillomania, although researchers do not yet understand the exact nature of these factors and their relationship to the disorder. Stressful life events, such as trauma, abuse, or changes in family or work situations, may contribute to the development or worsening of trichotillomania symptoms (American Psychiatric Association, 2013).

Symptoms of Trichotillomania

Individuals with trichotillomania may pull hair from any body part, including the scalp, eyelashes, and eyebrows. Hairpulling may be accompanied by feelings of tension or anxiety before pulling and a sense of relief or pleasure after pulling. The hairpulling may be intentional or automatic and may occur in response to specific triggers or situations. In addition to hair loss, individuals with trichotillomania may experience a range of physical symptoms, including skin damage, infections, and scarring, as well as emotional symptoms, such as distress or embarrassment about their appearance or behavior. There may be noticeable hair loss or bald patches, or the individual may chew on the hair they pull out. The disorder can lead to significant distress and social or occupational impairment (American Psychiatric Association, 2013).

Diagnosis of Trichotillomania

The diagnosis of trichotillomania is based on a thorough clinical assessment that includes a detailed history of the individual's hairpulling behavior, physical examination, and assessment of any associated symptoms or psychiatric conditions. To meet the diagnostic criteria for trichotillomania, the hairpulling behavior must result in hair loss and significant distress or impairment in social, occupational, or other important areas of functioning. The hairpulling must also not be attributable to another medical condition or substance use and must not be better accounted for by another mental disorder. In some cases, laboratory tests or imaging studies may rule out other potential causes of hair loss (American Psychiatric Association, 2013).

PSYCHOSOCIAL CONSIDERATIONS

A Social Perspective on Trichotillomania

While genetic and neurological factors may contribute to trichotillomania, psychosocial factors can also play a role in the development of the disorder. These factors include stress and anxiety, lack of social support, shame and embarrassment, and family dynamics (American Psychiatric Association, 2013). This disorder often begins in childhood or adolescence and can be associated with stress, anxiety, and underlying emotional challenges (Franklin et al., 2011). Socially, individuals with trichotillomania may experience embarrassment or shame due to noticeable hair loss, leading to withdrawal from social interactions, negative self-image, and potential impact on relationships with friends and family (Mason, 2018).

Treatment Approaches for Trichotillomania

Trichotillomania is a challenging disorder, and no single "gold standard" treatment works for everyone. Treatment typically involves a combination of medication and psychotherapy to reduce hairpulling behavior, minimize hair loss, and improve overall functioning and quality of life. SSRIs and other medications that affect serotonin and dopamine levels in the brain may work to treat the underlying anxiety and mood symptoms associated with trichotillomania. Psychotherapy, such as CBT or habit reversal training (HRT), can help individuals learn to recognize and control the

urge to pull their hair and develop alternative coping strategies to manage their anxiety and stress. In addition, support groups and educational resources can help promote coping and self-management strategies. Treatment for trichotillomania should be tailored to the individual's unique needs and circumstances and may require ongoing monitoring and adjustment over time (American Psychiatric Association, 2013).

HRT is a specific form of CBT that is often used in the treatment of trichotillomania. HRT involves identifying the triggers or situations that lead to hairpulling and developing alternative responses or behaviors to replace the hairpulling. For example, an individual is taught to recognize the urge to pull their hair and instead squeeze a stress ball or engage in a relaxing activity. HRT also involves increasing awareness of hairpulling behavior, tracking the frequency and severity of hairpulling, and addressing any underlying emotional or psychological factors that may contribute to the behavior. HRT has been shown to be an effective treatment for trichotillomania and may be used alone or in combination with medication and other forms of therapy (Morris et al., 2013).

Nursing Interventions

Nursing interventions may involve education about trichotillomania and its impact on the individual's health and well-being, as well as strategies for managing hairpulling behavior and promoting self-care. Nurses can also assist individuals in developing coping strategies and self-management techniques, such as mindfulness meditation or relaxation exercises, to help reduce anxiety and stress. In addition, nurses can work with individuals and their families to address any personal issues related to the disorder, such as stigma, social isolation, or relationship difficulties (Anderson, 2011).

Excoriation

Skin picking disorder, or **excoriation**, is a psychiatric condition classified under the obsessive-compulsive and related disorders category that involves repetitive and compulsive picking at the skin, leading to tissue damage, scarring, and sometimes serious medical complications like infections. The behavior is often driven by anxiety, stress, or underlying emotional conflicts and can become a chronic problem affecting various body areas (American Psychiatric Association, 2013). Clients may present with various physical manifestations, ranging from mild redness to severe wounds. A client-centered approach that thoroughly assesses the physical symptoms, underlying psychiatric conditions, and the psychosocial context is vital (Anderson & Clarke, 2017) (Figure 17.9).

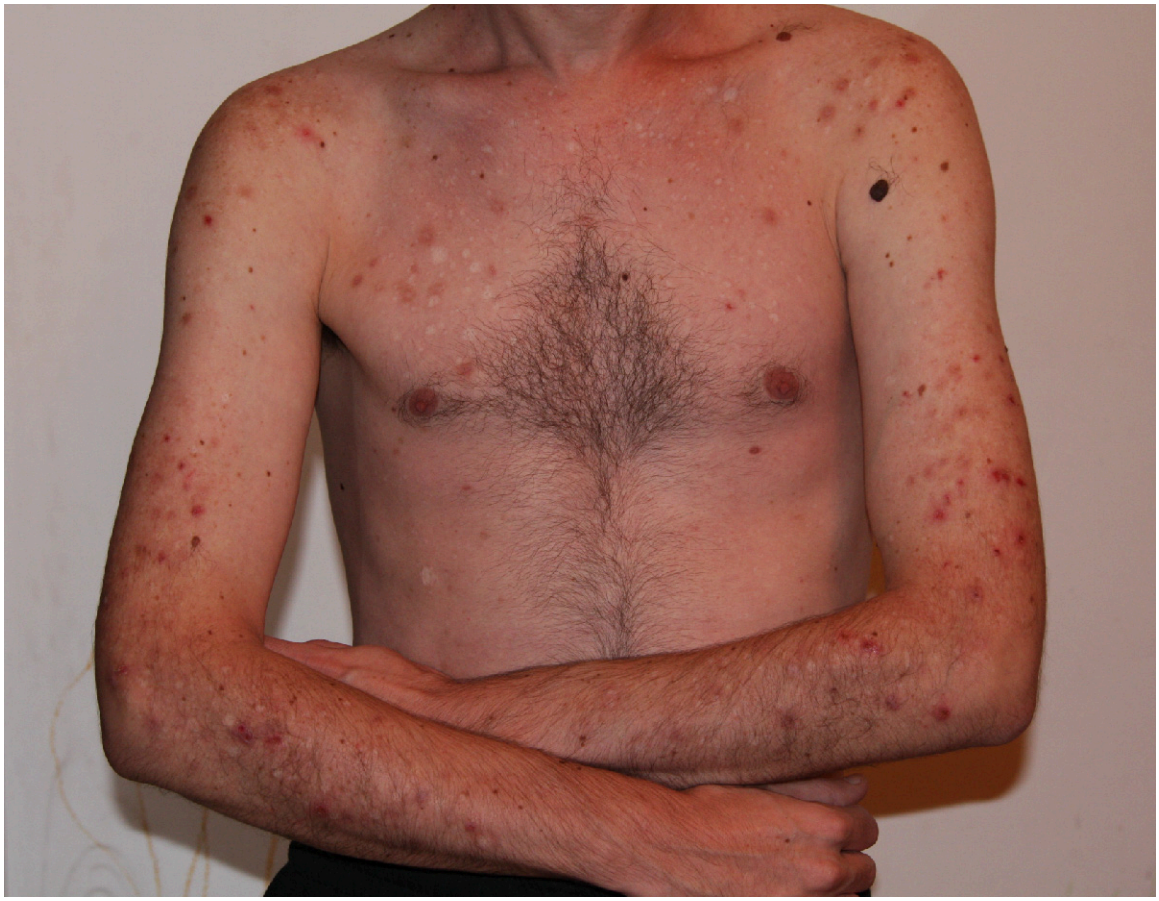


FIGURE 17.9 Excoriation can cause scars that can be seen by other people. (credit: "Derma me" by "Friend: professional photographer"/Wikimedia Commons, Public Domain)

Causes of Excoriation

The causes of excoriation are not fully understood, but it is believed to be related to genetic, environmental, and psychological factors. Research suggests that excoriation may be associated with abnormalities in brain structure and function, including alterations in neurotransmitters such as dopamine, serotonin, and glutamate. Trauma, stress, and other life events may also contribute to the development of excoriation. In addition, excoriation is often associated with other psychiatric conditions, such as anxiety, depression, or obsessive-compulsive disorder, and individuals with a family history of these conditions may be at increased risk of developing excoriation (American Psychiatric Association, 2013).

Signs, Symptoms, and Incidence of Excoriation

Individuals with excoriation may pick skin from any body part, including the face, arms, legs, and back. Skin picking may be accompanied by feelings of tension or anxiety before picking and a sense of relief or pleasure after picking. Skin picking can range from mild to severe and may lead to various physical and psychological symptoms. Physical symptoms may include skin lesions, scarring, infections, and other skin damage, as well as pain or discomfort. Psychological symptoms may include shame, guilt, anxiety, or depression and may interfere with social, occupational, or other areas of functioning (American Psychiatric Association, 2013).

The exact incidence of excoriation disorder is not well-established because it is often underdiagnosed and may be difficult to distinguish from other skin conditions or disorders. Some studies suggest that the prevalence of excoriation may be relatively high, particularly among individuals with other psychiatric conditions, such as obsessive-compulsive disorder or anxiety. For example, one study found that approximately 3.1 percent of adults aged eighteen to sixty-nine reported symptoms of excoriation in their lifetime. The disorder appears more common in females than males and often develops in adolescence or young adulthood (Grant & Chamberlain, 2020).

Diagnosis of Excoriation

The diagnosis of excoriation disorder is based on a thorough clinical assessment that includes a detailed history of

the individual's skin picking behavior, physical examination, and assessment of any associated symptoms or psychiatric conditions. To meet diagnostic criteria for excoriation, the skin picking behavior must result in skin damage and significant distress or impairment in social, occupational, or other important areas of functioning. The skin picking behavior must also not be attributable to another medical condition or substance use and must not be better accounted for by another mental disorder. In some cases, laboratory tests or imaging studies may rule out other potential causes of skin damage (American Psychiatric Association, 2013).

A commonality among those diagnosed with the disorder is the reported presence of stress and anxiety. Some individuals with excoriation disorder report that the act of skin picking provides temporary relief from emotional discomfort or distress (Kwon et al., 2020). Many individuals with excoriation disorder also struggle with other mental health conditions, such as OCD or depression, which can contribute to or exacerbate the skin picking behavior (Grant & Chamberlain, 2021).

Several types of excoriation disorders exist. They are classified based on the location and nature of the skin picking behavior.

- Acne excoriée is an excoriation that involves picking at acne lesions or other blemishes on the face, often resulting in scarring and discoloration.
- Dermatillomania is an excoriation that involves picking at healthy skin or minor imperfections, such as scabs or bumps, resulting in skin damage and scarring.
- Neurotic excoriation refers to a pattern of skin picking that occurs in response to anxiety or stress. An example of this would be an individual who, during stressful periods, picks, rubs, or scratches the skin to the point of scarring (Wong et al., 2013).
- Some excoriation is related to an underlying medical condition, such as pruritus or chronic skin conditions (American Psychiatric Association, 2013).

Treatment of Excoriation

The treatment of excoriation disorders typically involves a combination of medication and psychotherapy, CBT, and HRT. Medications that may be used to treat excoriation include SSRIs, commonly used to treat depression and anxiety disorders. Psychotherapy approaches may involve addressing underlying psychological or emotional factors contributing to skin picking behavior and developing alternative coping strategies and self-management techniques to reduce anxiety and promote relaxation. HRT may involve identifying triggers for skin picking, developing alternative behaviors or responses to these triggers, and tracking progress and success over time. In addition, support groups and educational resources may help promote coping and self-management strategies (American Psychiatric Association, 2013).

Self-care can be an important component of managing excoriation disorders and can help individuals reduce their symptoms and improve their overall quality of life. Some self-care strategies that may be helpful include maintaining a healthy and balanced diet. A balanced diet can help promote overall physical and mental health, which may reduce the frequency and severity of skin picking behavior. Engaging in regular exercise can help reduce stress and anxiety, which may be triggers for skin picking behavior. Techniques, such as mindfulness meditation, deep breathing exercises, or progressive muscle relaxation, can help individuals reduce stress and promote relaxation. Ensuring adequate sleep can help reduce stress and promote overall physical and mental health. Avoiding exposure to irritants, such as harsh soaps, chemicals, or allergens, can help reduce skin damage and irritation.

Nursing Interventions

Nursing interventions for excoriation disorder are an important component of the multidisciplinary care approach often used to manage this condition. Nursing interventions may include educating and supporting individuals with the disorder, developing coping strategies to manage triggers and reduce skin picking behavior, monitoring medication side effects, and promoting self-care strategies. Encouraging and reinforcing positive behaviors may also be an important nursing intervention. In addition, nurses may provide resources, such as support group referrals or educational materials, to help individuals with excoriation disorder manage their symptoms and improve their quality of life (Lochner et al., 2017).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a mental health condition that can develop after experiencing or witnessing

a terrifying event. The event may have been a threat to the safety or life of the person, or it may have been an event they witnessed. Although historically the condition may be most associated with soldiers returning from war, PTSD can occur in people who have experienced things like sexual abuse, rape, domestic abuse, natural disasters, or terrorist attacks. The person may suffer from chronic physical and emotional symptoms as they relive the trauma, and treatment usually includes psychotherapy and medications. Nurses are expected to be able to recognize the symptoms of PTSD and plan appropriate care for a person with PTSD wherever they might be working with them (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Historical Perspectives of PTSD

PTSD is a relatively new diagnosis in the field of mental health; the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-3*) formally recognized it in 1980. Health providers have recognized and treated symptoms of PTSD for centuries under different terms, such as "shell shock" and "combat fatigue." It was not until the Vietnam War that PTSD gained widespread recognition, as many veterans returning from the war exhibited symptoms of the disorder (Iribarren et al., 2005). The diagnostic criteria and understanding of PTSD have evolved since then, with a growing recognition of the impact of traumatic experiences on mental health and well-being (American Psychiatric Association, 2013).

Causes and Incidence of PTSD

According to the *DSM-5*, to be diagnosed with PTSD, a person must experience a life-threatening, traumatic event that evokes fear, helplessness, or shock. In addition, individuals report a persistent feeling of reexperiencing the event, avoid things associated with the event, and suffer persistent symptoms that indicate emotional arousal or stress response. These symptoms must last at least one month and cause significant impairment in functioning (American Psychiatric Association, 2013).

According to the National Center for PTSD (2023), approximately 5 to 6 percent of the U.S. population will experience PTSD at some point in their lives, with rates higher among certain groups, such as military veterans, first responders, and survivors of sexual assault or interpersonal violence. Women are more likely than men to develop PTSD.

Predisposing Factors

Several predisposing factors can increase the likelihood of developing PTSD after exposure to a traumatic event. Individuals who have experienced trauma earlier in their lives are more likely to develop PTSD after a subsequent traumatic event; exposure to childhood trauma, such as abuse or neglect, can increase the risk of developing PTSD later in life. A family history of mental illness, including PTSD, can increase an individual's risk of developing PTSD after a traumatic event. Certain personality traits, such as neuroticism and anxiety, have been found to be associated with an increased risk of developing PTSD. People who lack social support or have few resources to cope with stress are at greater risk of developing PTSD after a traumatic event. The severity and duration of the traumatic event can also increase the likelihood of developing PTSD (National Center for PTSD, 2023).

Signs and Symptoms of PTSD

The symptoms and severity of PTSD can vary greatly from person to person and may change over time (American Psychiatric Association, 2013). Signs may emerge months or even years after the traumatic event, highlighting the importance of early intervention for individuals who have experienced trauma. The hallmark symptoms of PTSD are intrusive thoughts or memories of the trauma, avoidance of trauma reminders, negative changes in mood or thinking, and hyperarousal or reactivity (American Psychiatric Association, 2013). Intrusive thoughts and memories can take the form of flashbacks or nightmares, and individuals may avoid situations or activities that remind them of the trauma. Negative changes in mood or thinking may include feelings of guilt, shame, or anger and difficulty experiencing positive emotions or maintaining close relationships. Hyperarousal or reactivity may include symptoms such as hypervigilance, irritability, or difficulty sleeping. Individuals with PTSD may also experience physical symptoms, such as headaches, chest pain, fatigue, and changes in appetite, weight, and sleep patterns (Peterson et al., 2019).

Changes in Thinking

PTSD is associated with various cognitive changes and difficulties, including negative changes in mood, beliefs, and perception of oneself and others. For example, individuals with PTSD may experience guilt, shame, or self-blame related to the traumatic event and a sense of detachment or estrangement from others (American Psychiatric

Association, 2013). They may also have negative beliefs or expectations about themselves, others, or the world, such as feelings of helplessness or a loss of trust in others. In addition, individuals with PTSD may have difficulty experiencing positive emotions or finding pleasure in activities they once enjoyed, which can contribute to a reduced quality of life. These changes in thinking and mood can be persistent and contribute to the overall complexity and challenges associated with treating PTSD.

Symptom Intensity and Complex PTSD

Symptom intensity and complexity are important factors to consider when evaluating the presence and severity of PTSD. Individuals with PTSD may experience a range of symptoms, from mild to severe, which can vary in intensity over time. In some cases, individuals may experience persistent and debilitating symptoms that interfere with their daily functioning and quality of life.

Complex PTSD, also known as developmental trauma disorder, is a subtype of PTSD that entails prolonged exposure to traumatic events, such as childhood abuse, neglect, or ongoing violence. Individuals with complex PTSD may experience a greater number and intensity of symptoms, including emotional dysregulation, self-perception and relational difficulties, and problems with impulse control (Giourou et al, 2018).

PSYCHOSOCIAL CONSIDERATIONS

A Psychosocial Perspective on PTSD

Psychosocial factors for PTSD are critical to understanding and treating the condition. The type and severity of the traumatic event can impact the development and severity of PTSD symptoms. The duration and frequency of the trauma and the individual's age at the time of exposure can also play a role. Social support from friends, family, and community members can be a protective factor against PTSD. The lack of social support or negative social reactions, such as blame or disbelief, can worsen PTSD symptoms. Preexisting mental health conditions, such as anxiety and depression, can increase the risk of developing PTSD after a traumatic event. The ability to cope with stress and regulate emotions is significant in PTSD recovery. Individuals who use avoidance as a coping strategy may be at greater risk of developing PTSD. Cultural norms, beliefs, and environmental factors, such as living in a high-crime area or experiencing discrimination, can contribute to the development of PTSD.

PTSD and Suicide

PTSD has been associated with an increased risk of suicide, particularly among individuals who have experienced trauma related to combat or sexual assault. In addition, studies have found that individuals with PTSD are more likely to report suicidal thoughts or behaviors than those without PTSD. This risk is further increased in individuals with comorbid depression or substance use disorders. The increased risk of suicide in individuals with PTSD highlights the importance of early identification and treatment of the disorder, as well as the need for suicide prevention strategies tailored to this population's specific needs and experiences (Bentley et al., 2016).

PTSD in Children

PTSD in children is a serious mental health concern that can significantly impair their functioning, academic performance, social relationships, and overall well-being (Scheering & Zeanah, 2001). Children with PTSD often experience persistent and distressing memories of the event, avoid reminders, have negative alterations in mood and cognition, and experience hyperarousal symptoms, such as irritability or sleep disturbances (American Psychiatric Association, 2013).

Some of the most common traumas reported by children diagnosed with PTSD are sexual or physical abuse and violent crimes. Disasters, such as floods, tornadoes, hurricanes, or fires, may also precipitate PTSD. Other events reported include school shootings, car crashes, war, the suicide of a friend or family member, or witnessing violence firsthand (National Center for PTSD, 2023). Regardless of the cause, early intervention and appropriate treatment, such as trauma-focused cognitive behavioral therapy (TF-CBT), can help mitigate the impact of PTSD on a child's life and foster resilience (Cohen et al., 2017).

The prevalence of PTSD in children varies depending on age, gender, type of trauma, and socioeconomic background. Girls are more likely to develop PTSD than boys, and the risk increases with the severity and frequency of the traumatic experience (Cohen et al., 2017). Research suggests that anywhere from 14 to 43 percent of

children experience at least one traumatic event during childhood, and up to 15 percent of girls and 6 percent of boys who have experienced trauma develop PTSD (National Center for PTSD, 2023). Rates of PTSD are highest after traumas involving interpersonal violence, such as rape or child abuse (Kessler et al., 2017).

Treatment of PTSD

PTSD is a complex and challenging disorder, but evidence-based interventions help individuals manage their symptoms and improve their quality of life. Treatment approaches for PTSD typically include psychotherapy, medication, or a combination. CBT is a widely used and effective psychotherapy approach for PTSD—particularly exposure therapy, which involves gradually exposing the individual to the memories and situations associated with the trauma in a safe and controlled environment. Eye movement desensitization and reprocessing (EMDR) is another psychotherapy approach that has shown promising results in treating PTSD. Medications, such as SSRIs and SNRIs, are often used to treat symptoms of depression and anxiety that are common in individuals with PTSD. Other interventions, such as mindfulness-based therapies and complementary and alternative treatments, may also be helpful for some individuals with PTSD (National Institute of Mental Health, 2022c).

Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is a structured psychotherapy approach designed to address the needs of individuals with PTSD and related symptoms. TF-CBT is a time-limited intervention that typically involves twelve to sixteen weekly sessions, and it includes a variety of techniques to help individuals manage their symptoms and improve their functioning. The therapy involves components, such as psychoeducation, relaxation techniques, cognitive restructuring, exposure therapy, and family involvement (Cohen & Mannarino, 2015). This type of therapy might be most beneficial for a veteran experiencing nightmares and flashbacks. Through gradual exposure, a therapist would assist the veteran in confronting memories and feelings related to the traumatic events in a safe and controlled environment. This gradual process would assist in reducing the emotional charge associated with those memories (Ennis et al., 2021).

Eye Movement Desensitization and Reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy approach that has been shown to be effective in treating symptoms of PTSD and related conditions. EMDR involves eye movements, hand tapping, or other bilateral stimulation techniques while the individual focuses on traumatic memories or triggers. The goal of EMDR is to facilitate the processing of traumatic memories and to reduce the intensity of associated emotional and physiological responses (Shapiro, 2014). EMDR typically involves a structured series of sessions and may include elements of CBT or other therapeutic approaches (National Center for PTSD, 2023).

LINK TO LEARNING

This short video from the Veterans Health Administration explains eye movement desensitization (https://openstax.org/r/77EMDP) and reprocessing (EMDP) for treatment of PTSD, sometimes used with veterans.

Medications

Medication can effectively treat PTSD, particularly when combined with psychotherapy. SSRIs and SNRIs are the most commonly used medications for PTSD because they have been shown to be effective in reducing accompanying symptoms of anxiety and depression (National Institute of Mental Health, 2023). Other medications that may be used to treat PTSD include tricyclic antidepressants and atypical antipsychotics. Benzodiazepines are generally not recommended for the treatment of PTSD, as they can be addictive and may interfere with the processing of traumatic memories (Food and Drug Administration [FDA], 2020).

Alternative Therapies

In addition to traditional treatments, several alternative and self-help therapies may also help with PTSD symptoms. Some examples include mindfulness-based therapies, yoga and meditation, equine therapy, and art therapy (National Center for PTSD, 2023). Mindfulness meditation, for instance, involves being present in the moment and observing one's thoughts and emotions without judgment. This practice can help individuals learn to regulate their emotions and reduce stress.

Self-help strategies can provide individuals with tools and techniques to manage their symptoms daily. Learning

about PTSD, its symptoms, and its treatment can help individuals understand their experiences and feel more in control of their symptoms. Relaxation techniques, such as deep breathing, progressive muscle relaxation, and guided imagery, can help individuals reduce anxiety and stress. Regular exercise has been shown to be effective in reducing symptoms of PTSD, particularly depression and anxiety. Participating in a support group for individuals with PTSD can give them a sense of community and help them feel less isolated. Creative activities, like art or writing, can help individuals process their emotions and trauma-related experiences. These self-help strategies can be combined with traditional treatments to provide individuals with a holistic approach to managing their symptoms (National Center for PTSD, 2023).

Nursing Interventions for PTSD

Nurses play a critical role in the care of individuals with PTSD and can provide a range of interventions to support their recovery. For example, nurses can use standardized assessment tools to evaluate symptoms of PTSD and monitor changes over time. They can also provide individuals with information about PTSD and available treatments to help them understand their experiences and feel more in control of their symptoms. Nurses can help individuals with PTSD develop self-care strategies to manage their symptoms and can provide a safe and supportive environment for clients to express their feelings and process their experiences. Nurses can help individuals access appropriate treatments, such as psychotherapy and medication, and make referrals to other health-care providers as needed. By working closely with other health-care team members, such as psychiatrists and social workers, nurses can ensure coordinated and comprehensive care for individuals with PTSD (American Nurses Association, 2022).

CLINICAL JUDGMENT MEASUREMENT MODEL

Applying the CJMM to a Person with PTSD

Estelle is a thirty-year-old female who was diagnosed with anxiety and PTSD following an incident when she was attacked and robbed in a parking garage three years ago. She lives alone and has asked to be readmitted to the psychiatric unit because she states that she is “starting to feel worse” and reports that the symptoms of her PTSD are starting to interfere with her work in the bank where she is employed. Her symptoms on admission appear to include intrusive thoughts, flashbacks, hypervigilance and avoidance behavior, disturbed sleep pattern, and persistent worry. Following the incident, she was prescribed Sertaline (Zoloft) for management of her anxiety, which she reports taking as prescribed.

Using the Clinical Judgment Measurement Model, the nurse can analyze the care planning for Estelle.

CJMM Step	CJMM Data
Recognize Cues	Estelle has to be assessed for signs of her ongoing anxiety and PTSD. Active listening and observation are used to gather information from her and confirm her symptoms of hypervigilance, avoidance behaviors, intrusive thoughts, and manifestations of anxiety, such as palpitations, sweaty palms, dry mouth, and so on.
Analyze Cues	During interactions with Estelle, the nurse has to try and understand the factors that contribute to her anxiety and PTSD. Discussion should focus on her previous post-traumatic experiences, how she coped with them, the stressors that she is currently experiencing, and any support systems that might be available to her.
Prioritize Hypotheses	A potential nursing diagnosis for Estelle will be developed based on the cues she has provided, such as her anxiety related to a post-traumatic event and her ineffective coping mechanisms. The prioritizing of a hypothesis will be based on the severity her symptoms, the impact that they are having on her well-being, and her readiness to participate in the treatment plan that will be made for her.

CJMM Step	CJMM Data
Generate Solutions	A safe and supportive environment will be created for Estelle to encourage therapeutic communication. The interdisciplinary team will review her medications and decide if they have to be adjusted in light of her ongoing and worsening symptoms. She will be encouraged to develop her coping strategies through activities such as participation in relaxation techniques, exploring approaches to stress management, and discussions on promoting self-care. Support groups for people with PTSD, either online or near where she lives will be identified.
Take Action	The nurse should establish a rapport with Estelle in order to validate her feelings and the experiences she has gone through. The nurse will continually monitor for the effectiveness of medications prescribed for Estelle and be mindful to observe for side effects and report any that occur. Estelle will be encouraged to participate in deep breathing and progressive muscle relaxation exercises to help her to relax. The interdisciplinary care team may discuss the possibility of using exposure therapy with Estelle in an attempt to gradually desensitize her to triggering stimuli.
Evaluate Outcome	Estelle's response to the interventions put in place for her will be evaluated. If these have been successful, she should demonstrate a reduction in her symptoms of anxiety, such as a decrease in the intrusive thoughts and avoidance behavior that she was having, as well as any physical symptoms of anxiety. Her overall mood should be more stable and her sleep quality improved. She should be able to identify her triggers effectively and manage any stress that she does develop more appropriately through the various techniques she has been practicing during her stay in the unit. She will have identified the community-based resources to assist in her long-term recovery and be at a level of social functioning that will enable her to return to her work at the bank.

By applying the Clinical Judgment Measurement Model, nurses can effectively address the complex needs of clients with anxiety and PTSD. This care planning put in place for Estelle highlights the importance of clinical reasoning, therapeutic communication, and collaborative care in nursing practice.

Acute Stress Disorder

After a traumatic event, such as a natural disaster, serious accident, or violent crime, a person can develop the psychiatric condition called **acute stress disorder (ASD)**. ASD is different from PTSD because it is a short-term condition. ASD symptoms typically begin within four weeks of the traumatic event and last for a minimum of three days and a maximum of one month. If symptoms persist beyond one month, the diagnosis may be changed to PTSD (American Psychiatric Association, 2013).

Causes of Acute Stress Disorder

The causes of ASD are multifactorial and likely involve complex interactions between biological, psychological, and environmental factors. For example, individuals who experience traumatic events may be at increased risk of developing ASD if they have a history of prior trauma, a preexisting mental health condition, or a lack of social support. In addition, neurobiological factors have been implicated in the development of ASD (Bryant & Harvey, 2000).

Diagnosis of ASD

The diagnosis of ASD is based on the presence of a cluster of symptoms—including intrusive thoughts or memories, avoidance of event reminders, and hyperarousal or hypervigilance—that occur in response to a traumatic event. According to the *DSM-5*, an individual may be diagnosed with ASD if they meet the following criteria: (1) exposure to a traumatic event; (2) presence of nine or more symptoms related to intrusion, negative mood, dissociation, avoidance, and arousal; (3) symptoms last for a minimum of three days and a maximum of one month; and (4)

symptoms cause significant distress or impairment in social, occupational, or other areas of functioning (American Psychiatric Association, 2013).

Treatment for ASD

Treatment for ASD typically involves a combination of pharmacotherapy and psychotherapy. SSRIs and SNRIs are effective in reducing symptoms of anxiety and depression associated with ASD. Psychotherapeutic interventions, such as CBT and cognitive restructuring, are effective in treating ASD (Bertolini et al., 2020).

Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is a type of psychotherapy that has been shown to be effective in treating ASD. TF-CBT is a structured intervention that involves several components, including psychoeducation, relaxation techniques, cognitive restructuring, exposure therapy, and trauma narrative development. TF-CBT aims to help individuals process the traumatic event, develop coping skills, and reduce symptoms of anxiety and depression associated with ASD (Bryant, 2022).

Cognitive restructuring, a key component of TF-CBT, has been shown particularly effective in treating ASD. Cognitive restructuring involves identifying and challenging negative or distorted thoughts and beliefs that may contribute to symptoms of anxiety and depression associated with ASD. For example, in cognitive restructuring, individuals learn to identify and challenge thoughts such as, "the world is a dangerous place" or "I am responsible for what happened," and replace them with more realistic and adaptive thoughts, such as "the world is generally safe" or "I am not responsible for what happened." Through this process, individuals can reduce symptoms of anxiety and depression and improve their overall functioning. Cognitive restructuring is typically used with other components of TF-CBT, such as exposure therapy and relaxation techniques (Bryant, 2022).

Medications

Medication treatment for ASD typically involves the use of SSRIs or SNRIs. These medications are commonly used to treat symptoms of anxiety and depression associated with ASD. In addition, providers may prescribe benzodiazepines over the short term to treat symptoms of anxiety and insomnia. Medications, such as imipramine, propranolol, morphine, hydrocortisone, and docosahexaenoic acid, have been administered to clients with ASD to help prevent escalation to PTSD (Bryant, 2022).

Nursing Interventions

Early intervention and ongoing support from nurses can improve outcomes for individuals with ASD and help prevent its evolution to PTSD. Nursing interventions for ASD typically involve providing emotional support and promoting coping strategies. Nursing intervention for ASD may include offering education on coping strategies, such as breathing techniques, guided imagery, mindfulness and meditation, laughter and humor relaxation techniques, deep breathing exercises, and mindfulness meditation (Felsenstein, 2024). Nurses can also provide referrals to mental health professionals for further assessment and treatment. In addition, nurses should be aware of the potential for comorbid physical health conditions, such as hypertension and cardiovascular disease. Therefore, they should monitor clients for signs and symptoms of these conditions (Mann & Marwaha, 2023).

Attachment Disorders

Also falling under the trauma umbrella are **attachment disorders**, a group of psychiatric conditions resulting from a disruption in the normal attachment process between a child and a caregiver. Children with attachment disorders may experience difficulties forming close, nurturing relationships and may exhibit avoidance, detachment, and aggression (American Psychiatric Association, 2013). Attachment disorders are thought to result from genetics and from environmental factors, including a history of neglect, abuse, or multiple placements in foster care (Chaffin et al., 2006). In addition, children with attachment disorders are at increased risk for other mental health conditions, such as depression and anxiety, and may have difficulties in academic and social settings (Turner et al., 2019).

Attachment Theory

Developed by John Bowlby, **attachment theory** is a psychological model that explains how early interactions between infants and their caregivers can shape the development of social and emotional functioning across the lifespan. In other words, the theory describes the importance of attachment in regard to personal development. Attachment plays a crucial role in an individual's ability to form emotional connections and can greatly influence future relationships (Mcleod, 2017). According to the theory, infants develop a secure or insecure attachment style

based on the responsiveness of their caregivers to their needs (Bowlby, 1969). Securely attached infants develop a sense of trust and confidence in their caregivers and are more likely to form close, nurturing relationships with others throughout life. In contrast, insecurely attached infants may develop anxious or avoidant attachment styles, resulting in difficulties forming close relationships and regulating emotions. Attachment theory has been widely researched and applied to various psychological and social phenomena, including romantic relationships, parenting, and mental health (Mikulincer & Shaver, 2016). There are four main attachment styles: secure, anxious, avoidant, and disorganized (Huang, 2020).

Secure Attachment

Secure attachment in adults is characterized by the ability to form close and trusting relationships, regulate emotions, and communicate effectively with others. Secure attachment is characterized by a child's ability to trust and rely on their caregivers for comfort and support in times of distress (American Psychiatric Association, 2013). Securely attached children generally grow up to be emotionally available and responsive adults. Adults with secure attachment styles are comfortable with intimacy and rely on others for support during times of stress or distress. As a result, they can maintain a healthy balance of independence and dependence in their relationships (Mikulincer & Shaver, 2016).

Research suggests that individuals with secure attachment styles have better mental health outcomes, including lower levels of anxiety and depression and higher levels of life satisfaction (Mikulincer & Shaver, 2016). In addition, secure attachment has been associated with positive outcomes in various life domains, including academic achievement, career success, and social relationships.

Anxious Attachment

Anxious attachment is a type of insecure attachment characterized by a need for closeness and intimacy but with a persistent fear of rejection or abandonment. Children with anxious attachment styles may cling to their caregivers and become anxious or distressed when separated from them. While this is normal, expected behavior for children between approximately nine months and two years, it can be diagnosed as a malady in older children. They may become easily overwhelmed by stress and have difficulty regulating their emotions (Cassidy & Shaver, 2016).

In adults, anxious attachment can lead to various relationship difficulties, including clinginess, jealousy, and emotional volatility. In addition, adults with anxious attachment styles may have a negative view of themselves and be highly critical of their partners. They may also experience intense anxiety and distress when their partners are unavailable. Research suggests that anxious attachment styles are associated with a range of negative outcomes, including higher levels of anxiety and depression, poorer social functioning, and difficulties in regulating emotions (Mikulincer & Shaver, 2016).

Avoidant/Dismissive Attachment

Avoidant/dismissive attachment is a type of insecure attachment characterized by a need for independence and discomfort with intimacy and closeness. Children with avoidant/dismissive attachment styles may seem emotionally detached or indifferent to their caregivers and may not seek comfort or support during distress (Cassidy & Shaver, 2016). They may also be highly self-sufficient and resist being comforted by others.

In adults, avoidant/dismissive attachment can lead to a preference for emotional distance and independence in relationships. Adults with avoidant attachment styles may avoid close relationships and feel uncomfortable with intimacy or emotional expression. They may also need control and resist being vulnerable or dependent on others (Mikulincer & Shaver, 2016).

Research suggests that avoidant/dismissive attachment styles are associated with various negative outcomes, including difficulties in forming and maintaining close relationships, higher levels of anxiety and depression, and decreased emotional regulation (Mikulincer & Shaver, 2016).

Disorganized Attachment

Disorganized attachment is a type of insecure attachment characterized by inconsistent or unpredictable behavior in caregivers, leading to confusion and fear in children. Children with disorganized attachment styles may exhibit a range of behaviors, such as freezing or appearing dazed, showing fear or aggression toward their caregivers, or engaging in disorganized and confused behavior during interactions (Cassidy & Shaver, 2016).

Disorganized attachment can manifest in adults as a lack of relationship coherence or organization. Adults with disorganized attachment styles may struggle with emotional regulation and have difficulty managing their own emotional responses to stress and conflict. They may also experience confusion or fear in their relationships and have difficulty making sense of their own behavior or the behavior of others (Mikulincer & Shaver, 2016).

Research suggests that disorganized attachment styles are associated with various negative outcomes, including higher levels of anxiety and depression, difficulties in regulating emotions, and challenges in forming and maintaining close relationships (Mikulincer & Shaver, 2016).

Diagnosing Attachment Disorders in Children

Attachment disorders in children can manifest in various ways, including behavioral, emotional, and social difficulties. For example, children with attachment disorders may display aggressive or hostile behavior toward caregivers, peers, and authority figures. They may also be withdrawn, emotionally detached, or overly compliant. In addition, children with attachment disorders may have difficulty forming close relationships with others and struggle with social skills, such as sharing, taking turns, and cooperating with others. Emotional regulation may also be a challenge, leading to mood swings, tantrums, and difficulties with self-soothing. These difficulties can interfere with academic achievement, social development, and well-being (Ellis et al., 2022).

The DSM-5 includes two diagnoses related to attachment disorders in children: **reactive attachment disorder (RAD)** and **disinhibited social engagement disorder (DSED)**. Both can result from a history of neglect, abuse, or multiple placements in foster care and are associated with difficulties in emotional regulation, social skills, and overall functioning (American Psychiatric Association, 2013). The criteria for RAD include a consistent pattern of emotionally withdrawn or unresponsive behavior toward caregivers, a lack of positive attachments to caregivers, and limited social and emotional responsiveness to others (American Psychiatric Association, 2013). In addition, children with RAD may exhibit persistent fear, sadness, or irritability and may avoid or resist comfort from caregivers. The criteria for DSED include a pattern of indiscriminate, overly trusting behavior toward unfamiliar adults and an absence of appropriate wariness of strangers (American Psychiatric Association, 2013). Children with DSED may approach and interact with strangers in an excessively friendly or familiar manner without regard for their own safety.

Attachment Disorders in Adults

Attachment disorders can also occur in adults and may result from various factors, such as childhood trauma, disrupted family relationships, or the loss of a loved one. Attachment disorders can manifest as difficulties in forming and maintaining close relationships, emotional dysregulation, and self-esteem challenges. Adults with attachment disorders may struggle with intimacy and trust and engage in maladaptive behaviors, such as emotional withdrawal or overly dependent behavior. These individuals often appear disconnected or disengaged from other people's feelings and tend to withdraw from connections. They may also have difficulty maintaining social relationships, whether romantic or platonic, and may struggle to show and receive affection. In addition, attachment disorders have been associated with various mental health conditions, such as depression, anxiety, and personality disorders (Mikulincer & Shaver, 2016).

Treatment of Attachment Disorders

The treatment for attachment disorders typically involves therapy. Therapeutic interventions may include attachment-based interventions, such as parent-child interaction therapy or play therapy, to improve attachment and promote positive interactions between caregivers and children (Zeanah et al., 2016). For adults, attachment-focused therapies, such as attachment-based psychotherapy or emotion-focused therapy, address underlying attachment issues and promote healthier relationship patterns (Brisch, 2014). While medication may target specific symptoms associated with attachment disorders, it is not considered a first-line treatment (Kobak et al., 2015).

Nursing Interventions

Developing a nursing care plan for clients with attachment disorders involves a comprehensive assessment of the client's physical, emotional, and behavioral needs. The care plan should be individualized and based on the client's specific symptoms and personal and cultural preferences. It may include therapeutic interventions to promote positive interactions between caregivers and children, such as providing a safe and nurturing environment and promoting healthy attachment. In addition, the care plan may include medication management, if necessary, and education and support for the client and their family (Mayo Clinic, 2022a).

17.5 Dissociative Identity Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define dissociative disorder
- Recall the symptoms and prevalence of dissociative identity disorder
- Outline approaches to treating dissociative identity disorder

A disruption in consciousness, memory, identity, or perception not caused by substance use or a medical condition are considered a **dissociative disorder** (American Psychiatric Association, 2013). The most commonly known dissociative disorder is dissociative identity disorder. Formerly known as multiple personality disorder, **dissociative identity disorder** is characterized by the presence of two or more distinct personality states, with a disconnection in the individual's sense of self and actions (Moore, 2016). People with dissociative identity disorder experience frequent **dissociative amnesia**, which is a gap in memory involving important personal information (Drescher, 2022). This disorder may also encompass a range of dissociative symptoms, such as **dissociative fugue**, which may entail unexpected or unplanned travel and amnesia regarding one's identity, and depersonalization/derealization disorder, marked by feelings of detachment from oneself or their surroundings (American Psychiatric Association, 2013).

Defining Dissociative Disorder

Dissociative disorders are psychiatric conditions characterized by disruptions in consciousness, memory, identity, emotion, perception, behavior, and sense of self (American Psychiatric Association, 2013). These disturbances may be sudden or gradual, acute or chronic. Dissociative disorders are thought to arise as a psychological defense against trauma, enabling the person to compartmentalize memories and experiences that are too much for them to process (Subramanyam et al., 2020).

Diagnosing Dissociative Disorders

Diagnosing dissociative disorders can be a complex process that requires a comprehensive clinical assessment by mental health professionals knowledgeable about these conditions. The diagnosis generally involves a detailed interview to explore the client's symptoms, taking a history of trauma, and performing a mental status examination. The use of specific diagnostic tools, such as the Dissociative Experiences Scale (DES) or the Structured Clinical Interview for Dissociative Disorders (SCID-D), can aid in assessing the severity and nature of dissociative symptoms (Loewenstein, 2018). The clinician assesses the nature, timing, and duration of dissociative symptoms, such as memory loss, depersonalization, and personality alterations. In addition to evaluating the client's symptoms, clinicians gather information from family members, previous medical records, and other sources to form a holistic understanding of the client's condition. It is important to rule out other medical and psychiatric conditions that may present with similar symptoms, such as seizure disorders or psychotic disorders, to ensure an accurate diagnosis (American Psychiatric Association, 2013).

Possible Causes of Dissociative Disorders

Dissociative disorders are often caused by psychological trauma and may result in significant distress or impairment in social, occupational, or other important areas of functioning. The underlying mechanisms are not fully understood, but the disorders are believed to be coping strategies that separate distressing or traumatic information from conscious awareness (American Psychiatric Association, 2013).

Symptoms and Prevalence of Dissociative Identity Disorder

DID is a complex psychiatric condition characterized by the presence of two or more distinct identity states. These identities recurrently take control of an individual's behavior, consciousness, and memories, leading to significant distress and functional impairment (American Psychiatric Association, 2013). The prevalence of DID varies across cultures and populations. In the general population, the prevalence rate is estimated to be around 1.5 percent internationally (Mitra & Jain, 2021). Research indicates that DID is more common among females, and there may be a significant correlation between DID and a history of childhood trauma or abuse (Mitra & Jain, 2021).

Symptoms of DID typically include identity confusion, identity alteration, and amnesia. Identity confusion refers to inner conflict or confusion regarding a person's identity. Identity alteration involves the display of different

personalities or identities, while amnesia refers to the inability to recall personal information that cannot be explained by ordinary forgetfulness.

Additionally, individuals with DID may experience depersonalization, derealization, self-harm, and suicidal tendencies (Drescher, 2022). The symptom of **depersonalization** refers to an alteration in the perception or experience of oneself, where an individual may feel detached or estranged from their thoughts, feelings, body, or actions. It often presents as a sensation of observing oneself from an outside perspective or feeling as if one's emotions and physical sensations are not truly their own (Simeon, 2024). On the other hand, **derealization** involves a feeling of detachment or estrangement from one's surroundings. People experiencing derealization may perceive the external world as unreal, dreamlike, or distorted. Objects, places, and even people may seem unfamiliar or changed in some way, leading to a sense of unreality or confusion. Like depersonalization, derealization can be deeply unsettling, impairing one's ability to engage with their environment (Simeon, 2024).

Treatment of Dissociative Identity Disorder

The treatment for DID is typically long-term and involves various therapeutic approaches tailored to the individual's unique needs and symptoms. The primary goal of treatment is to integrate the separate identity states into a cohesive and functional whole, thereby improving overall functioning and quality of life (International Society for the Study of Trauma and Dissociation [ISSTD], 2011).

Psychotherapy is considered the mainstay of treatment for DID, emphasizing building trust, fostering a strong therapeutic alliance, and providing a safe environment for exploring traumatic memories and identity fragmentation (Gentile et al., 2013). Cognitive behavioral techniques challenge distorted thought patterns. Psychodynamic interventions help clients understand how past traumas have shaped their current identity structure and help promote the integration of various identity states into a cohesive self. Dialectical behavior therapy emphasizes mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness (Hohfeler, 2016). Pharmacological interventions, such as antidepressants or anxiolytics, may also be used to manage comorbid conditions like depression or anxiety. They are not considered a primary treatment for DID, however, because they do not specifically treat the dissociation (Gentile et al., 2013).

Integrated Functioning

The process of synthesizing different aspects of a person's identity, experience, and functioning into a cohesive and harmonious whole is called **integrated functioning**. This concept is particularly relevant in DID, where individuals experience fragmentation and disconnection among different identity states (Brand et al., 2019). In DID, integration involves merging various identity states into a unified sense of self. This process may include recognizing and accepting different parts as aspects of a single, complex person rather than as separate and disconnected entities. The goal is not to erase or negate the different parts but to acknowledge and harmonize them into a whole (Subramanyam et al., 2020). Many individuals with DID have amnesia or disconnection between different identity states. Integrating memories involves linking these disconnected memories to create a coherent narrative of one's life, including traumatic and nontraumatic experiences (Berntsen & Rubin, 2006). Integration of emotions and behaviors focuses on connecting emotions and behaviors across different identity states. It may involve recognizing patterns, understanding emotional triggers, and developing adaptive ways to express and manage emotions (Fassbinder et al., 2016). The ultimate goal of integration is to facilitate overall functioning in daily life. This improvement in functioning includes enhanced relationships, adequate vocational functioning, reduced distress, and improved quality of life. Achieving integrated functioning is not necessarily about the absence of symptoms, but about the ability to live a fulfilling and balanced life (ISSTD, 2011).

Individual Psychotherapy

Individual psychotherapy is considered the primary treatment modality for DID. It is a highly specialized and complex process that must be carefully tailored to the unique needs of each individual (Huntjens et al., 2019). Individual therapy begins with a comprehensive assessment to understand the client's symptoms, history, needs, and goals. The initial phase of therapy often focuses on stabilization, including managing acute symptoms, building coping skills, and addressing any immediate safety concerns, such as self-harm or suicidality. Once stable, clients may shift to therapy to process traumatic memories and experiences. These therapies can involve techniques like trauma-focused CBT, but it must be done carefully, considering the fragmented nature of memory and identity in DID. Therapy concludes with a focus on maintaining gains, generalizing skills to everyday life, and preparing for

termination. This phase ensures the individual can function effectively outside the therapeutic relationship (Huntjens et al., 2019).

Establishing Safety

Establishing safety with DID clients is a crucial aspect of care, especially in nursing, where staff is often the first line of support and contact for these individuals. Implementing strategies to promote safety can enhance the therapeutic relationship, foster trust, and contribute to the recovery process. Education about the nature of DID, including the complex interplay of dissociation, trauma, and identity fragmentation, is crucial. Knowledge about the disorder can guide appropriate interventions and reduce misconceptions (ISSTD, 2011). A calm, predictable environment can minimize triggers for dissociation. This might include consistent staffing, clear communication, gentle handling of personal belongings, and respecting personal space (Purvis et al., 2013). Reassurance, grounding techniques, and client-centered communication can facilitate reorientation and emotional regulation. Collaborating with the client to develop individualized safety plans, including coping strategies and emergency contacts, can empower the client and build trust (Brand et al., 2013). Understanding the client's cultural background and ethical considerations is crucial for respectful and effective care because this can shape the experience of DID and the therapeutic relationship. By focusing on these key areas, nurses can play a vital role in establishing safety with DID clients, creating a foundation for therapeutic intervention and recovery (Kwame & Petrucka, 2021).

Confronting

Confrontation in therapy in the treatment of DID is delicate. It involves addressing behaviors, beliefs, or experiences that may be problematic or hinder progress. Confrontation does not necessarily mean aggressive or forceful challenges. It can be a gentle process of pointing out discrepancies or exploring contradictions in a client's thoughts, feelings, or behaviors. The goal is to help the client gain insight and make positive changes (Rajhans et al., 2020). Aggressive or poorly timed challenges can exacerbate dissociation, increase resistance, or damage the therapeutic alliance (ISSTD, 2011). Before any confrontation can occur, develop a solid foundation of trust and safety, understand the unique experiences of each identity state, build rapport, and create a secure environment to explore challenging topics (Loewenstein, 2018).

Time the decision to confront specific issues carefully. The therapist must assess the client's readiness and the therapeutic relationship's stability. Pacing is also crucial, allowing for gradual exploration and avoiding overwhelming the client (Kwame & Petrucka, 2021). In DID, confronting traumatic memories prematurely or without adequate preparation can lead to retraumatization. Therapists must be cautious in approaching trauma-related content, ensuring the client has the necessary coping resources. While confrontation can be a useful therapeutic tool, it requires caution, empathy, and a clear understanding of the complex dynamics of DID. A client-centered approach that prioritizes safety, collaboration, and gradual exploration is likely to be more effective and ethical (Loewenstein, 2018).

Integration and Rehabilitation

Rehabilitation in DID focuses on reintegration into daily life, improving functionality, and achieving life goals. Building supportive relationships with family, friends, and community is vital. Peer support groups also play a valuable role. Rehabilitation often involves a multidisciplinary approach, including medical care, psychotherapy, occupational therapy, and social work. Coordination among these professionals ensures comprehensive care (Saha et al., 2020). Developing strategies for managing stress and avoiding triggers can prevent the recurrence of dissociative symptoms and promote ongoing recovery (SAMHSA, 2014).

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competencies in Treatment of DID

Applying the QSEN competencies to the treatment of DID helps guide the nurse to prioritize client safety, ethical considerations, and evidence-based interventions.

- Client-centered care: Understand the unique experiences of DID clients, including their history, individual identity states, and needs. Engage clients in shared decision-making and respect their preferences and values (Sherwood & Barnsteiner, 2017).

- Teamwork and collaboration: Collaborate with an interdisciplinary team, including therapists, psychiatrists, social workers, and family members. Maintain open communication and shared goal-setting to support the client's integration and rehabilitation (Ndibu Muntu Keba Kebe et al., 2019).
- Evidence-based practice: Utilize evidence-based interventions like individual psychotherapy, cognitive behavioral techniques, and dialectical behavior therapy. Regularly assess outcomes to refine the treatment plan (Fassbinder et al., 2016).
- Quality improvement: Monitor the client's progress throughout treatment, identifying areas for improvement. Utilize DID assessment tools and client feedback to ensure ongoing quality of care (Wong et al., 2020).
- Safety: Establish a safe therapeutic environment that promotes trust and minimizes triggers or retraumatization. Implement safety protocols to manage crises and prevent self-harm or harm to others (Loewenstein, 2018).
- Informatics: Leverage electronic health records and other informatics tools to track progress, document interventions, and coordinate care across providers. Ensure privacy and confidentiality in handling sensitive information related to DID and trauma history (Kariotis et al., 2022).

QSEN competencies provide a comprehensive framework for safe, effective, and ethical care for DID clients. By focusing on client-centered care, teamwork, evidence-based practice, quality improvement, safety, and informatics, nurses can contribute to the successful treatment and support of individuals with DID (Sherwood & Barnsteiner, 2017).

Summary

17.1 Stress and Anxiety

Individuals often experience stress, both emotional and physical, during their lifetime. Chronic stress has been linked to adverse health outcomes, such as weakened immune systems, slow wound healing, and an increased risk of chronic diseases (Ford et al., 2023). As such, nursing professionals must recognize signs of stress in their clients and employ effective stress-reduction techniques. Effective strategies to alleviate client stress include clear communication, creating a comfortable environment, involving clients in decision-making, and providing psychological support (Chesak et al., 2019).

Anxiety is a diagnosable mental health condition that comes in various forms and degrees. Anxiety is characterized by feelings of fear, apprehension, and unease, often accompanied by physical symptoms, such as sweating, palpitations, and shortness of breath. There are many strategies that a person can employ to help prevent or relieve anxiety. If these are unsuccessful, the person might be recommended a range of therapeutic or pharmaceutical approaches to treatment.

17.2 Anxiety-Related Disorders

GAD, phobias, and panic disorder are distinct anxiety disorders, each with unique characteristics and treatment approaches. GAD is characterized by chronic and excessive worry about daily life, often accompanied by physical symptoms, such as muscle tension and sleep disturbances (American Psychiatric Association, 2013). Phobias are marked by an intense and irrational fear of specific objects or situations that leads to avoidance behavior; exposure therapy is a common and effective treatment for phobias (Choy et al., 2007). Panic disorder involves recurrent and unexpected panic attacks, often accompanied by anticipatory anxiety and avoidance of panic-inducing situations. While these disorders share some common features, such as the involvement of fear and anxiety, their diagnostic criteria, underlying mechanisms, and treatment strategies differ, necessitating a tailored approach to care for each individual (Cleveland Clinic, 2023).

17.3 Obsessive–Compulsive and Related Disorders

Obsessive-compulsive disorder (OCD) is a chronic mental health disorder in which obsessive thoughts lead to anxiety that individuals attempt to soothe with compulsive rituals. The condition can be very disruptive for the person, leading to challenges in their ability to work, study, or carry out social relationships. In addition, the condition may result in physical and emotional difficulties for the person. There are a variety of treatments, among them, pharmaceuticals, imaginal exposure, exposure and response prevention, and habit reversal training.

17.4 Trauma-Induced and Stress-Related Disorders

This section explored various mental and emotional disorders, providing insight into causes, diagnosis, symptoms, nursing care, and treatment approaches. BDD, hoarding, trichotillomania, excoriation, PTSD, ASD, and attachment disorders all have genetic, neurobiological, and environmental influences to various degrees. Most of these disorders respond to a combination of pharmaceutical and therapeutic interventions, and many also benefit from alternative and self-help therapies. Planning nursing care necessitates understanding each client's situation, background, history, and symptoms, and individualizing care to support recovery.

17.5 Dissociative Identity Disorder

Dissociative disorders are mental conditions characterized by a disconnection between thoughts, memories, feelings, actions, or sense of identity. These disorders often stem from trauma. DID is characterized by the presence of two or more distinct identity states that control an individual's behavior, consciousness, and memory. Symptoms include memory gaps, altered perceptions, confusion about personal identity, and the existence of different personalities. DID is a complex disorder requiring a nuanced and individualized treatment approach, emphasizing safety, psychotherapeutic intervention, integration, and rehabilitation. Understanding the definition, symptoms, and treatment strategies is essential for effectively managing and supporting individuals with DID (American Psychiatric Association, 2013).

Key Terms

acute stress disorder (ASD) psychiatric condition that can occur in the aftermath of a traumatic event
anxiety heightened state of arousal and worry that may not always have a clear external cause
attachment disorders group of psychiatric conditions resulting from a disruption in the normal attachment process between a child and a caregiver
attachment theory theory that suggests early attachments have lasting effects
biofeedback technique used to increase awareness of and control over some body functions
body dysmorphic disorder (BDD) mental disorder in which a person is preoccupied with perceived defects or flaws in their appearance
compulsion repeated behavior or mental act that a person feels driven to complete in response to an obsession
depersonalization alteration in the perception or experience of oneself, where an individual may feel detached or estranged from their thoughts, feelings, body, or actions
derealization feeling of detachment or estrangement from one's surroundings
desensitization exposure therapy that involves gradually exposing the individual to the feared stimulus or situation until they no longer experience anxiety in response to it
disinhibited social engagement disorder (DSED) attachment disorder that makes it hard for children to form an emotional bond with others
dissociative amnesia gaps in memory involving important personal information
dissociative disorder group of mental conditions characterized by a disconnection between thoughts, memories, feelings, actions, or sense of identity
dissociative fugue characterized by unexpected travel and amnesia regarding one's identity
dissociative identity disorder characterized by the presence of two or more distinct identity states that control an individual's behavior, consciousness, and memory
excoriation psychiatric condition classified under the obsessive-compulsive and related disorders category that involves repetitive and compulsive picking at the skin, leading to tissue damage, scarring, and sometimes serious medical complications like infections
exposure and response prevention (ERP) treatment for OCD that involves gradually exposing oneself to anxiety-provoking stimuli while simultaneously refraining from engaging in compulsion
generalized anxiety disorder mental health condition characterized by persistent and excessive worry about everyday life events and activities
habit reversal training (HRT) behavioral therapy technique primarily used for treating tic disorders and body-focused repetitive behaviors
hoarding disorder mental health condition characterized by persistent difficulty discarding or parting with possessions
imaginal exposure therapeutic approach that involves mentally confronting and engaging with a feared situation, traumatic memory, or anxiety-provoking thought in a safe and controlled environment
integrated functioning process of synthesizing different aspects of a person's identity, experience, and functioning into a cohesive and harmonious whole
obsession repeated thought, urge, or mental image that causes anxiety
obsessive-compulsive disorder (OCD) chronic mental health disorder in which obsessive thoughts lead to compulsive rituals
panic attack sudden and intense episode of anxiety brought on by a real or perceived threat
panic disorder reaction to stress that usually exhibits anxiety in the form of a panic attack
phobia excessive and irrational fear of a specific object, situation, or activity that is typically harmless
reactive attachment disorder (RAD) condition in which an infant or young child doesn't establish healthy attachments with parents or caregivers
resilience ability developed to adapt to difficult or challenging life experiences
stress body's response to external pressures or threats, often resulting in physiological and emotional reactions
trichotillomania mental health disorder characterized by a chronic need to pull out one's hair

Assessments

Review Questions

1. What statement best defines stress and explains how the body reacts to it?
   a. Stress is relaxation, and the body reacts by slowing the heart rate.
   b. Stress is a response to danger, and the body reacts by decreasing energy production.
   c. Stress is a response to perceived threats or challenges; the body reacts by activating the fight-or-flight response.
   d. Stress is happiness, and the body reacts by releasing endorphins.

2. What is a positive coping strategy for stress?
   a. ignoring the problem
   b. engaging in deep breathing exercises
   c. increasing caffeine intake
   d. watching distressing news

3. What best describes the prevalence and impact of anxiety in society?
   a. Anxiety is rare and has little impact on daily life.
   b. Anxiety is common and can significantly impact daily functioning.
   c. Anxiety affects only children and has no lasting impact.
   d. Anxiety is a fabricated condition with no real consequences.

4. What approach is often utilized in managing and treating anxiety?
   a. encouraging the avoidance of all anxiety-inducing situations
   b. prescription of antianxiety medication and cognitive behavioral therapy
   c. using only self-help books without professional guidance
   d. suppressing all anxious feelings without addressing underlying issues

5. What disorder is characterized by chronic and excessive worry about various aspects of daily life?
   a. phobia
   b. panic disorder
   c. generalized anxiety disorder
   d. panic attack

6. What is a common treatment approach for specific phobias?
   a. medication only
   b. exposure therapy
   c. cognitive restructuring alone
   d. breathing retraining exercises

7. What distinguishes a panic disorder from other anxiety disorders?
   a. chronic worry
   b. fear of specific objects
   c. recurrent and unexpected panic attacks
   d. muscle tension

8. A person experiencing intense fear and avoidance of heights would most likely be diagnosed with what kind of disorder?
   a. generalized anxiety disorder
   b. social anxiety disorder
   c. specific phobia
   d. panic disorder

9. What is a possible cause of obsessive-compulsive disorder (OCD)?
   a. lack of sleep
   b. genetic and neurological factors
   c. vitamin deficiency
   d. high sugar intake

10. What is one common symptom of OCD?
   a. uncontrollable laughter
   b. recurring and unwanted thoughts followed by repetitive behaviors
   c. sudden onset of fever
   d. consistent forgetfulness

11. What therapeutic approach is commonly used in the treatment of OCD?
   a. art therapy
   b. electroconvulsive therapy
   c. cognitive behavioral therapy, including exposure and response prevention
   d. music therapy

12. When planning nursing care for an individual with OCD, what is an essential consideration?
   a. encouraging the client to suppress obsessions
   b. tailoring care to the client's specific obsessions and compulsions
   c. avoiding any discussion of the client's symptoms
   d. implementing a strict, unmodifiable daily routine

13. What is a symptom of body dysmorphic disorder (BDD)?
   a. fear of heights
   b. excessive cleaning
   c. obsessive focus on perceived flaws in appearance
   d. compulsive shopping

14. What is one of the main challenges in dealing with a person who has a hoarding disorder?
   a. lack of physical symptoms
   b. resistance to treatment
   c. easily managed with medication
   d. quick recovery with therapy

15. How can trichotillomania be treated?
   a. physical exercise only
   b. cognitive behavioral therapy
   c. avoidance of hairbrushes
   d. daily vitamin intake

16. What is a nursing intervention for someone with excoriation?
   a. encouraging outdoor activities
   b. providing support for behavioral changes
   c. prescribing medication independently
   d. focusing on improving diet

17. When planning nursing care for post-traumatic stress disorder (PTSD), what is essential?
   a. ignoring the trauma's impact
   b. encouraging the client to forget the event
   c. understanding trauma's impact and individualizing care
   d. using a one-size-fits-all approach

18. What is one treatment approach for acute stress disorder (ASD)?
   a. long-term psychoanalytic therapy
   b. short-term cognitive behavioral therapy
   c. solely relying on support groups
   d. immediate surgical intervention

19. What is one key issue in diagnosing and treating attachment disorders?
   a. overemphasis on genetic factors
   b. difficulty in identifying in adulthood
   c. early identification and intervention
   d. relying solely on self-reporting

20. What is the term for the feeling of detachment or being estranged from your surroundings?
   a. depersonalization
   b. deluded thinking
   c. derealization
   d. denial

21. What is the primary treatment modality for dissociative identity disorder?
   a. desensitization
   b. individual psychotherapy
   c. antipsychotic medication
   d. group therapy

22. Why are dissociative disorders thought to arise?
   a. They are part of the symptoms associated with delirium.
   b. The person is deluded.
   c. They are part of a personality disorder.
   d. They act as a psychological defense against trauma.

Check Your Understanding Questions

1. What is stress, and how does the human body typically react?

2. Name and describe at least two coping strategies individuals might employ to manage stress.

3. How prevalent is anxiety in the general population, and how can it impact an individual's daily life?

4. What are some common approaches to managing and treating anxiety, and how do they address the underlying issues?

5. What are the key characteristics of generalized anxiety disorder, and how does it differ from panic disorder and phobias?

6. How does exposure therapy work in the treatment of specific phobias?

7. What are some recognized causes or contributing factors to the development of obsessive-compulsive disorder (OCD)?

8. What are the characteristic signs and symptoms of OCD?

9. What are some common treatment approaches for managing obsessive-compulsive disorder?

10. How can understanding the underlying causes and symptoms of body dysmorphic disorder (BDD) influence a nurse's approach to client care?

11. Why is recognizing and treating a person with a hoarding disorder particularly challenging, and how can nurses effectively navigate these challenges?

12. What unique nursing interventions are required for a person with excoriation, and how might these interventions differ from treatment for other disorders?
13. Explain how trauma might have an impact in developing the symptoms of dissociative disorders.
14. List the primary symptoms of DID, and explain how they might present in a client.

Reflection Questions

1. How can understanding the physiological response to stress aid health-care providers in treating clients experiencing acute or chronic stress?
2. How might individual preferences and needs influence the choice of coping strategies for stress, and why is it important to consider these factors?
3. Why is it vital for health-care providers to recognize the prevalence and impact of anxiety, and how does this awareness shape the care provided?
4. How do current approaches for managing and treating anxiety reflect an integrative and holistic understanding of the condition, and why is this perspective valuable in health care?
5. There are many causes of generalized anxiety disorder (GAD). How does this complexity influence individualized treatment approaches?
6. Reflect on the role of empathy and client-centered care in planning nursing interventions for a person with a specific phobia. How can these principles guide treatment?
7. Reflect on the immediate and ongoing care needed for a person experiencing a panic attack. How can a nurse's actions in the moment and follow-up care facilitate recovery?
8. As a nurse caring for a person with excoriation disorder, how can you tailor interventions to address both the physical and psychological aspects of the condition?

What Should the Nurse Do?

Maria is a twenty-eight-year-old female who has been diagnosed with OCD and has been struggling with severe contamination fears, leading her to wash her hands repeatedly throughout the day. This ritual has resulted in red, chapped skin on her hands. Maria is distressed and finds it difficult to complete daily tasks or leave the house.

History: Maria's symptoms began to appear in her early twenties and have gradually worsened. She has a family history of anxiety disorders. Previous treatments have included medication and outpatient therapy, with some improvement, but recent stressors have led to a relapse.

Treatment Plan: Maria's treatment plan includes a combination of CBT with ERP, medication management with an SSRI, and coordination with a psychiatric nurse for education and ongoing support.

1. What are the essential considerations for the nursing care plan for Maria?
2. What interventions could be useful in assisting Maria with her handwashing compulsion?
3. How might a nurse collaborate with the interdisciplinary team in Maria's care?
4. What client education might be necessary for Maria to manage her OCD in daily life?

Sarah, a twenty-nine-year-old female, was referred to mental health services by her primary care physician. She reported experiencing memory gaps, feeling like she's "watching herself from afar," and periods where she acts like different people, including a timid child and an angry young male. Family members have also noted her shifting behaviors. Sarah's history includes a traumatic childhood with physical and emotional abuse.

Symptoms: Distinct identity states, memory gaps related to personal information, confusion about personal identity, altered perceptions and behaviors

Diagnosis: After a thorough evaluation, Sarah was diagnosed with DID.

Treatment: Sarah's treatment plan included establishing safety, psychotherapy focusing on integration and rehabilitation, collaboration with a multidisciplinary team, and regular monitoring and assessment.

5. Based on the information provided, what indicators led to the diagnosis of DID in Sarah's case?
6. What are the essential components of Sarah's treatment plan for DID, and why are they vital?
7. How can nurses play a role in the care and support of a DID client like Sarah?

Competency-Based Assessments

1. As a nurse, you may work in a hectic and stressful environment some days. It will be important to understand how to recognize stress to reduce the effects. What is stress and what are three physiological responses the body exhibits when under stress?
2. When you are working and find yourself feeling stressed, what are some steps you can take to reduce the stress?
3. As a working nurse, you may encounter clients with various levels of anxiety. What are three evidence-based approaches for managing and treating anxiety in clients? Provide examples of interventions for each approach.
4. During the assessment phase of a client, how might you differentiate between symptoms of generalized anxiety disorder, specific phobia, and panic attacks?
5. When planning nursing interventions for a person with a phobia, how would you address cultural considerations that may influence the individual's response to treatment?
6. In the midst of a panic attack, prioritize nursing actions to ensure the safety and well-being of an individual.
7. When working in psychiatric-mental health settings, how do you incorporate alternative treatments to align with the principles of client-centered care?
8. As a nurse who is selecting treatment approaches for OCD, how can you balance the individual's preferences with evidence-based practices to ensure the most effective and client-centered care?
9. In planning nursing care for a person with OCD, how can cultural competence contribute to the development of a culturally sensitive care plan?
10. Outline a treatment approach for a person with acute stress disorder (ASD). What specific strategies will you use to prevent progression to PTSD?
11. As a nurse, what are the potential challenges you may face when providing care for a person with hoarding disorder, and how might these challenges impact the therapeutic relationship?
12. What are the key challenges in diagnosing and treating attachment disorders, and how can you contribute to the development of a therapeutic relationship with individuals affected by attachment issues?
13. Outline the key approaches to treating DID, including stages and considerations for integration and rehabilitation.

References

Alisic, E., Zalta, A., van Wesel, F., Larsen, S., Hafstad, G., Hassanpour, K., & Smid, G. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry: The Journal of Mental Science, 204*, 335–340. https://doi.org/10.1192/bjp.bp.113.131227

American Academy of Child and Adolescent Psychiatry. (2022). *Anxiety disorders resource center*. https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

American Lung Association. (2021). *Dust and indoor air quality briefing*. https://www.lung.org/getmedia/42925e21-85cc-4a25-b9e4-e71cc98deccd/dust-indoor-air-quality.pdf

American Nurses Association. (2022). *Psychiatric-mental health nursing: Scope and standards of practice* (3rd ed.). American Nurses Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American

Psychiatric Association.

American Psychiatric Association. (2020, March 5). *Rumination: A cycle of negative thinking*. https://www.psychiatry.org/News-room/APA-Blogs/Rumination-A-Cycle-of-Negative-Thinking

American Psychiatric Association. (2021). *What is hoarding disorder?* https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

American Psychological Association. (2017, July). *What is exposure therapy?* https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy

American Psychological Association. (2020). Stress. In *APA dictionary of psychology*. https://www.apa.org/topics/stress

American Psychological Association. (2022, February 14). *What's the difference between stress and anxiety?* Apa.org. https://www.apa.org/topics/stress/anxiety-difference

Anderson, J. (2011). *Help and hope for people with trichotillomania*. American Nurse. https://www.myamericannurse.com/help-and-hope-for-people-with-trichotillomania/

Anderson, S., & Clarke, V. (2017). Disgust, shame and the psychosocial impact of skin picking: Evidence from an online support forum. *Journal of Health Psychology, 24*(13), 1773–1784. https://doi.org/10.1177/1359105317700254

Anxiety and Depression Association of America. (2022, October 28). *Facts & statistics*. https://adaa.org/understanding-anxiety/facts-statistics

Attia, M., Ibrahim, F. A., Elsady, M. A.-E., Khorkhash, M. K., Rizk, M. A., Shah, J., & Amer, S. A. (2022). Cognitive, emotional, physical, and behavioral stress-related symptoms and coping strategies among university students during the third wave of COVID-19 pandemic. *Frontiers in Psychiatry, 13*. https://doi.org/10.3389/fpsyt.2022.933981

Azrin, N., & Nunn, R. (1973). Habit-reversal: A method of eliminating nervous habits and tics. *Behaviour Research and Therapy, 11*(4), 619–628. http://doi.org/10.1016/0005-7967(73)90119-8

Bailey, R., & Pico, J. (2020). Defense mechanisms. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK559106/

Baldwin, D. S., Anderson, I. M., Nutt, D. J., Allgulander, C., Bandelow, B., den Boer, J. A., Christmas, D. M., Davies, S., Fineberg, N., Lidbetter, N., Malizia, A., McCrone, P., Nabarro, D., O'Neill, C., Scott, J., van der Wee, N., & Wittchen, H. U. (2014). Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology. *Journal of Psychopharmacology, 28*(5), 403–439. https://doi.org/10.1177/0269881114525674

Bandelow, B., & Michaelis, S. (2015). Epidemiology of anxiety disorders in the 21st century. *Dialogues in Clinical Neuroscience, 17*(3), 327–335.

Bandelow, B., Baldwin, D., Abelli, M., Bolea-Alamanac, B., Bourin, M., Chamberlain, S., Cinosi, E., Davies, S., Domschke, K. Fineberg, N., Grünblatt, E., Jarema, M., Kim, Y.-K., Maron, E., Masdrakis, V., Mikova, O., Nutt, D., Pallanti, S., Pini, S., . . . Fineberg, N. (2017). Biological markers for anxiety disorders, OCD and PTSD: A consensus statement. Part II: Neurochemistry, neurophysiology and neurocognition. *The World Journal of Biological Psychiatry, 18*(3), 162–214. https://doi.org/10.1080/15622975.2016.1190867

Bandelow, B., Michaelis, S., & Wedekind, D. (2017). Treatment of anxiety disorders. *Generalized Anxiety Disorders, 19*(2), 93–107. https://doi.org/10.31887/dcns.2017.19.2/bbandelow

Bandelow, B., Reitt, M., Röver, C., Michaelis, S., Görlich, Y., & Wedekind, D. (2015, July). Efficacy of treatments for anxiety disorders: A meta-analysis. *Int Clin Psychopharmacol, 30*(4), 183–192. https://doi.org/10.1097/YIC.0000000000000078

Barlow, D., & Durand, V. (2015). *Abnormal psychology: An integrative approach*. Cengage Learning.

Bentley, K., Franklin, J., Ribeiro, J., Kleiman, E., Fox, K., & Nock, M. (2016). Anxiety and its disorders as risk factors for suicidal thoughts and behaviors: A meta-analytic review. *Clinical Psychology Review*, *43*, 30–46. https://doi.org/10.1016/j.cpr.2015.11.008

Berlin, R., Butler, P., & Perloff, M. (2015). Gabapentin therapy in psychiatric disorders: A systematic review. *The Primary Care Companion for CNS Disorders*, *17*(5). https://doi.org/10.4088/PCC.15r01821

Berntsen, D., & Rubin, D. C. (2006). The centrality of event scale: A measure of integrating a trauma into one's identity and its relation to post-traumatic stress disorder symptoms. *Behaviour Research and Therapy, 44*(2), 219–231. https://doi.org/10.1016/j.brat.2005.01.009

Bertolini, F., Robertson, L., Ostuzzi, G., Meader, N., Bisson, J. I., Churchill, R., & Barbui, C. (2020). Early pharmacological interventions for acute traumatic stress symptoms: A network meta-analysis. *The Cochrane Database of Systematic Reviews, 2020*(5), CD013613. https://doi.org/10.1002/14651858.CD013613

Bodryzlova, Y., Audet, J. S., Bergeron, K., & O'Connor, K. (2019). Group cognitive-behavioural therapy for hoarding disorder: Systematic review and meta-analysis. *Health & Social Care in the Community, 27*(3), 517–530. https://doi.org/10.1111/hsc.12598

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Brand, B. L., McNary, S. W., Myrick, A. C., Classen, C. C., Lanius, R., Loewenstein, R. J., Pain, C., & Putnam, F. W. (2013). A longitudinal naturalistic study of patients with dissociative disorders treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(4), 301–308. https://doi.org/10.1037/a0027654

Brand, B. L., Schielke, H. J., Putnam, K. T., Putnam, F. W., Loewenstein, R. J., Myrick, A., Jepsen, E. K. K., Langeland, W., Steele, K., Classen, C. C., & Lanius, R. A. (2019). An online educational program for individuals with dissociative disorders and their clinicians: 1-year and 2-year follow-up. *Journal of Traumatic Stress, 32*(1), 156–166. https://doi.org/10.1002/jts.22370

Bright, K. S., Mughal, M. K., Wajid, A., Lane-Smith, M., Murray, L., Roy, N., Van Zanten, S. V., Mcneil, D. A., Stuart, S., & Kingston, D. (2019). Internet-based interpersonal psychotherapy for stress, anxiety, and depression in prenatal women: Study protocol for a pilot randomized controlled trial. *Trials, 20*(1). https://doi.org/10.1186/s13063-019-3897-z

Brisch, K. (2014). *Treating attachment disorders: From theory to therapy* (2nd ed.). The Guilford Press.

Bryant, R. (2022, May 10). *Treatment of acute stress disorder in adults*. https://www.uptodate.com/contents/treatment-of-acute-stress-disorder-in-adults

Bryant, R., & Harvey, A. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment.* American Psychological Association. https://doi.org/10.1037/10346-000

Buchanan, B., Rossell, S., Maller, J., Toh, W., Brennan, S., & Castle, D. (2013). Brain connectivity in body dysmorphic disorder compared with controls: A diffusion tensor imaging study. *Psychological Medicine, 43*(12), 2513–2521. https://doi.org/10.1017/S0033291713000421

Cassidy, J., & Shaver, P. (2016). *Handbook of attachment: Theory, research, and clinical applications* (3rd ed.). Guilford Press.

Castle, D., Beilharz, F., Phillips, K., Brakoulias, V., Drummond, L. M., Hollander, E., Ioannidis, K., Pallanti, S., Chamberlain, S., Rossell, S., Veale, D., Wilhelm, S., Van Ameringen, M., Dell'Osso, B., Menchon, J., & Fineberg, N. (2021). Body dysmorphic disorder: A treatment synthesis and consensus on behalf of the International College of Obsessive-Compulsive Spectrum Disorders and the Obsessive Compulsive and Related Disorders Network of the European College of Neuropsychopharmacology. *International Clinical Psychopharmacology, 36*(2), 61–75. https://doi.org/10.1097/YIC.0000000000000342

Catchings, C. (2019, November 15). What's the difference between an anxiety attack and a panic attack? https://www.talkspace.com/mental-health/conditions/articles/anxiety-attack-vs-panic-attack-one/

Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E.,

Lyon, T., LeTourneau, E., & Miller-Perrin, C. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, *11*(1), 76–89. https://doi.org/10.1177/1077559505283699

Chesak, S. S., Morin, K. H., Cutshall, S., Carlson, M., Joswiak, M. E., Ridgeway, J. L., Vickers, K. S., Sood, A. (2019). Stress management and resiliency training in a nurse residency program: Findings from participant focus groups. *Journal for Nurses in Professional Development, 35*(6), 337–343. https://doi.org/10.1097/nnd.0000000000000589

Choy, Y., Fyer, A., & Lipsitz, J. (2007). Treatment of specific phobia in adults. *Clinical Psychology Review*, *27*(3), 266–286. https://doi.org/10.1016/j.cpr.2006.10.002

Chu, B., Marwaha, K., & Ayers, D. (2022, September 12). Physiology, stress reaction. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK541120/

Cleveland Clinic. (2022, August 3). *Generalized anxiety disorder (GAD): Symptoms & treatment*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/23940-generalized-anxiety-disorder-gad

Cleveland Clinic. (2023, February 12). *Panic attacks & panic disorder*. https://my.clevelandclinic.org/health/diseases/4451-panic-attack-panic-disorder

Cohen, J., & Mannarino, A. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America*, *24*(3), 557–570. https://doi.org/10.1016/j.chc.2015.02.005

Cohen, J., Mannarino, A., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

Comparcini, D., Tomietto, M., Cicolini, G., Dickens, G. L., Mthimunye, K., Marcelli, S., & Simonetti, V. (2022). Pre-registration nursing students' anxiety and academic concerns after the second wave of COVID-19 pandemic in Italy: A cross-sectional study. *Nurse Education Today*, 118, 105520. https://doi.org/10.1016/j.nedt.2022.105520

Craske, M. G., & Barlow, D. H. (2008). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 1–64). The Guilford Press

Craske, M., Treanor, M., Conway, C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58*, 10–23. https://doi.org/10.1016/j.brat.2014.04.006

Davis, M., Eshelman, E., & McKay, M. (2019). *The relaxation and stress reduction workbook* (7th ed.). New Harbinger Publications.

Davis, T., Ollendick, T., & Ost, L. (2009). Intensive treatment of specific phobias in children and adolescents. *Cognitive and Behavioral Practice*, *16*(3), 294–303. https://doi.org/10.1016/j.cbpra.2008.12.008

de Jongh, A., Ernst, R., Marques, L., & Hornsveld, H. (2013). The impact of eye movements and tones on disturbing memories involving PTSD and other mental disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 44*(4), 477–483. https://doi.org/10.1016/j.jbtep.2013.07.002

de Witte, M., Pinho, A. D. S., Stams, G. J., Moonen, X., Bos, A. E. R., & van Hooren, S. (2022). Music therapy for stress reduction: A systematic review and meta-analysis. *Health Psychology Review, 16*(1), 134–159. https://doi.org/10.1080/17437199.2020.1846580

Department of Respiratory Medicine. (2022). *Grounding techniques to help with anxiety*. https://www.royalberkshire.nhs.uk/media/ijqdxpkb/grounding-techniques-to-help-with-anxiety_apr22.pdf

Donnelly, M. R., Reinberg, R., Ito, K. L., Saldana, D., Neureither, M., Schmiesing, A., Jahng, E., & Liew, S. L. (2021). Virtual reality for the treatment of anxiety disorders: A scoping review. *The American Journal of Occupational Therapy: Official Publication of the American Occupational Therapy Association, 75*(6), 7506205040. https://doi.org/10.5014/ajot.2021.046169

Dozier, M. E., & Ayers, C. R. (2017). The etiology of hoarding disorder: A review. *Psychopathology, 50*(5), 291–296.

https://doi.org/10.1159/000479235

Drescher, J. (2022). *What are dissociative disorders?* Psychiatry.org; American Psychiatric Association. https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders

Dubovsky, S. L., & Marshall, D. (2022). Benzodiazepines remain important therapeutic options in psychiatric practice. *Psychotherapy and Psychosomatics, 91*(5), 307–334. https://doi.org/10.1159/000524400

Dunner, D. L., Aaronson, S. T., Sackeim, H. A., Janicak, P. G., Carpenter, L. L., Boyadjis, T., Brock, D. G., Bonneh-Barkay, D., Cook, I. A., Lanocha, K., Solvason, H. B., & Demitrack, M. A. (2014). A multisite, naturalistic, observational study of transcranial magnetic stimulation for patients with pharmacoresistant major depressive disorder: Durability of benefit over a 1-year follow-up period. *The Journal of Clinical Psychiatry, 75*(12), 1394–1401. https://doi.org/10.4088/JCP.13m08977

El, S., Hassan, S., El-Azzab, I., Mohamed, M., Ali, A., Taha, A., & Ahmed, A. (2023). Original article efficiency of nursing intervention on psychological adjustment, perfectionism and symptoms among patients with obsessive compulsive disorder. *International Egyptian Journal of Nursing Sciences and Research, 3*(2), 796–815.

Ellis, E., Yilanli, M., & Saadabadi, A. (2022). Reactive attachment disorder. [Updated 2022 May 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; https://www.ncbi.nlm.nih.gov/books/NBK537155/

Enander, J., Ivanov, V. Z., Andersson, E., Mataix-Cols, D., Ljótsson, B., & Rück, C. (2014). Therapist-guided, internet-based cognitive-behavioural therapy for body dysmorphic disorder (BDD-NET): A feasibility study. *BMJ Open, 4*(9), e005923. https://doi.org/10.1136/bmjopen-2014-005923

Enander, J., Ivanov, V., Mataix-Cols, D., Kuja-Halkola, R., Ljótsson, B., Lundström, S., Pérez-Vigil, A., Monzani, B., Lichtenstein, P., & Rück, C. (2018). Prevalence and heritability of body dysmorphic symptoms in adolescents and young adults: A population-based nationwide twin study. *Psychological Medicine, 48*(16), 2740–2747. https://doi.org/10.1017/S0033291718000375

Ennis, N., Sijercic, I., & Monson, C. M. (2021). Trauma-focused cognitive-behavioral therapies for posttraumatic stress disorder under ongoing threat: A systematic review. *Clinical Psychology Review, 88*, 102049. https://doi.org/10.1016/j.cpr.2021.102049

Fassbinder, E., Schweiger, U., Martius, D., Brand-de Wilde, O., & Arntz, A. (2016). Emotion regulation in schema therapy and dialectical behavior therapy. *Frontiers in Psychology, 7*, 1373. https://doi.org/10.3389/fpsyg.2016.01373

Felsenstein, D. R. (2024). Stress management strategies for NP practice. *The Nurse Practitioner, 49*(2), 39–46. https://doi.org/10.1097%2F01.NPR.0000000000000144

FHE Health. (2016, May 19). *Is procrastination a sign of a mental health issue?* https://fherehab.com/news/7985-2/

Fink, G. (Ed.). (2016). *Stress: Concepts, cognition, emotion, and behavior*. Academic Press.

Foa, E., Kozak, M., Goodman, W, Hollander, E., Jenike, M., & Rasmussen, S. (1995). DSM-IV field trial: Obsessive-compulsive disorder. *The American Journal of Psychiatry, 152*(1), 90–96. https://doi.org/10.1176/ajp.152.1.90

Fontenelle, L. F., Muhlbauer, J. E., Albertella, L., & Eppingstall, J. (2021). Traumatic and stressful life events in hoarding: The role of loss and deprivation. *European Journal of Psychotraumatology, 12*(1), 1947002. https://doi.org/10.1080/20008198.2021.1947002

Food and Drug Administration. (2020, October 2). *FDA requiring boxed warning updated to improve safe use of benzodiazepine drug class*. FDA: U.S. Food & Drug Administration. https://www.fda.gov/drugs/drug-safety-and-availability/fda-requiring-boxed-warning-updated-improve-safe-use-benzodiazepine-drug-class

Ford, D. M., Budworth, L., Lawton, R., Teale, E. A., & O'Connor, D. B. (2023). In-hospital stress and patient outcomes: A systematic review and meta-analysis. *PloS One, 18*(3), e0282789. https://doi.org/10.1371/journal.pone.0282789

Franklin, M. E., Zagrabbe, K., & Benavides, K. L. (2011). Trichotillomania and its treatment: A review and recommendations. *Expert Review of Neurotherapeutics, 11*(8), 1165–1174. https://doi.org/10.1586/ern.11.93

Freud, A. (1966). *The ego and the mechanisms of defense*. International Universities Press. (Original work published 1936)

Gautam, S., Jain, A., Gautam, M., Vahia, V., & Gautam, A. (2017). Clinical practice guidelines for the management of generalised anxiety disorder (GAD) and panic disorder (PD). *Indian Journal of Psychiatry, 59*(Suppl 1), S67–S73. https://doi.org/10.4103/0019-5545.196975

Gentile, J. P., Dillon, K. S., & Gillig, P. M. (2013). Psychotherapy and pharmacotherapy for patients with dissociative identity disorder. *Innovations in Clinical Neuroscience, 10*(2), 22–29.

Gevirtz, R. (2013). The promise of heart rate variability biofeedback: Evidence-based applications. *Biofeedback, 41*(3), 110–120.

Giourou, E., Skokou, M., Andrew, S., Alexopoulou, K., Gourzis, P., & Jelastopulu, E. (2018). Complex posttraumatic stress disorder: The need to consolidate a distinct clinical syndrome or to reevaluate features of psychiatric disorders following interpersonal trauma? *World Journal of Psychiatry, 8*(1), 12–19. https://doi.org/10.5498/wjp.v8.i1.12

Goddard A. W. (2017). The neurobiology of panic: A chronic stress disorder. *Chronic Stress, 1*, 2470547017736038. https://doi.org/10.1177/2470547017736038

Gould, R. L., Wetherell, J. L., Kimona, K., Serfaty, M. A., Jones, R., Graham, C. D., Lawrence, V., Livingston, G., Wilkinson, P., Walters, K., Le Novere, M., Leroi, I., Barber, R., Lee, E., Cook, J., Wuthrich, V. M., & Howard, R. J. (2021). Acceptance and commitment therapy for late-life treatment-resistant generalised anxiety disorder: A feasibility study. *Age and Ageing, 50*(5), 1751–1761. https://doi.org/10.1093/ageing/afab059

Grajfoner, D., Ke, G. N., & Wong, R. M. M. (2021). The effect of pets on human mental health and wellbeing during COVID-19 lockdown in Malaysia. *Animals: An Open Access Journal from MDPI, 11*(9), 2689. https://doi.org/10.3390/ani11092689

Grant, J. E., & Chamberlain, S. R. (2021). Trichotillomania and skin-picking disorder: An update. *Focus (American Psychiatric Publishing), 19*(4), 405–412. https://doi.org/10.1176/appi.focus.20210013

Grant, J. E., Dougherty, D. D., Chamberlain, S. (2020). Prevalence, gender correlates, and co-morbidity of trichotillomania. *Psychiatry Res*. https://doi.org/10.1016/j.psychres.2020.112948

Grant, J., & Chamberlain, S. (2020). Prevalence of skin picking (excoriation) disorder. *Journal of Psychiatric Research*, *130*, 57–60. https://doi.org/10.1016/j.jpsychires.2020.06.033

Greenberg, J., Falkenstein, M., Reuman, L., Fama, J., Marques, L., & Wilhelm, S. (2013). The phenomenology of self-reported body dysmorphic disorder by proxy. *Body Image, 10*(2), 243–246. https://doi.org/10.1016/j.bodyim.2013.01.001

Greenberg, M. (2017). *The stress-proof brain: Master your emotional response to stress using mindfulness and neuroplasticity*. New Harbinger Publications.

Harrison, A., Fernández de la Cruz, L., Enander, J., Radua, J., & Mataix-Cols, D. (2016). Cognitive-behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review, 48*, 43–51. https://doi.org/10.1016/j.cpr.2016.05.007

Hasbi, M., & Effendy, E. (2019). Hypnotherapy: A case of anxiety person who doesn't want to use medication. *Open Access Macedonian Journal of Medical Sciences, 7*(16), 2698–2700. https://doi.org/10.3889/oamjms.2019.820

Hepsomali, P., & Groeger, J. A. (2021). Diet, sleep, and mental health: Insights from the UK Biobank Study. *Nutrients, 13*(8), 2573. https://doi.org/10.3390/nu13082573

Hezel, D. M., and Simpson, H. B. (2019). *Exposure and response prevention for obsessive-compulsive disorder: A review and new directions*. Indian J Psychiatry. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_516_18

Hohfeler, R. A. (2016). Intensive psychotherapy for persistent dissociative processes: The fear of feeling real, by R. A. Chefetz. *Journal of Trauma & Dissociation, 17*(5), 608–608. https://doi.org/10.1080/15299732.2016.1205394

Huang, S. (2020, August 24). *Attachment styles*. Simply Psychology. https://www.simplypsychology.org/attachment-styles.html

Huntjens, R. J. C., Rijkeboer, M. M., & Arntz, A. (2019). Schema therapy for dissociative identity disorder (DID): Rationale and study protocol. *European Journal of Psychotraumatology, 10*(1), 1571377. https://doi.org/10.1080/20008198.2019.1571377

International OCD Foundation. (2023). *OCD*. https://iocdf.org/about-ocd/

International Society for the Study of Trauma and Dissociation (2011). Guidelines for treating dissociative identity disorder in adults, third revision: Summary version. *Journal of Trauma & Dissociation: The Official Journal of the International Society for the Study of Dissociation (ISSD), 12*(2), 188–212. https://doi.org/10.1080/15299732.2011.537248

Iribarren, J., Prolo, P., Neagos, N., & Chiappelli, F. (2005). Post-traumatic stress disorder: Evidence-based research for the third millennium. *Evidence-Based Complementary and Alternative Medicine: eCAM*, *2*(4), 503–512. https://doi.org/10.1093/ecam/neh127

Jaroszewski, A., & Wilheim, S. (2022). Body dysmorphic disorder. *Neuroscience and Behavioral Psychology*. https://doi.org/10.1016/B978-0-323-91497-0.00186-7

Jassi, A., Shahriyarmolki, K., Taylor, T., Peile, L., Challacombe, F., Clark, B., & Veale, D. (2020). OCD and COVID-19: A new frontier. *Cognitive Behaviour Therapist, 13*, e27. https://doi.org/10.1017/S1754470X20000318

Julian L. J. (2011). Measures of anxiety: State-Trait Anxiety Inventory (STAI), Beck Anxiety Inventory (BAI), and Hospital Anxiety and Depression Scale-Anxiety (HADS-A). *Arthritis care & research*, *63 Suppl 11*(0 11), S467–S472. https://doi.org/10.1002/acr.20561

Kaplan, J. S., & Tolin, D. F. (2011, September 7). *Exposure therapy for anxiety disorders*. Psychiatric Times. https://www.psychiatrictimes.com/view/exposure-therapy-anxiety-disorders

Kariotis, T. C., Prictor, M., Chang, S., & Gray, K. (2022). Impact of electronic health records on information practices in mental health contexts: Scoping review. *Journal of Medical Internet Research, 24*(5), e30405. https://doi.org/10.2196/30405

Kehoe, E., & Egan, J. (2019). Interpersonal attachment insecurity and emotional attachment to possessions partly mediate the relationship between childhood trauma and hoarding symptoms in a non-clinical sample. *Journal of Obsessive-Compulsive and Related Disorders, 21*, 37–45. https://doi.org/10.1016/j.jocrd.2018.12.001

Kelmendi, B., Adams, T. G., Southwick, S., Abdallah, C. G., & Krystal, J. H. (2017). Posttraumatic stress disorder: An integrated overview and neurobiological rationale for pharmacology. *Clinical Psychology: A Publication of the Division of Clinical Psychology of the American Psychological Association, 24*(3), 281–297. https://doi.org/10.1111/cpsp.12202

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., Cardoso, G., Degenhardt, L., de Girolamo, G., Dinolova, R. V., Ferry, F., Florescu, S., Gureje, O., Haro, J. M., Huang, Y., Karam, E. G., Kawakami, N., Lee, S., Lepine, J. P., Levinson, D., Navarro-Mateu, F., … Koenen, K. C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology, 8*(sup5), 1353383. https://doi.org/10.1080/20008198.2017.1353383

Kim, Y. K. (2019). Panic disorder: Current research and management approaches. *Psychiatry Investigation, 16*(1), 1–3. https://doi.org/10.30773/pi.2019.01.08

Kishikawa, Y., Tanaka, S., Iwanaga, K., Nakagawa, I., Shiotsuka, T., Tsuda, N., Kobachi, Y., Hirano, K., & Murakami, Y. (2022). Effects of pain-related catastrophic thinking, anxiety, and depression on pain intensity and quality of life in patients with knee and low back pain. *Journal of Physical Therapy Science, 34*(9), 625–629. https://doi.org/10.1589/jpts.34.625

Klaperski, S., Koch, E., Hewel, D., Schempp, A., & Müller, J. (2019). Optimizing mental health benefits of exercise: The influence of the exercise environment on acute stress levels and wellbeing. *Mental Health & Prevention, 15*(15), 200173. https://doi.org/10.1016/j.mhp.2019.200173

Knowles, K. A., & Olatunji, B. O. (2019). Enhancing inhibitory learning: The utility of variability in exposure. *Cognitive and Behavioral Practice, 26*(1), 186–200. https://doi.org/10.1016/j.cbpra.2017.12.001

Kobak, R., Zajac, K., Herres, J., & Krauthamer Ewing, E. S. (2015). Attachment based treatments for adolescents: The secure cycle as a framework for assessment, treatment and evaluation. *Attachment & Human Development, 17*(2), 220–239. https://doi.org/10.1080/14616734.2015.1006388

Kriakous, S. A., Elliott, K. A., Lamers, C., & Owen, R. (2021). The effectiveness of mindfulness-based stress reduction on the psychological functioning of healthcare professionals: A systematic review. *Mindfulness, 12*(1), 1–28. https://doi.org/10.1007/s12671-020-01500-9

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: Barriers, facilitators, and the way forward. *BMC Nursing, 20*(1), 1–10. https://doi.org/10.1186/s12912-021-00684-2

Kwon, C., Sutaria, N., Khanna, R., Almazan, E., Williams, K., Kim, N., Elmariah, S., & Kwatra, S. G. (2020). Epidemiology and comorbidities of excoriation disorder: A retrospective case-control study. *Journal of Clinical Medicine, 9*(9), 2703. https://doi.org/10.3390/jcm9092703

Kyriakou, K., Resch, B., Sagl, G., Petutschnig, A., Werner, C., Niederseer, D., Liedlgruber, M., Wilhelm, F., Osborne, T., & Pykett, J. (2019). Detecting moments of stress from measurements of wearable physiological sensors. *Sensors (Basel, Switzerland)*, *19*(17), 3805. https://doi.org/10.3390/s19173805

Lee, M., Mpavaenda, D., & Fineberg, N. (2019). Habit reversal therapy in obsessive compulsive related disorders: A systematic review of the evidence and CONSORT evaluation of randomized controlled trials. *Frontiers Media SA*. https://doi.org/10.3389/fnbeh.2019.00079

Lochner, C., Roos, A., & Stein, D. J. (2017). Excoriation (skin-picking) disorder: A systematic review of treatment options. *Neuropsychiatric Disease and Treatment, 13*, 1867–1872. https://doi.org/10.2147/NDT.S121138

Loewenstein, R. J. (2018). Dissociation debates: Everything you know is wrong. *Dialogues in Clinical Neuroscience*, *20*(3), 229–242. https://doi.org/10.31887/DCNS.2018.20.3/rloewenstein

Mann, S., & Marwaha R. (2023). Posttraumatic stress disorder. [Updated 2023 Jan 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; https://www.ncbi.nlm.nih.gov/books/NBK559129/

Maslenikov, N., Tsukarzi, E. E., & Mosolov, S. N. (2017). Treatment-resistant depression in schizophrenia: Clinical response predictors of repetitive transcranial magnetic stimulation (rTMS). *European Neuropsychopharmacology, 27*, S693–S694. https://doi.org/10.1016/s0924-977x(17)31287-7

Mason, J. (2018). *Exploring the discourses of compulsive hair-pulling: A body-exploring the discourses of compulsive hair-pulling: A body-mapping study mapping study*. Retrieved August 23, 2023, from https://scholars.wlu.ca/cgi/viewcontent.cgi?article=3183&context=etd

Mayo Clinic. (2017, October 13). *Generalized anxiety disorder*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/generalized-anxiety-disorder/diagnosis-treatment/drc-20361045

Mayo Clinic. (2018a, February 3). *Hoarding disorder*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/hoarding-disorder/symptoms-causes/syc-20356056

Mayo Clinic. (2018b, May 4). *Panic attacks and panic disorder*. https://www.mayoclinic.org/diseases-conditions/panic-attacks/symptoms-causes/syc-20376021

Mayo Clinic. (2019, October 5). *Serotonin and norepinephrine reuptake inhibitors (SNRIs)*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/depression/in-depth/antidepressants/art-20044970

Mayo Clinic. (2022a, May 12). *Reactive attachment disorder*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/reactive-attachment-disorder/diagnosis-treatment/drc-20352945

Mayo Clinic. (2022b, December 13). *Body dysmorphic disorder*. Mayo Clinic. Retrieved February 23, 2023, from https://www.mayoclinic.org/diseases-conditions/body-dysmorphic-disorder/diagnosis-treatment/drc-20353944

Mayo Clinic. (2023a, June 9). *Specific phobias*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/specific-phobias/symptoms-causes/syc-20355156

Mayo Clinic. (2023b, December 21). *Obsessive-compulsive disorder (OCD)*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/obsessive-compulsive-disorder/diagnosis-treatment/drc-20354438

Mcleod, S. (2017). *Attachment theory*. Simplypsychology.org; Simply Psychology. https://www.simplypsychology.org/attachment.html

Melaragno, A. J. (2021). Pharmacotherapy for anxiety disorders: From first-line options to treatment resistance. *Focus (American Psychiatric Publishing), 19*(2), 145–160. https://10.1176/appi.focus.20200048

Mikulincer, M., & Shaver, P. (2016). Attachment in adulthood: Structure, dynamics, and change (2nd ed.). Guilford Press.

Millen, A., Linkovski, O., Dunn, L. B., & Rodriguez, C. I. (2017). Ethical challenges in treating hoarding disorder: Two primary care clinical case studies. *Focus (American Psychiatric Publishing), 15*(2), 185–189. https://doi.org/10.1176/appi.focus.20170002

Mitra, P., & Jain, A. (2021, November 21). *Dissociative identity disorder*. PubMed. https://www.ncbi.nlm.nih.gov/books/NBK568768/

Moore J. W. (2016). What is the sense of agency and why does it matter? *Frontiers in Psychology, 7*, 1272. https://doi.org/10.3389/fpsyg.2016.01272

Morris, S., Zickgraf, H., Dingfelder, H., & Franklin, M. (2013). Habit reversal training in trichotillomania: Guide for the clinician. *Expert Review of Neurotherapeutics*, *13*(9), 1069–1077. https://doi.org/10.1586/14737175.2013.827477

Na, H. R., Kang, E. H., Lee, J. H., & Yu, B. H. (2011). The genetic basis of panic disorder. *Journal of Korean Medical Science, 26*(6), 701–710. https://doi.org/10.3346/jkms.2011.26.6.701

Nakao, M., Shirotsuki, K., & Sugaya, N. (2021). Cognitive–behavioral therapy for management of mental health and stress-related disorders: Recent advances in techniques and technologies. *BioPsychoSocial Medicine, 15*(1). https://doi.org/10.1186/s13030-021-00219-w

Nash, J. (2022, September 23). *Systematic desensitization steps: 13 techniques & worksheets*. PositivePsychology.com. https://positivepsychology.com/systematic-desensitization/

National Center for PTSD. (2023). *About the National Center for PTSD*. Retrieved March 20, 2023, from https://www.ptsd.va.gov

National Institute of Mental Health. (2016). *Panic disorder: When fear overwhelms*. https://www.nimh.nih.gov/health/publications/panic-disorder-when-fear-overwhelms

National Institute of Mental Health. (2022a). *Generalized anxiety disorder: When worry gets out of control*. https://www.nimh.nih.gov/health/publications/generalized-anxiety-disorder-gad

National Institute of Mental Health. (2022b). *Obsessive compulsive disorder*. https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

National Institute of Mental Health. (2022c). *Post-traumatic stress disorder*. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

National Institute of Mental Health. (2023). *Anxiety disorders*. https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Ndibu Muntu Keba Kebe, N., Chiocchio, F., Bamvita, J. M., & Fleury, M. J. (2019). Profiling mental health professionals in relation to perceived interprofessional collaboration on teams. *SAGE Open Medicine, 7*. https://doi.org/10.1177/2050312119841467

Nuss, P. (2015). Anxiety disorders and GABA neurotransmission: A disturbance of modulation. *Neuropsychiatric*

Disease and Treatment, 11, 165–175. https://doi.org/10.2147/NDT.S58841

Pauls, D. (2008). The genetics of obsessive compulsive disorder: A review of the evidence. *American Journal of Medical Genetics. Part C, Seminars in Medical Genetics, 148C*(2), 133–139. https://doi.org/10.1002/ajmg.c.30168

Perera, T., George, M. S., Grammer, G., Janicak, P. G., Pascual-Leone, A., & Wirecki, T. S. (2016). The clinical TMS society consensus review and treatment recommendations for TMS therapy for major depressive disorder. *Brain Stimulation, 9*(3), 336–346. https://doi.org/10.1016/j.brs.2016.03.010

Perkins, A. (2019). Body dysmorphic disorder: The drive for perfection. *Nursing, 49*(3), 28–33. https://doi.org/10.1097/01.nurse.0000553273.24557.58

Peterson, A. L., Foa, E. B., & Riggs, D. S. (2019). Prolonged exposure therapy. In B. A. Moore & W. E. Penk (Eds.), *Treating PTSD in military personnel: A clinical handbook* (pp. 46–62). The Guilford Press.

Phillips, K. A., Menard, W., Fay, C., & Weisberg, R. (2005). Demographic characteristics, phenomenology, comorbidity, and family history in 200 individuals with body dysmorphic disorder. *Psychosomatics, 46*(4), 317–325. https://doi.org/10.1176/appi.psy.46.4.317

Postlethwaite, A., Kellett, S., & Mataix-Cols, D. (2019). Prevalence of hoarding disorder: A systematic review and meta-analysis. *Journal of Affective Disorders*, *256*, 309–316. https://doi.org/10.1016/j.jad.2019.06.004

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services, 34*(4), 360–386. https://doi.org/10.1080/0145935X.2013.859906

Rajhans, P., Hans, G., Kumar, V., & Chadda, R. K. (2020). Interpersonal psychotherapy for patients with mental disorders. *Indian Journal of Psychiatry, 62*(Suppl 2), S201–S212. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_771_19

Rapinesi, C., Kotzalidis, G., Ferracuti, S., Sani, G., Girardi, P., & Del Casale, A. (2019). Brain stimulation in obsessive-compulsive disorder (OCD): A systematic review. *Current Neuropharmacology, 17*(8), 787–807. https://doi.org/10.2174/1570159X17666190409142555

Reid, J., Laws, K., Drummond, L., Vismara, M., Grancini, B., Mpavaenda, D., & Fineberg, N. (2021). Cognitive behavioural therapy with exposure and response prevention in the treatment of obsessive-compulsive disorder: A systematic review and meta-analysis of randomised controlled trials. *Comprehensive Psychiatry, 106*. https://doi.org/10.1016/j.comppsych.2021.152223

Rnic, K., Dozois, D. J., & Martin, R. A. (2016). Cognitive distortions, humor styles, and depression. *Europe's Journal of Psychology, 12*(3), 348–362. https://doi.org/10.5964/ejop.v12i3.1118

Robinson, O. J., Vytal, K., Cornwell, B. R., & Grillon, C. (2013). The impact of anxiety upon cognition: Perspectives from human threat of shock studies. *Frontiers in Human Neuroscience, 7*, 203. https://doi.org/10.3389/fnhum.2013.00203

Rodak, K., Kokot, I., & Kratz, E. M. (2021). Caffeine as a factor influencing the functioning of the human body-friend or foe? *Nutrients, 13*(9), 3088. https://doi.org/10.3390/nu13093088

Rodriguez, C. I., Levinson, A., Patel, S. R., Rottier, K., Zwerling, J., Essock, S., Shuer, L., Frost, R. O., & Simpson, H. B. (2016). Acceptability of treatments and services for individuals with hoarding behaviors. *Journal of Obsessive-Compulsive and Related Disorders, 11*, 1–8. https://doi.org/10.1016/j.jocrd.2016.07.001

Rose, M., & Devine, J. (2014). Assessment of patient-reported symptoms of anxiety. *Dialogues in Clinical Neuroscience, 16*(2), 197–211. https://doi.org/10.31887/DCNS.2014.16.2/mrose

Rosenbaum, J. F. (2020). Benzodiazepines: A perspective. *American Journal of Psychiatry, 177*(6), 488–490. https://doi.org/10.1176/appi.ajp.2020.20040376

Saha, S., Chauhan, A., Buch, B., Makwana, S., Vikar, S., Kotwani, P., & Pandya, A. (2020). Psychosocial rehabilitation of people living with mental illness: Lessons learned from community-based psychiatric rehabilitation centres in

Gujarat. *Journal of Family Medicine and Primary Care, 9*(2), 892–897. https://doi.org/10.4103/jfmpc.jfmpc_991_19

Saxena, S., & Rauch, S. (2000). Functional neuroimaging and the neuroanatomy of obsessive-compulsive disorder. *The Psychiatric Clinics of North America, 23*(3), 563–586. https://doi.org/10.1016/s0193-953x(05)70181-7

Scheering, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14*(4), 799–815. https://doi.org/10.1023/A:1013002507972

Schoenmakers, E. C., van Tilburg, T. G., & Fokkema, T. (2015). Problem-focused and emotion-focused coping options and loneliness: How are they related? *European Journal of Ageing, 12*(2), 153–161. https://doi.org/10.1007/s10433-015-0336-1

Schuman-Olivier, Z., Trombka, M., Lovas, D. A., Brewer, J. A., Vago, D. R., Gawande, R., Dunne, J. P., Lazar, S. W., Loucks, E. B., & Fulwiler, C. (2020). Mindfulness and behavior change. *Harvard Review of Psychiatry, 28*(6), 371–394. https://doi.org/10.1097/HRP.0000000000000277

Sekowski, M. (2022). Does psychosocial ego development partially mediate the association between defense mechanisms and death attitude? *Omega: Journal of Death & Dying, 85*(3), 716–731. https://doi-org.lib-proxy.jsu.edu/10.1177/0030222820956734

Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal, 18*(1)71–77. https://doi.org/10.7812%2FTPP%2F13-098

Sherwood, G., & Barnsteiner, J. (2017). *Quality and safety in nursing: A competency approach to improving outcomes* (2nd ed.). Wiley-Blackwell. https://psnet.ahrq.gov/issue/quality-and-safety-nursing-competency-approach-improving-outcomes-second-edition

Simeon, D. (2024). *Depersonalization/derealization disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis*. https://www.uptodate.com/contents/depersonalization-derealization-disorder-epidemiology-pathogenesis-clinical-manifestations-course-and-diagnosis

Smith, S. (2018, April 10). *5-4-3-2-1 coping technique for anxiety*. University of Rochester Medical Center. https://www.urmc.rochester.edu/behavioral-health-partners/bhp-blog/april-2018/5-4-3-2-1-coping-technique-for-anxiety.aspx

Strawn, J. R., Geracioti, L., Rajdev, N., Clemenza, K., & Levine, A. (2018). Pharmacotherapy for generalized anxiety disorder in adult and pediatric patients: An evidence-based treatment review. *Expert Opinion on Pharmacotherapy*, *19*(10), 1057–1070. https://doi.org/10.1080/14656566.2018.1491966

Subramanyam, A. A., Somaiya, M., Shankar, S., Nasirabadi, M., Shah, H. R., Paul, I., & Ghildiyal, R. (2020). Psychological interventions for dissociative disorders. *Indian Journal of Psychiatry, 62*(Suppl 2), S280–S289. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_777_19

Substance Abuse and Mental Health Services Administration. (2014). *Understanding the impact of trauma*. National Library of Medicine; Substance Abuse and Mental Health Services Administration (US). https://www.ncbi.nlm.nih.gov/books/NBK207191/

Substance Abuse and Mental Health Services Administration. (2023, February 8). *Post-traumatic stress disorder (PTSD)*. https://www.samhsa.gov/mental-health/post-traumatic-stress-disorder

Thanveer, F., & Khunger, N. (2016). Screening for body dysmorphic disorder in a dermatology outpatient setting at a tertiary care centre. *Journal of Cutaneous and Aesthetic Surgery, 9*(3), 188–191. https://doi.org/10.4103/0974-2077.191649

Toussaint, L., Nguyen, Q. A., Roettger, C., Dixon, K., Offenbächer, M., Kohls, N., Hirsch, J., & Sirois, F. (2021). Effectiveness of progressive muscle relaxation, deep breathing, and guided imagery in promoting psychological and physiological states of relaxation. *Evidence-Based Complementary and Alternative Medicine: eCAM*, 2021. https://doi.org/10.1155/2021/5924040

Tse, J., & Haslam, N. (2021). Inclusiveness of the concept of mental disorder and differences in help-seeking between Asian and White Americans. *Frontiers in Psychology*, *12*, https://doi.org/10.3389/fpsyg.2021.699750

Turner, M., Beckwith, H., Duschinsky, R., Forslund, T., Foster, S. L., Coughlan, B., Pal, S., & Schuengel, C. (2019). Attachment difficulties and disorders. *InnovAiT, 12*(4), 173. https://doi.org/10.1177/1755738018823817

Vandekerckhove, M., & Wang, Y. L. (2017). Emotion, emotion regulation and sleep: An intimate relationship. *AIMS Neuroscience, 5*(1), 1–17. https://doi.org/10.3934/Neuroscience.2018.1.1

Veale, D., Anson, M., Miles, S., Pieta, M., Costa, A., & Ellison, N. (2014). Efficacy of cognitive behaviour therapy versus anxiety management for body dysmorphic disorder: A randomised controlled trial. *Psychotherapy and Psychosomatics, 83*(6), 341–353. https://doi.org/10.1159/000360740

Weir, K. (2020, April 1). *Treating people with hoarding disorder*. American Psychological Association. https://www.apa.org/monitor/2020/04/ce-corner-hoarding

Wong, E., Mavondo, F., & Fisher, J. (2020). Patient feedback to improve quality of patient-centred care in public hospitals: A systematic review of the evidence. *BMC Health Services Research, 20*(1). https://doi.org/10.1186/s12913-020-05383-3

Wong, J. W., Nguyen, T. V., & Koo, J. Y. (2013). Primary psychiatric conditions: Dermatitis artefacta, trichotillomania and neurotic excoriations. *Indian Journal of Dermatology, 58*(1), 44–48. https://doi.org/10.4103/0019-5154.105287

Yamamoto-Mitani, N., Noguchi-Watanabe, M., & Fukahori, H. (2016). Caring for clients and families with anxiety: Home care nurses' practice narratives. *Global Qualitative Nursing Research*, *3*. https://doi.org/10.1177/2333393616665503

Yan, A. F., Stevens, P., Holt, C., Walker, A., Ng, A., McManus, P., Basen-Enguist, K., Weinhardt, L. S., Underwood, S. M., Asan, O., & Wang, M. Q. (2019). Culture, identity, strength and spirituality: A qualitative study to understand experiences of African American women breast cancer survivors and recommendations for intervention development. *European Journal of Cancer Care, 28*(3). https://doi.org/10.1111/ecc.13013

Zakhary, L. (2021, August 13). *Picking your skin? Learn four tips to break the habit*. Harvard Health Publishing. https://www.health.harvard.edu/blog/picking-your-skin-learn-four-tips-to-break-the-habit-2018112815447

Zeanah, C., Chesher, T., Boris, N., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2016). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder and disinhibited social engagement disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(11), 990–1003. https://doi.org/10.1016/j.jaac.2016.08.004

Zhaoyang, R., Scott, S. B., Smyth, J. M., Kang, J. E., & Sliwinski, M. J. (2020). Emotional responses to stressors in everyday life predict long-term trajectories of depressive symptoms. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine, 54*(6), 402–412. https://doi.org/10.1093/abm/kaz057

CHAPTER 18
Personality Disorders

FIGURE 18.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Personality is like the fingerprint of the soul, defining who individuals are and shaping how they interact with the world. It's what makes people unique, influencing their thoughts, feelings, and behaviors. Whereas some people are outgoing and adventurous, others are more reserved and introspective; personalities encompass a wide range of traits that contribute to individuality.

For some individuals, however, personality traits can become so rigid and deeply ingrained that they interfere with their ability to navigate life smoothly. This is where personality disorders come into play. Picture it like a kaleidoscope of maladaptive patterns that influence how someone perceives themselves, relates to others, and copes with life's challenges. Personality disorders are not just quirks or simple character flaws, they are serious behavioral health conditions that require understanding, compassion, and specialized treatment.

By understanding the complexity of personality and the unique struggles faced by those with personality disorders, nurses can promote empathy, reduce stigma, and foster a more compassionate society. It's important to remember that nobody is defined solely by their disorder, and everyone needs a chance to be seen and understood beyond their diagnosis. Through education, awareness, and support, nurses can help create a world where individuals with personality disorders are empowered to embrace their strengths, navigate their challenges, and lead fulfilling lives.

18.1 Identification and Diagnosis

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the general symptoms of personality disorders and how they develop
- Describe and identify diagnostic criteria for personality disorders

Understanding the symptoms and diagnostic process of personality disorders is essential in recognizing and addressing these complex mental health conditions. Personality disorders are classified into three clusters: cluster A, schizoid personality disorder; cluster B, antisocial personality disorder; and cluster C, avoidant personality disorder. This section explores the general symptoms exhibited by individuals with personality disorders, such as difficulties in interpersonal relationships, emotional instability, and distorted self-image. Additionally, this section will delve into the diagnostic process, which involves a provider comprehensively assessing a person's symptoms, taking a personal history, and observing behaviors. By gaining insight into the symptoms and diagnostic criteria of personality disorders, nurses can develop a better understanding of these conditions and their impact on individuals' lives, promoting early recognition and effective intervention.

Symptoms and Signs of Personality Disorders

Personality disorders are characterized by rigid and inflexible traits that are pervasive and persist over time (American Psychiatric Association [APA], 2022a). These patterns are typically stable and consistent, beginning in adolescence or early adulthood and continuing throughout a person's life. While specific symptoms and signs vary depending on the type of personality disorder, some common features and patterns often exist. Here are some general symptoms and signs that can be associated with personality disorders:

- Distorted self-perception: Individuals with personality disorders may have an unstable or unclear sense of self, fluctuating self-esteem, and a tendency to define themselves through their relationships or external validation.
- Dysfunctional relationships: Difficulty establishing and maintaining healthy relationships is often a hallmark of personality disorders. This can manifest as intense, unstable, or conflicted relationships, a fear of abandonment, or patterns of idealization and devaluation.
- Emotional instability: People with personality disorders may experience intense and fluctuating emotions, such as anger, anxiety, depression, or chronic feelings of emptiness. Emotional regulation may be challenging, leading to impulsive or self-destructive behaviors.
- Maladaptive coping mechanisms: Individuals with personality disorders may employ maladaptive coping strategies, such as substance misuse, self-harm, or engaging in risky behaviors as a means of managing distress or avoiding emotional pain.
- Cognitive and perceptual distortions: Distorted thinking patterns, including black-and-white thinking, excessive suspicion, and difficulty with empathy or perspective-taking, are common in personality disorders.
- Impaired functioning in multiple areas: Personality disorders often interfere with various domains of life, such as work, education, relationships, and self-care.

Clients with personality disorders have symptoms in two or more of the following areas: cognition (ways of perceiving and interpreting self, other people, or events), affectivity (the range, intensity, lability, and appropriateness of emotional response), interpersonal functioning, and impulse control.

Defining Personality and When It Becomes a Disorder

The unique and enduring patterns of thoughts, emotions, and behaviors that characterize individuals and distinguish them from others is a person's **personality** (APA, 2022a). It encompasses a person's consistent ways of perceiving, interpreting, and interacting with the world around them. Personality is shaped by a combination of genetic, biological, and environmental factors, including upbringing, culture, and life experiences. It is considered relatively stable over time, but it can also evolve and change to some extent as individuals grow, learn, and adapt to new circumstances.

The characteristics, whether considered positive or negative, that make up one's personality are considered their **personality traits**. A person is considered to have a **personality disorder** when they exhibit enduring patterns of thoughts, emotions, and behaviors that deviate significantly from cultural norms and these patterns cause

significant distress and impairment in functioning (APA, 2022a). These patterns are characterized by rigidity, inflexibility, and maladaptive behaviors that affect various aspects of an individual's life. The key diagnostic factor is the impact on functioning and well-being. While everyone has unique personality traits, a personality disorder is diagnosed when these traits cause significant distress, disrupt daily life, and lead to difficulties in relationships, work, or other areas of functioning.

Possible Causes of Personality Disorder

Personality disorders are among the least understood mental health conditions (Fariba et al., 2023). Scientists are still trying to figure out precisely what causes them. So far, they believe the following factors may contribute to the development of personality disorders:

- Genetics: Scientists have identified malfunctioning genes that may be a factor in schizotypal, borderline personality disorder (BPD), antisocial personality disorder (ASPD), and obsessive-compulsive personality disorder (OCPD). They are also researching genetic links to certain emotions, such as aggression, anxiety, and fear, which are traits that can play a role in personality disorders (Cleveland Clinic, 2022).
- Brain changes: Scientists have been able to identify brain differences in certain people with personality disorders (Cleveland Clinic, 2022). For example, research on paranoid personality disorder has shown altered amygdala functioning. The amygdala is the part of the brain involved in the formation and storage of emotional memories, particularly those associated with fear and aggression.
- Childhood trauma and abuse: Adverse experiences during childhood, such as abuse, neglect, trauma, or inconsistent parenting, can contribute to the development of personality disorders. For example, people with borderline personality disorder have higher rates of childhood sexual trauma (Cleveland Clinic, 2022).
- Cultural factors: Cultural factors may also play a role in the development of personality disorders, as demonstrated by the varying rates of personality disorders between different countries.

CULTURAL CONTEXT

Personality Disorders and Cultural Factors

Part of the defining feature of a personality disorder is that the behaviors exhibited must be *different* from the cultural norms of the client. Different cultures have different standards for what is considered "normal" behavior and this must be taken into account during the diagnostic process. Behavior that is considered normal in one culture can lead to stigma, discrimination, ostracization, and even institutionalization and incarceration in another.

The differences in the prevalence of personality disorders between cultures may be influenced by factors, such as race, ethnicity, social requirements, and the dimension of individualism-collectivism. These standards will influence the personality and behaviors of the population and how personality disorders are diagnosed. Asian cultures tend to be collectivistic, emphasizing cooperation and contribution to the needs of the group above the needs of the individual, which can lead to lower rates of antisocial personality disorders.

Maladaptive and Undesirable Behavior

Patterns of thoughts, emotions, and actions that are ineffective or counterproductive to normal, everyday life are considered **maladaptive behavior**. Individuals with personality disorders typically turn to maladaptive behaviors as coping mechanisms to help manage distress or avoid emotional pain. For example, individuals with borderline personality disorder may engage in impulsive and self-destructive behaviors, such as self-harm or substance misuse, as a way to regulate intense emotions. These coping strategies may provide temporary relief but can lead to further distress and negative consequences in the long run.

Emotional dysregulation is a common feature of many personality disorders. Individuals may experience intense and rapidly shifting emotions, such as anger, sadness, fear, or emptiness. Their emotional responses may be disproportionate to the situation or difficult to control, leading to impulsive and disruptive behaviors. For instance, individuals with antisocial personality disorder may engage in the financial manipulation or exploitation of others. They often display a lack of remorse or empathy, which allows them to engage in these behaviors.

People with personality disorders often exhibit distorted and maladaptive patterns of thinking. They may hold rigid beliefs, engage in black-and-white thinking, or have a skewed perception of themselves and others. These cognitive

distortions can contribute to negative self-image, feelings of worthlessness, and impaired decision-making abilities. For example, individuals with avoidant personality disorder may have an intense fear of rejection or criticism, leading to avoidance of social situations and persistent feelings of inadequacy.

Personality disorders often involve difficulties in forming and maintaining healthy relationships. Individuals may struggle with maintaining boundaries, have intense and unstable relationships, or exhibit manipulative and controlling behaviors. For instance, individuals with narcissistic personality disorder often have an exaggerated sense of self-importance, lack empathy, and exploit others for personal gain. These interpersonal difficulties can lead to conflicts, social isolation, and a cycle of turbulent relationships.

Maladaptive behaviors are not intentional or chosen by individuals with personality disorders. They arise from deep-seated patterns ingrained over time and are often rooted in underlying emotional and psychological struggles. Addressing these behaviors requires a comprehensive and individualized approach that combines therapy, support, and skill-building techniques to promote healthier coping mechanisms, improved interpersonal relationships, and enhanced emotional regulation.

LINK TO LEARNING

The Oxford Health NHS Foundation Trust has created a short video about diagnosing, treating, and living with a personality disorder (https://openstax.org/r/77persondisordr) that features discussions with clients with personality disorders and professionals who help in their treatment.

Diagnosis of Personality Disorders

Personality disorders can only be diagnosed by highly trained, qualified professionals—generally a psychiatrist, a psychiatric nurse practitioner, or a clinical psychologist—following a comprehensive and complex history and behavioral assessment of the client. It is important to remember that many clients who are diagnosed with personality disorders do not initially present seeking treatment for personality disorder (Fariba et al., 2023). Many present with other complaints, such as depression, anxiety, issues with interpersonal relationships, or persistent problems at work. It is up to the clinician to perform an accurate diagnosis.

The process usually begins with an initial assessment, during which the clinician gathers information about the individual's symptoms, medical history, and personal background. They may conduct interviews with the individual and, if possible, obtain information from family members or friends. They might employ certain tests, such as the McLean Screening Instrument for Borderline Personality Disorder (McKay et al., 2022), which is a ten-question yes/no survey questioning feelings and relationships. The clinician will observe the client's behavior for characteristics, such as appropriate emotional responses during therapy sessions. Other mental diagnoses, such as mood disorders, substance misuse, or anxiety, can have symptoms that mimic personality disorders, and providers must rule them out.

Two of the most defining diagnostic characteristics of personality disorders are their persistence or the length of time that the symptoms have been present and how significantly they impair the client's life (APA, 2022a). The clinician must consider whether the symptoms and patterns of behavior of the personality disorder appeared before young adulthood; if they are consistent with the client's long-term functioning; and if they significantly impair the client's functioning in various areas of life, such as work, relationships, or self-care. Only after gathering all of this relevant information is the clinician able to make an informed decision about the client's diagnosis.

18.2 Cluster Disorders (A, B, C)

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the key features related to different types of cluster A personality disorders
- Outline the key features related to different types of cluster B personality disorders
- Outline the key features related to different types of cluster C personality disorders

Personality disorders can be grouped into three distinct clusters, each characterized by its own unique features and

patterns. These clusters provide a framework for understanding the different types of personality disorders and the challenges associated with them (Fariba et al., 2023).

Cluster A comprises the "odd and eccentric" personalities (APA, 2022a). People in this cluster often exhibit peculiar behaviors, unconventional thoughts, and may come across as distant or detached. They may have difficulties forming and maintaining social relationships and display patterns of suspicion, magical thinking, or idiosyncratic beliefs.

Cluster B consists of the "dramatic, emotional, and erratic" personalities. Individuals within this cluster tend to exhibit intense emotions, have unpredictable and turbulent relationships, and display attention-seeking behaviors. They may struggle with emotional regulation, have a fragile self-image, and exhibit impulsive or manipulative tendencies.

Cluster C encompasses the "anxious and fearful" personalities. Individuals in this cluster often experience high levels of anxiety, fear, and a strong desire for security. They may exhibit patterns of avoidance, dependency, or perfectionism as a way to manage their anxieties and seek reassurance.

Understanding these three clusters helps nurses recognize and categorize the diverse presentations of personality disorders. While each cluster shares certain characteristics, it is important to remember that individuals within these clusters can still have unique experiences and variations in symptom severity.

Cluster A

Cluster A personality disorders include paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder (APA, 2022a). Cluster A is characterized by eccentric, odd, or peculiar behavior, thinking, and beliefs. Individuals with these disorders often struggle socially. They can often appear distrustful of and detached from others (Figure 18.2).

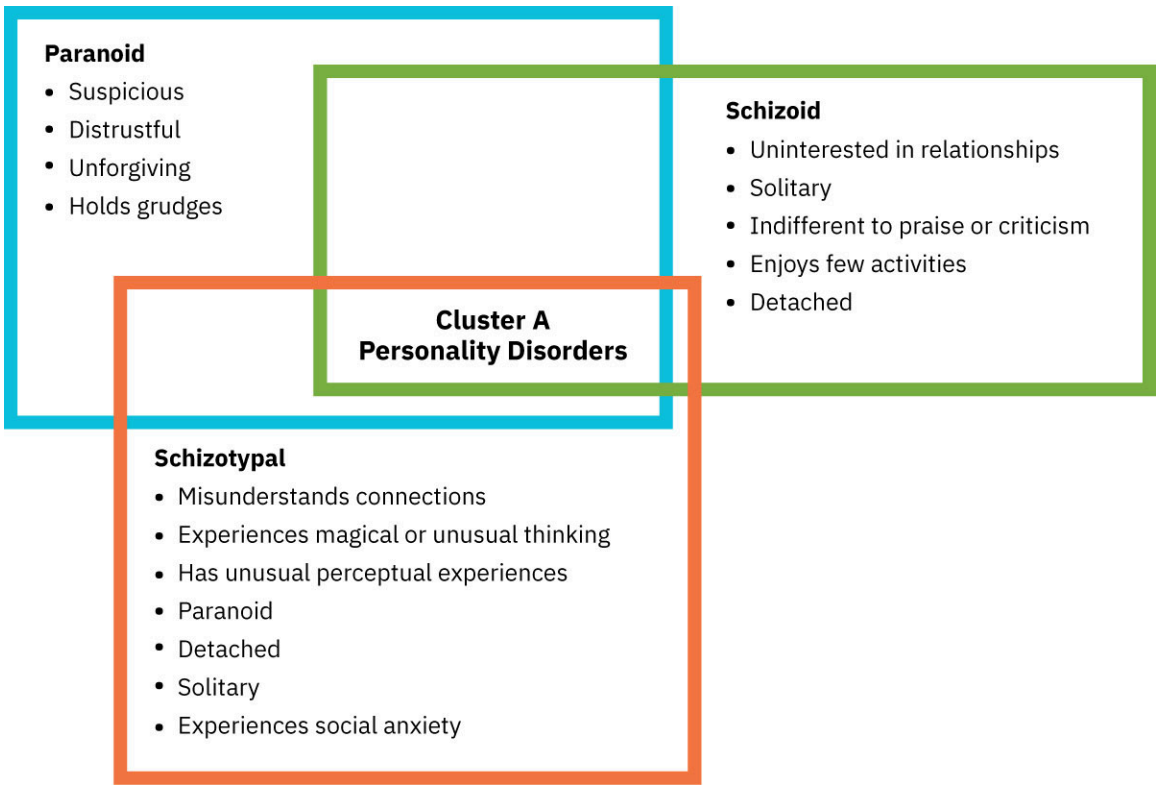


FIGURE 18.2 Cluster A personality disorders have similar symptoms. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Paranoid

Paranoid personality disorder is characterized by a pervasive pattern of distrust and suspicion of others (APA, 2022a). It is diagnosed in individuals with four or more of the following characteristics beginning in early adulthood:

- suspects that others are abusing, hurting, or misleading them without any proof
- is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
- is hesitant to share any information with others due to unjustified fear that the information will be used against them
- attributes hidden, often threatening meanings to harmless remarks or events
- is unforgiving and persistently holds grudges
- is quick to perceives attacks on their self or character or reputation that are not obvious to others and tends to react angrily
- has persistent, unfounded suspicions regarding the fidelity of their spouse or sexual partner

People with this condition believe that others will exploit, injure, or deceive them, even when no evidence exists to support this belief. They are preoccupied with the idea of loyalty from friends and associates and are often highly suspicious, even when these people show supportive behavior.

Schizoid

Schizoid personality disorder is characterized by a pattern of detachment from social relationships and a limited range of emotional expression (APA, 2022a). It is diagnosed in individuals with four or more of the following characteristics beginning in early adulthood:

- lack of interest in and desire for close relationships, including family relationships
- tendency to choose solitary occupations or hobbies
- lack of desire for or enjoyment of sexual experiences
- seeming enjoyment of few, if any, activities
- lack of close friends or confidants other than immediate family
- indifference to praise or criticism from others
- limited range of emotional expression, appearing detached or having a flattened affect

Schizotypal

Schizotypal personality disorder is a mental health condition characterized by odd or eccentric behavior, unusual beliefs or magical thinking, social and interpersonal difficulties, and a tendency toward perceptual and cognitive distortions (APA, 2022a). It is diagnosed in individuals with five or more of the following characteristics beginning in early adulthood:

- The false belief that coincidental events relate to oneself, called **ideas of reference**. For example, a person shopping in a store sees two strangers laughing and believes that they are laughing at them, when, in reality, the other two people do not even notice them.
- Strange beliefs or magical thinking that influence behavior and are not consistent with cultural norms. The idea that one can influence the outcome of specific events by doing something that has no bearing on the circumstances is called **magical thinking**. For example, a person watching a baseball game exhibits magical thinking when believing that holding the remote control in a certain position caused their favorite player to hit a home run.
- Unusual perceptual experiences, including bodily illusions. A **body illusion** refers to a discrepancy between the actual physical characteristics of the body and the way it is perceived by an individual. For example, the client may report feeling as if their body is not their own.
- Peculiar thinking and speech.
- Paranoid ideation, feeling suspicious of others or like people are “out to get” them.
- Emotional expressions that are flat, inappropriate, or lacking in range, such as a blunted or restricted affect.
- Behaviors or appearance that is considered eccentric, peculiar, or unusual.
- Few close relationships outside of immediate family members and a preference for solitary activities.
- Extreme anxiety and discomfort in social situations.

Cluster B

Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders (Figure 18.3). Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior. These individuals may also have a history of unstable relationships.

Cluster B Personality Disorders			
Antisocial	**Borderline**	**Histrionic**	**Narcissistic**
• Deceitful • Impulsive • Aggressive • Reckless • Irresponsible	• Maintains unstable relationships • Experiences identity disturbance • Impulsive • Emotionally unstable • Volatile • Paranoid • Self-destructive	• Seeks attention • Sexually provocative • Overdramatic • Communicates with little substance • Suggestible	• Expresses grandiosity • Dreams of perfection • Acts superior • Feels entitled • Exploits others • Lacks empathy

FIGURE 18.3 Cluster B personality disorders involve excessive emotion. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Antisocial

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood (Mayo Foundation for Medical Education and Research, 2023). In childhood or adolescence, symptoms may appear in the form of aggression, dishonesty, theft, property destruction, and disregard for rules. Antisocial personality is not diagnosed in clients before the age of eighteen, however, because their personalities are still developing. A person needs to be eighteen years or older to be diagnosed with antisocial personality disorder, but symptoms usually begin in adolescence. Typically, adolescents will be diagnosed with conduct disorder then antisocial personality disorder when they turn eighteen. Antisocial personality disorder is diagnosed in individuals with three or more of the following characteristics (APA, 2022a):

- failure to conform to social norms and laws; repeatedly engaging in illegal activities
- deceitfulness, lying, or using aliases for personal gain or pleasure
- impulsivity or failure to plan ahead
- irritability and aggressiveness, often resulting in physical violence and assaults
- reckless disregard for the safety of self or others
- consistent irresponsibility, such as neglecting work or financial obligations
- lack of remorse, indifference, or rationalizing behavior that harms or exploits others

Borderline

The central features of borderline personality disorder are a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics beginning in early adulthood (APA, 2022a):

- desperate attempts to avoid real or imagined abandonment
- a history of unstable and intense personal relationships that are characterized by **splitting**, or the alternating between extremes of idealization and devaluation of one's partner
- identity disturbance, characterized by an unstable self-image or sense of self
- impulsivity in at least two potentially self-damaging areas, such as reckless spending, substance misuse, reckless driving, binge eating, or engaging in unprotected sex
- recurrent suicidal behaviors, gestures, or threats or self-harming behaviors
- emotional instability due to marked reactivity of mood, such as intense and rapidly shifting emotions that may only last a few hours
- chronic feelings of emptiness or boredom
- inappropriate, intense anger or difficulty controlling anger, often resulting in frequent displays of temper, physical fights, or verbal aggression
- transient, stress-related paranoid thoughts or severe dissociative symptoms (**dissociative symptoms** include

the experience of detachment from oneself or reality) during times of extreme stress

LINK TO LEARNING

The National Education Alliance for Borderline Personality Disorder (https://openstax.org/r/77borderlineweb) is a comprehensive site for those seeking information on BPD.

Histrionic

The essential features of histrionic personality disorder are a pattern of pervasive and excessive emotionality and attention-seeking behavior that begins by early adulthood and is present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics (APA, 2022a):

- discomfort in situations where one is not the center of attention, often seeking to be the focus of others through exaggerated behaviors and emotions
- interaction with others that is characterized by inappropriate, seductive, or provocative behavior
- rapidly shifting and shallow expression of emotion
- use of physical appearance to draw attention to oneself, often with excessive attention to detail or exaggerated sexuality
- speech that is lacking in detail and lacking in substance
- theatrical and exaggerated emotional expression, often with rapidly shifting and exaggerated emotions
- suggestible, easily influenced by others or circumstances, with a tendency to consider relationships to be more intimate than they actually are

Narcissistic

Narcissistic personality disorder is characterized by an inflated sense of self-importance, a constant need for admiration and attention, and a lack of empathy for others. It is diagnosed in individuals beginning in early adulthood with five or more of the following characteristics (APA, 2022a):

- has a feeling of **grandiosity**—an exaggerated sense of self-importance—with beliefs of being unique, superior, and deserving of special treatment
- dreams of limitless power, brightness, beauty, or the perfect love
- believes they are exceptional and should only be associated with other special, high-status people
- has an excessive need for admiration and a constant craving for attention, validation, and praise
- has a sense of entitlement (i.e., expecting favorable treatment from others and feeling entitled to special privileges)
- partakes in interpersonal exploitation, which entails taking advantage of others for personal gain, often without empathy or concern for others' feelings or needs
- lacks empathy and the ability to recognize or identify with the feelings and needs of others
- feels envious of others or believes others are envious of them
- demonstrates arrogant or haughty behaviors or attitudes

Cluster C

Cluster C personality disorders share a common theme of anxious and fearful behaviors (Figure 18.4). They are characterized by a chronic pattern of thoughts, feelings, and behaviors that are driven by a sense of fear, insecurity, and a desire for safety (Cleveland Clinic, 2022).

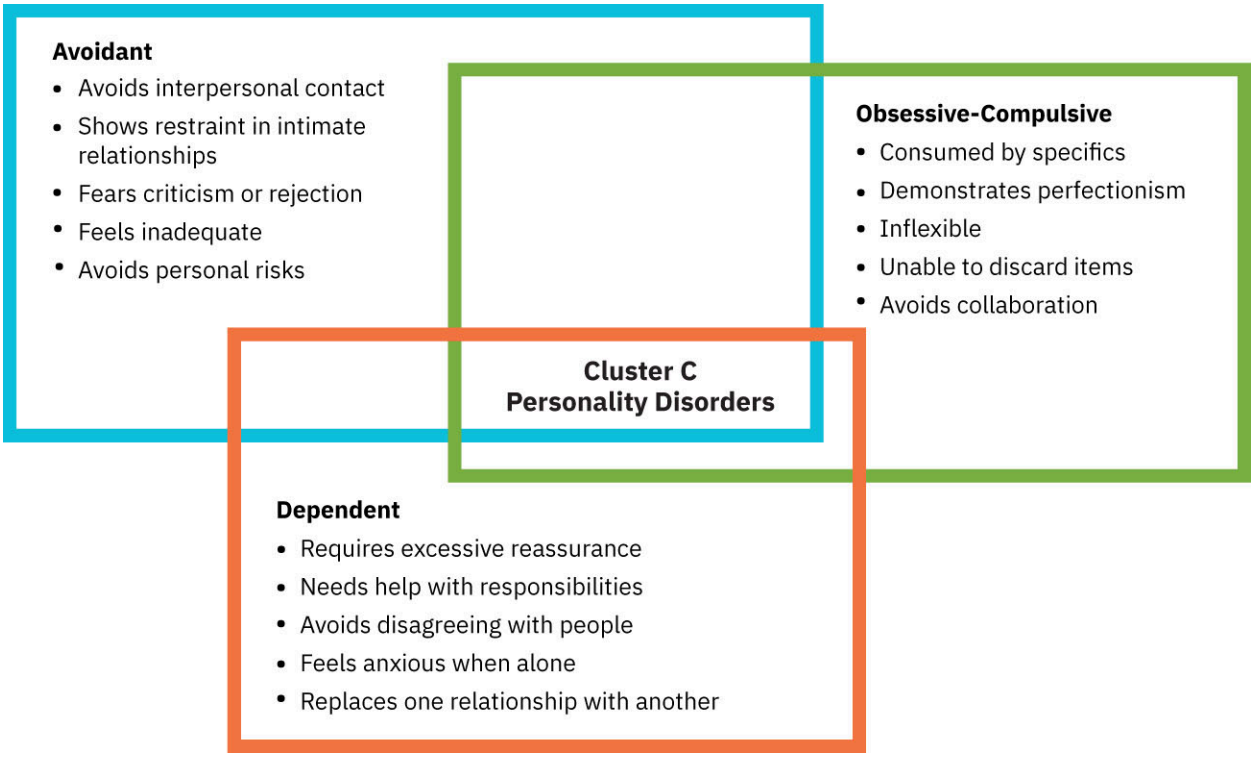


FIGURE 18.4 The three cluster C personality disorders demonstrate anxiety and fear. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Avoidant

Avoidant personality disorder (AVPD) is characterized by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to criticism or rejection. It is diagnosed in individuals beginning in early adulthood with four or more of the following characteristics (APA, 2022a):

- avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
- is unwilling to get involved with people unless certain of being liked
- shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- is preoccupied with being criticized or rejected in social situations
- is inhibited in new interpersonal situations because of feelings of inadequacy
- views self as socially inept, personally unappealing, or inferior to others
- is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Dependent

Dependent personality disorder (DPD) is characterized by a pervasive and excessive need to be taken care of by others. To be diagnosed, individuals must demonstrate five or more of the following characteristics beginning in early adulthood (APA, 2022a):

- needs excessive amounts of reassurance and advice from others when making everyday decisions
- requires others to take on most of the major responsibilities for their life
- has trouble disagreeing with people since they are afraid of losing their support or acceptance
- has trouble doing things on their own due to a lack of self-confidence
- has a strong need for support from others to the point of volunteering to do things that are unenjoyable in order to get it
- feels anxious or helpless when alone because of fears of being unable to care for themselves
- is eager to seek another relationship for approval and support when a close relationship ends
- has consuming, unrealistic fears of being left to take care of themselves

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder (OCPD) is a psychological disorder characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, and control. It is diagnosed in individuals with four or more of the following characteristics beginning in early adulthood (APA, 2022a):

- is consumed with specifics, guidelines, timetables, orders, or lists so that the main point of the action is lost
- demonstrates perfectionism that gets in the way of finishing tasks (i.e., is unable to finish a job because they cannot reach their own excessively stringent standards)
- is overly devoted to work to the detriment of personal hobbies and relationships
- has an inflexible adherence to morals, ethics, or values, often with an unwillingness to compromise or bend the rules
- is unable to discard or get rid of items, even when they have no practical value, due to a perceived need to save them or an intense emotional attachment to them
- is hesitant to assign duties to others or collaborate with them unless they completely adopt their style of doing things
- is stringent about saving money; tends to hoard money for future catastrophic events
- shows rigidity and stubbornness

Obsessive-compulsive personality disorder (OCPD) is an entirely different disorder than obsessive-compulsive disorder (OCD). OCPD includes long-term personality traits characterized by extreme perfectionism, rigidity, and adherence to rules. A person with OCPD is often proud of these personality traits. Conversely, OCD includes uncontrollable, recurring thoughts (obsessions) and/or behaviors (compulsions) that cause the individual significant emotional distress. Review 17.3 Obsessive–Compulsive and Related Disorders for more details about obsessive-compulsive disorder.

18.3 Nursing Care and Treatment Approaches

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Comprehend approaches and challenges to treating personality disorders
- Outline coping mechanisms for clients living with a personality disorder and special considerations for children
- Describe nursing care for a person with a personality disorder

When it comes to the treatment of personality disorders, a comprehensive approach that combines various interventions is essential. This section focuses on general treatment approaches and the important role of nursing care in supporting individuals with personality disorders. From therapy to medication, lifestyle modifications to psychoeducation, health-care providers use a number of different interventions to address the unique needs of each client. Nursing care serves as a cornerstone in this process, encompassing assessment, planning, and implementation of individualized care plans. Nurses provide crucial support, guidance, and therapeutic interventions to help clients manage their symptoms, improve coping skills, and enhance overall well-being.

Approaches to Treatment

Personality disorders are some of the most difficult disorders to treat in psychiatry (Fariba et al., 2023). Clients with personality disorders often do not have insight into their condition and are unlikely to seek treatment for a personality disorder. They often go undiagnosed unless they seek treatment for another psychiatric or medical challenge.

Individuals with personality disorders struggle to recognize that their difficulties in life are related to their personalities. They may truly believe their problems are a result of other people or outside factors. It is very common for clients with personality disorders also to have comorbid disorders, including substance misuse, anxiety, depression, or eating disorders. Medications may treat underlying co-occurring conditions, such as anxiety or depression. Psychotherapy, however, is recommended as the first line of treatment for all different personality disorders in order to help correct maladaptive thoughts and behaviors.

Medications Used for Specific Symptoms

There are no medications specifically approved by the Food and Drug Administration (FDA) to treat personality disorders (Fariba et al., 2023). However, several types of psychiatric medications may help with various personality disorder symptoms:

- Antidepressants: Antidepressants, including SSRIs, such as fluoxetine and sertraline, may be useful for those with a depressed mood, anger, impulsivity, irritability, or hopelessness.
- Mood stabilizers: As their name suggests, mood stabilizers, such as valproate or lamotrigine, can help even out mood swings or reduce irritability, impulsivity, and aggression. Prescribing these, along with potential augmentation with second-generation antipsychotics, can be effective for schizoid and schizotypal types.
- Antipsychotic medications: Also called neuroleptics, these may be helpful if symptoms include losing touch with reality (psychosis) or, in some cases, if there are anxiety or anger problems. Examples include olanzapine and quetiapine.
- Antianxiety medications: These may help with anxiety, agitation, or insomnia. But in some cases, they can increase impulsive behavior, so they're not prescribed for certain types of personality disorders. Examples of these medications include clonazepam and buspirone.

With respect to medication, nursing care includes educating clients on the medicine, including the purpose, potential benefits, and possible side effects. Monitor the client's response to medication closely, and assess for any changes in symptoms, side effects, or adverse reactions. Monitor medication adherence, and communicate any concerns or observations to the prescribing health-care provider. Document all related information thoroughly.

Psychosocial Therapies

Psychotherapy is the primary form of treatment for personality disorders. Various modalities, such as CBT, DBT, and psychodynamic therapy, have proven effective. These therapies help individuals identify and change maladaptive thoughts, beliefs, and behaviors; develop healthier coping strategies; improve social and interpersonal skills; and enhance self-awareness.

Different personality disorders will have different goals in therapy and will require different tactics. For example, due to their paranoia and lack of trust, clients with cluster A disorders tend to do much better with individual therapy than group therapy (Fariba et al., 2023). Those suffering from cluster B disorders, such as borderline personality disorder, can greatly benefit from group therapy.

Cognitive Behavioral Therapy

CBT is a form of psychotherapy that focuses on the connections between thoughts, feelings, and behaviors (American Psychological Association, n.d.-b). It is based on the premise that thoughts influence emotions and actions, and by changing thoughts, clients can effectively change their behavior and emotional well-being. CBT recognizes the importance of behavioral change in improving functioning. It helps clients with personality disorders identify the thoughts behind problematic behaviors and develop alternative, more adaptive behaviors. This may involve practicing new coping strategies, problem-solving approaches, and social skills in real-life situations. Through behavioral change, individuals can experience improved interpersonal functioning and increased overall satisfaction in life. For example, histrionic clients can benefit from CBT focusing on their need for attention. Likewise, individuals with cluster C personality disorders tend to benefit from CBT to address assertiveness, independence, and attitude.

Dialectical Behavior Therapy

DBT is a type of cognitive behavioral therapy that was originally created for clients with borderline personality disorder to help them cope with stress, control emotions, and establish healthy relationships. It is considered the gold standard for treating borderline personality disorder and is also used for other types of disorders. The client learns how to be aware of how thoughts, feelings, and behaviors link together. They learn how to use their senses to be aware of what is happening around them and use strategies, such as mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation, to react calmly in a crisis, avoid negative impulsive behavior, and improve relationships.

Self-Care and Coping Strategies

Engaging in self-help strategies, such as maintaining a healthy lifestyle, practicing stress management techniques,

developing healthy relationships, and engaging in activities that promote self-care and personal growth, can be beneficial for individuals with personality disorders.

PSYCHOSOCIAL CONSIDERATIONS

Stress Management: Stimulate the Parasympathetic Nervous System

For clients seeking immediate relief from intense symptoms, such as panic or depersonalization, nurses can teach how to stimulate the parasympathetic nervous system. Stimulation of the vagal nerve can result in an immediate, direct relief of intense emotions. This can be accomplished by doing the following:

- Applying ice or ice-cold water to the face.
- Performing paced-breathing techniques in which the exhalation phase is at least two to four counts longer than the inhalation phase. For example, advise the client to inhale while counting to four and then exhale while counting to eight.

Challenges to the Treatment of Personality Disorders

There are multiple issues with personality disorders that make them among the most difficult of psychiatric disorders to treat. Many individuals with a personality disorder lack insight into their condition and do not recognize their own emotional dysregulation, so they may exhibit treatment resistance. For example, clients with narcissistic personality disorder (NPD) rarely, if ever, come in for treatment and tend to be resistant to all suggestions (APA, 2022a), although they would benefit from intensive psychotherapy.

Issues of stigma may also prevent clients with suspected or diagnosed personality disorders from seeking treatment. Personality disorders still face stigma and misconceptions in society. Individuals with antisocial personality disorder, for instance, may experience stigma due to societal perceptions of them as "criminals" or "untrustworthy." This stigma can discourage them from seeking treatment and create barriers to accessing the help they need.

Another challenge is the chronic nature of personality disorders and the deeply ingrained nature of associated thoughts, feelings, and behaviors. For example, clients with avoidant personality disorder may require long-term therapy to address their fear of social interaction and develop healthier coping mechanisms. Maintaining motivation and engagement in treatment over an extended period can be challenging for both the individual and the nurse.

Many individuals with personality disorders may also struggle with comorbid conditions, such as depression, anxiety, or substance use disorders. For example, a nurse working with a client with narcissistic personality disorder and alcohol use disorder must address both the grandiosity and entitlement associated with narcissism and the underlying issues contributing to substance misuse. Treating both the personality disorder and the other diagnoses simultaneously is complex and requires integrated treatment approaches.

A nurse's attitudes and feelings about clients with personality disorders can significantly affect their ability to plan and deliver effective nursing care. Attitudes and biases may arise due to personal experiences, societal stereotypes, or the challenging nature of working with individuals who have personality disorders. It is essential for nurses to recognize and address these biases to ensure the provision of compassionate and unbiased care. Addressing personal biases is an ongoing process that requires commitment and self-awareness. By adopting strategies to address their own biases, nurses can create a more inclusive and empathetic care environment for individuals with personality disorders, ultimately enhancing the quality of nursing care provided.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care

Strategies for assisting nurses in overcoming biases when working with clients with personality disorder include the following:

Self-reflection: Nurses should engage in regular self-reflection to identify and understand their own biases. This

involves acknowledging personal attitudes and considering how these attitudes may influence interactions with clients.

Education and training: Education and training on personality disorders will enhance nurses' understanding. Increased knowledge can help challenge stereotypes and misconceptions, fostering empathy and compassion.

Supervision and support: A supportive work environment will allow nurses to discuss challenges openly. Regular supervision can provide a platform for addressing biases, sharing experiences, and seeking guidance.

Cultural competence training: Training programs that focus on cultural competence and emphasize the need to appreciate and respect diverse perspectives, including those associated with mental health conditions, will enhance nursing care.

Client-centered approach: A tailored, client-centered approach helps shift the focus away from diagnostic labels and fosters a more holistic view of the client.

Promote empathy: Nurses should empathize with the challenges faced by individuals with personality disorders. This can be achieved through activities that promote perspective-taking and understanding the impact of the disorder on the client's life.

Continuous learning: A culture of continuous learning and professional development keeps nurses abreast of current research and evidence-based practices in mental health care and helps challenge outdated beliefs and practices.

Peer collaboration: Collaboration among nursing staff is critical. Peer discussions and collaboration provide opportunities for sharing insights, strategies, and coping mechanisms when working with challenging client populations.

(The Joint Commission, 2023)

Coping with Personality Disorders

Coping with a personality disorder poses unique challenges for individuals in major aspects of their daily lives. Personal and work relationships will both be a focus of treatment. It is essential for the nurse to approach the experience with self-awareness and understanding, recognizing that a personality disorder is just one aspect of a person's identity, while acknowledging the importance of goals centered around personal and work relationships.

Interpersonal Relationships

Clients with personality disorders often struggle with interpersonal relationships due to their patterns of thinking and behavior (Cleveland Clinic, 2022). Symptoms, such as intense and unstable emotions, difficulty recognizing and maintaining boundaries, or a tendency toward social isolation, can result in unstable relationships. Coping with a personality disorder in personal relationships requires cooperation from both the client and their loved ones. It is crucial for loved ones to develop an understanding of the specific personality disorder and its associated symptoms. Educating themselves about the challenges the client faces helps them differentiate the person from the disorder, fostering empathy, and reducing the likelihood of taking behaviors personally (Kasalova et al., 2018). Individuals with personality disorders often struggle with their own emotional pain. Encouraging empathy and compassion among loved ones, while educating them to set and respect boundaries, can promote healthier relationship dynamics. Recognizing the underlying challenges the client faces allows for more understanding and support.

Given that communication can be a significant challenge in relationships affected by personality disorders, clients should focus on developing effective communication skills. Additionally, recognizing and working on emotional sensitivity and regulation can help prevent unnecessary conflicts. Setting clear and healthy boundaries is essential to protect the well-being of both the individual and their loved ones. Open and honest communication regarding acceptable behavior is vital. Consistency in enforcing these boundaries is key to maintaining healthier relationship dynamics.

In the Workplace

Self-awareness and self-management are the keys for individuals with a personality disorder who are learning to cope in the workplace. It is essential for these clients to develop self-awareness regarding their symptoms, triggers, and coping mechanisms. Understanding one's own strengths and limitations can help in managing symptoms and

minimizing their impact on work interactions. Additionally, practicing self-management techniques, such as stress reduction strategies and emotion regulation skills, can contribute to a more stable and productive work environment.

Deciding whether or not to disclose a personality disorder in the workplace is a personal choice (Job Accommodation Network, 2023). If an individual chooses to disclose, it can be helpful to have open and honest communication with a trusted supervisor or human resources department. This can facilitate the implementation of workplace accommodations or adjustments that support the individual's needs. For example, a client with a personality disorder might benefit from a private, quiet area for grounding or reflection. Establishing clear communication channels and expressing any specific requirements or triggers can foster a more understanding and supportive work environment.

Clients with a personality disorder may benefit from seeking other support within the workplace. This can include connecting with employee assistance programs, seeking out mentorship or coaching opportunities, or joining support groups. Having a support network can provide emotional support, guidance, and practical strategies for coping with workplace challenges.

Identifying and leveraging personal strengths can contribute to success in the workplace. Recognizing areas where one excels and capitalizing on those strengths can boost confidence and job performance. Actively seeking professional development opportunities can enhance skills and knowledge, leading to increased confidence and job satisfaction. Pursuing relevant training, attending workshops, or engaging in ongoing learning can provide individuals with the tools to navigate workplace challenges and adapt to changing work environments.

Maintaining healthy boundaries at work is crucial for individuals with a personality disorder. Setting clear expectations regarding workload, personal space, and interpersonal interactions can help manage stress and prevent burnout. Communicating boundaries assertively and respectfully can contribute to a more harmonious and productive work environment.

Overall, it is important to manage stress and perform regular self-care and stress management techniques. This can include engaging in activities outside of work that promote relaxation, setting boundaries between work and personal life, and seeking therapy or counseling to address specific work-related concerns. Taking care of one's physical and mental well-being can enhance resilience and coping abilities in the workplace and help the client with better stress management.

Issues in Children

Managing a personality disorder in children can be a complex and challenging task that requires a multidimensional approach. It's important to note that personality disorders are typically not diagnosed in children, as they are considered more ingrained, stable patterns of behavior that develop during adolescence or adulthood and last over time (APA, 2022a). Antisocial personality disorder is never diagnosed in children under age eighteen. Children may, however, exhibit traits or behaviors that resemble those associated with personality disorders. For example, a child with conduct disorder may engage in such behaviors as bullying and physically threatening others, behavior that is associated with antisocial personality disorder. (See Children and Adolescents for more information on conduct disorder.) There are several general guidelines for treating children with such challenging personality traits.

Early intervention and professional assessment are critical in the treatment of childhood personality issues. If a child displays persistent and extreme patterns of behavior that are causing significant distress or impairment, it is important to seek professional help. Mental health professionals experienced in working with children can conduct a comprehensive assessment to determine the underlying causes and appropriate interventions.

Developing an individualized treatment plan is key for effectively managing behavioral disorders in children with characteristics of personality disorders (Mayo Foundation for Medical Education and Research, 2022). The plan may include various components, such as therapy, behavior management techniques, and support for the child and their family. Collaborate closely with mental health professionals to tailor the treatment approach to the child's specific needs. As with adults, psychotherapy can be beneficial in helping children with personality disorder-like traits develop healthier coping mechanisms, emotional regulation skills, and improved social interactions. Different therapeutic approaches, such as play therapy or family therapy, may also be effective, depending on the child's age, symptoms, and individual circumstances.

It's important to communicate and collaborate with teachers and school staff to ensure appropriate support and accommodations for the child. Sharing information about the child's behaviors, challenges, and treatment plan can help create a supportive learning environment and facilitate targeted interventions if needed.

Consistency in parenting practices and setting clear boundaries is important for children with personality disorder-like traits. Providing a nurturing and structured environment with clear rules and expectations can help them develop a sense of security and stability. Positive reinforcement and constructive discipline techniques are essential for promoting healthy behaviors and emotional well-being.

It is also important to consider the caregivers when treating a child with personality disorder-like traits. It can be emotionally demanding for the caregivers; therefore, it is essential for them to prioritize their own well-being and seek support when needed. Engaging in self-care activities, accessing support groups or counseling for themselves, and finding assistance can help caregivers maintain their own mental and emotional well-being.

Planning Nursing Care

Planning nursing care for a client with a personality disorder begins with a thorough assessment of the client. Assessment of the client with a personality disorder includes interviewing the client, observing verbal and nonverbal behaviors, completing a mental status examination, and performing a psychosocial assessment.

Nursing Diagnoses

After thoroughly assessing clients, nurses create individualized nursing care plans based on the client's response to their mental health disorder(s). Common nursing diagnoses related to the clusters of personality disorders include the following:

- Cluster A: social isolation, disturbed thought process, risk for loneliness
- Cluster B: risk for suicide, risk for self-directed violence, social isolation, chronic low self-esteem, ineffective coping
- Cluster C: anxiety, risk for loneliness, social isolation

Examples of common nursing diagnoses for clients diagnosed with borderline personality disorder are described in (Table 18.1).

Nursing Diagnosis	Definition	Selected Defining Characteristics and/or Risk Factors
Risk for suicide	Susceptible to self-inflicted, life-threatening injury	Reports desire to die Statements regarding killing self Hopelessness Social isolation
Risk for self-mutilation	Deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension	Cuts or scratches on body Ingestion or inhalation of harmful substances Self-inflicted burns
Risk for other-directed violence	Susceptible to behaviors in which an individual demonstrates they can be physically, emotionally, and/or sexually harmful to others	History of childhood abuse History of cruelty to animals History of witnessing family violence History of fire-setting

TABLE 18.1 Common Nursing Diagnoses for Clients with Borderline Personality Disorder

Nursing Diagnosis	Definition	Selected Defining Characteristics and/or Risk Factors
Ineffective coping	A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts that fail to manage demands related to well-being	Destructive behavior toward self or others Ineffective coping strategies Ineffective problem-solving skills
Defensive coping	Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard	Difficulty maintaining relationships Hypersensitivity to criticism Projection of blame Projection of responsibility
Social isolation	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state	Hostility Values incongruent with cultural norms History of rejection
Ineffective family health management related to manipulative behavior	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state	Impaired communication patterns Disturbed thought processes Delusional thinking
Risk for spiritual distress as manifested by poor relationships	A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being	Ineffective coping strategies Perceived insufficient meaning in life Hopelessness Social alienation

TABLE 18.1 Common Nursing Diagnoses for Clients with Borderline Personality Disorder

Outcomes and Goals

When working with clients with personality disorders, goals should address the nursing diagnoses with priority on safety. One way to do this is through the use of SMART objectives:

- S = specific
- M = measurable
- A = attainable
- R = realistic
- T = time specific

(Substance Abuse and Mental Health Administration, 2024).

For example, if the client is hospitalized and receiving acute care, and has a nursing diagnosis of *risk for self-mutilation*, a SMART outcome could be, "The client will refrain from intentional self-inflicted injury during hospitalization." For a client receiving long-term outpatient therapy, with a nursing diagnosis of *social isolation*, a SMART outcome could be, "The client will meet a friend for coffee by the end of the month." Examples of other SMART outcomes for clients with a personality disorder may include the following: the client will seek help from staff when experiencing urges to self-mutilate during hospitalization, the client will identify three triggers to displays of violence by the end of the day, and the client will describe two preferred healthy coping strategies by the end of the week.

Implementing Interventions

When implementing planned interventions for clients with personality disorders, the nurse must always consider safety first. Develop a crisis/safety plan with the client that includes components such as these: thoughts or behaviors that increase the risk of harming self or others; people, events, or situations that trigger those thoughts or behaviors; and coping strategies and resources.

For example, if a client performs superficial self-injurious behavior, the nurse should act based on agency policy while remaining neutral and dressing the client's self-inflicted wounds in a matter-of-fact manner. The client may be asked to write down the sequence of events leading up to the injuries, as well as the consequences, before staff will discuss the event. This cognitive exercise encourages the client to think independently about their triggers and behaviors and facilitates discussion about alternative actions.

De-escalation is an important intervention for certain clients with personality disorder. **De-escalation** is the use of strategies and communication techniques to calm and reduce agitation or aggression in individuals experiencing heightened emotional distress or crisis (The Joint Commission, 2019).

CLINICAL JUDGMENT MEASUREMENT MODEL

Take Action: Knowing How and When to De-Escalate a Client with Personality Disorder

Taking action involves implementing appropriate interventions based on nursing knowledge, care priorities, and planned goals and outcomes to ensure optimal health in a client. When working with clients with a personality disorder, promoting safety for the nurse and the client includes being able to de-escalate when necessary. The nurse should implement de-escalation strategies if the client exhibits early signs of increasing levels of anxiety or agitation.

Strategies include the following:

- speaking in a calm voice
- avoiding overreacting
- implementing active listening
- expressing support and concern
- avoiding continuous eye contact
- asking how you can help
- reducing stimuli
- moving slowly
- remaining patient and not rushing them
- offering options instead of trying to take control
- avoiding touching the client without permission
- verbalizing actions before initiating them
- providing space so the client doesn't feel trapped
- avoiding arguing and judgmental comments
- setting limits early and enforcing them consistently across team members
- addressing manipulative behaviors therapeutically

If the client continues to escalate, measures must be taken to keep the client and others safe. Review signs of crisis and crisis interventions in Court Involvement. If interventions are not effective in de-escalating a client at risk to themselves or others, seclusion or restraints may be required. Review using seclusion and restraints in Schizophrenia Spectrum Disorders and Other Psychotic Disorders.

Other interventions for clients with personality disorders should ultimately focus on strategies to assist with the regulation of emotions and improving interpersonal relationships (Drescher, 2022). Table 18.2 lists some of these strategies.

Strategy	Description
Establish therapeutic relationships	Build trust through empathetic communication, active listening, and consistent, nonjudgmental support. Validate the client's feelings and experiences while expressing empathy to promote a sense of understanding and support.
Educate on the disorder	Provide education about the specific personality disorder, its symptoms, and effective coping strategies to enhance the client's understanding and self-awareness.
Set clear and consistent boundaries	Clearly define and maintain therapeutic boundaries to establish a sense of safety and predictability for both the client and the nursing staff.
Crisis intervention and safety planning	Develop and implement crisis intervention plans, including safety plans and coping strategies to address and manage emotional crises.
Emotional skill-building	Offer skill-building sessions to enhance coping mechanisms, emotion regulation, and interpersonal skills through techniques, such as DBT or CBT.
Medication management	Administer and monitor medications, such as mood stabilizers or anxiety reducers, as prescribed, to manage specific symptoms.
Structured routine	Provide a structured routine to create a sense of order and predictability, which can contribute to a feeling of safety and stability for the client.
Collaboration with multidisciplinary team	Collaborate with psychiatrists, advanced practice providers, psychologists, social workers, and other health-care professionals to ensure a comprehensive and holistic approach to care.
Reality orientation	Provide gentle redirection and clarification to help maintain a shared reality, especially for clients who may experience distortions in perception.
Social skills training	Offer social skills training to enhance interpersonal effectiveness through role-playing exercises, communication skills training, and problem-solving scenarios.
Encourage self-reflection	Facilitate self-reflection to help clients gain insight into their thoughts and behaviors, promoting personal growth and self-awareness.
Encourage healthy lifestyle practices	Promote activities that contribute to overall well-being, such as regular exercise, proper nutrition, and adequate sleep.
Encourage participation in support groups	Facilitate participation in support groups or group therapy to provide opportunities for peer support and sharing coping strategies.

TABLE 18.2 Strategies for Helping Clients with Personality Disorders Regulate Emotions

Self-Reflection by Nurses

Caring for clients with a personality disorder can be challenging both mentally and emotionally for the nurse (Bekelepi & Martin, 2022). When providing nursing care for such clients, it is necessary to self-reflect frequently to

ensure that the nurse-client relationship remains therapeutic and the treatment plan is progressing. Self-reflection allows nurses to identify and understand their own biases, assumptions, and prejudices that may influence their interactions with clients. It helps them recognize any negative attitudes or judgments they may hold toward individuals with personality disorders. By becoming aware of these biases, nurses can work toward providing nonjudgmental and unbiased care.

When working with clients with personality disorders, transference and countertransference dynamics can arise (see Psychoanalytical Theories and Therapies). For example, a client with dependent personality disorder may develop strong feelings of dependency on their nurse, while the nurse may experience countertransference feelings of overprotectiveness or frustration. Managing these relationships requires nurses to deal with their own complex emotions while maintaining appropriate boundaries with the client.

Personality disorders often involve deeply ingrained patterns of behavior and emotional difficulties. Self-reflection helps nurses develop empathy and compassion by encouraging them to put themselves in the client's shoes and understand the challenges they face. This empathy can lead to more client-centered care and help build a therapeutic alliance with the client.

REAL RN STORIES

Personality Disorder

Nurse: Susan, RN
Years in Practice: 14
Clinical Setting: Acute psychiatric unit
Geographic Location: Texas

As a registered nurse working in an acute psychiatric unit, Susan often encountered clients with various mental health challenges, including personality disorders. One particular client, Rodney, stands out in her memory.

Rodney was a thirty-five-year-old male admitted to the unit due to severe emotional dysregulation and self-harming behaviors. He had a diagnosis of borderline personality disorder (BPD) and had a history of tumultuous relationships and impulsive behaviors.

Initially, Susan found it challenging to establish a therapeutic relationship with Rodney. He exhibited intense mood swings, often oscillating between extreme anger and profound sadness within minutes. He frequently engaged in attention-seeking behaviors, such as threatening self-harm or attempting to manipulate staff members.

Despite the difficulties, Susan remained committed to providing compassionate care to Rodney. She utilized her training in de-escalation techniques to manage his outbursts and maintain a safe environment for both Rodney and the staff. Susan also collaborated closely with the multidisciplinary team, including psychiatrists, psychologists, and social workers, to develop a comprehensive treatment plan tailored to Rodney's unique needs.

Over time, Susan noticed gradual improvements in Rodney's condition. Through consistent therapy sessions and medication management, he gained insight into his maladaptive coping mechanisms and learned healthier ways to regulate his emotions. Susan also worked with Rodney to develop coping skills, such as mindfulness and distress tolerance techniques, to help him navigate stressful situations more effectively.

Despite setbacks along the way, including instances of self-harm and brief hospital readmissions, Susan witnessed significant progress in Rodney's recovery journey. With ongoing support from the health-care team and encouragement from Susan, he began to rebuild his life outside the hospital walls, forming more stable relationships and pursuing meaningful activities.

Through her experience with Rodney, Susan learned the importance of patience, empathy, and perseverance when caring for clients with personality disorders. She recognized that while challenging, providing compassionate and nonjudgmental care could make a profound difference in their lives, helping them achieve greater stability and well-being.

Support for Nurses Treating a Client with Personality Disorder

Clients can work for years to receive adequate treatment for a personality disorder. Navigating the emotional intensity, treatment resistance, interpersonal difficulties, and boundary issues can be challenging not just for the client but for the nurse as well (Bekelepi & Martin, 2022). It is important for nurses to seek support and resources when dealing with clients with personality disorders. Here are some avenues for receiving support:

- Consult with colleagues: Discuss the challenges and concerns with colleagues, especially those who have experienced working with similar client populations. They may provide insights, guidance, or suggestions based on their own experiences.
- Supervision and mentoring: Seek supervision or mentoring from more experienced nurses or nurse leaders. They can offer guidance, support, and feedback on challenging situations with clients with personality disorders.
- Professional development and training: Take advantage of professional development opportunities, such as workshops, seminars, or online courses, that focus on understanding personality disorders and developing effective strategies for working with this population. Enhancing knowledge and skills can increase confidence and ability to provide quality care.
- Consult the mental health team: Reach out to the mental health team within the health-care facility, including psychiatrists, nurse practitioners, psychologists, or social workers. They can provide consultation and guidance specific to the client's diagnosis and help nurses understand and manage the challenges they encounter.
- Employee assistance programs (EAP): Many health-care organizations have EAPs that offer counseling and support services to employees. EAPs can provide confidential assistance for dealing with work-related stress, burnout, or difficult client situations. They make connections with mental health professionals who can offer guidance and support.
- Support groups or peer networks: Seek out support groups or peer networks specifically designed for health-care professionals who work with clients with personality disorders or challenging mental health conditions. These forums provide a space to share experiences, exchange advice, and receive support from others facing similar challenges.
- Personal therapy: Consider seeking personal therapy or counseling to address any emotional or psychological impacts of working with challenging client populations. Therapy can provide a confidential space to process feelings, develop coping strategies, and gain insights into reactions and boundaries.

Remember that seeking support is not a sign of weakness but a proactive step toward maintaining a nurse's well-being and providing optimal care to clients. Nurses should take care of themselves both professionally and personally, and utilize the available resources to navigate the unique challenges associated with clients with personality disorders.

LINK TO LEARNING

Registerednursing.org lists eight areas of self-care for nurses (https://openstax.org/r/77nurseselfcare) along with specific suggestions and resources to help with mental, emotional, physical, and other dimensions to fight stress and burnout.

Summary

18.1 Identification and Diagnosis

There are multiple types of personality disorders, but they tend to have certain symptoms in common that lead to diagnosis. A personality disorder may exist when a personality exhibits enduring patterns of thoughts, emotions, and behaviors that deviate significantly from cultural norms and cause significant distress and impairment in functioning. While everyone has unique personality traits, a personality disorder is diagnosed when these traits cause significant distress, disrupt daily life, and lead to difficulties in relationships, work, or other areas of functioning. A personality disorder is diagnosed through a thorough assessment by a trained professional, such as a psychiatrist. It requires a history, behavioral observations, and meeting certain criteria specific to each disorder.

18.2 Cluster Disorders (A, B, C)

Cluster A personality disorders include paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. Cluster A is characterized by eccentric, odd, or peculiar behavior, thinking, and beliefs. Individuals with these disorders often struggle socially. They can often appear distrustful and detached to others.

Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior. They may also have a history of unstable relationships.

Cluster C personality disorders share a common theme of anxious and fearful behaviors. They are characterized by a chronic pattern of thoughts, feelings, and behaviors that are driven by a sense of fear, insecurity, and a desire for safety. The three personality disorders within cluster C are avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder (OCPD).

18.3 Nursing Care and Treatment Approaches

Treating personality disorders can be a difficult process. Psychotherapy is the top recommended modality for all personality disorders. Cognitive behavioral therapy can be very helpful, as can dialectical behavioral therapy, which was developed specifically for borderline personality disorder. There are no medications specifically approved to treat personality disorders, but they may be prescribed for other related symptoms, such as anxiety or depression.

Clients living with personality disorders often struggle with interpersonal relationships and work challenges. Increasing self-awareness, learning to set personal boundaries, and regulating emotional responses can help with these challenges. Educating family members on the nature of these disorders can also help encourage empathy.

Nursing care for clients with personality disorders begins with safety, empathy, and understanding. Nurses must approach the client with a consideration for the whole person, and not just as a diagnosis. Setting goals and limits for the client early when creating the treatment plan will help the nurse-client relationship. There are various skills to help people with personality disorders learn how to cope. Nurses must also remember that self-care is an important part of caring for these clients in order to minimize stress and ensure that they maintain their ability to provide the best care possible to clients.

Key Terms

body illusion discrepancy between the actual physical characteristics of the body and the way it is perceived by an individual

de-escalation use of strategies and communication techniques to calm and reduce agitation or aggression in individuals experiencing heightened emotional distress or crisis

dissociative symptoms experience of detachment from oneself or reality

grandiosity exaggerated sense of self-importance, with beliefs of being unique, superior, and deserving of special treatment, associated with narcissistic personality disorder

ideas of reference false belief that coincidental events relate to oneself

magical thinking idea that one can influence the outcome of specific events by doing something that has no bearing on the circumstances

maladaptive behavior patterns of thoughts, emotions, and actions that are ineffective or counterproductive to normal everyday life

personality unique and enduring patterns of thoughts, emotions, and behaviors that characterize an individual and distinguish them from others

personality disorder when a personality exhibits enduring patterns of thoughts, emotions, and behaviors that deviate significantly from cultural norms and cause significant distress and impairment in functioning

personality traits characteristics, whether considered positive or negative, that make up one's personality

splitting alternating between extremes of idealization and devaluation of one's partner

Assessments

Review Questions

1. What behavior is a client with a diagnosis of antisocial personality disorder demonstrating when they engage in binge drinking?
    a. a defiant personality
    b. emotional regulation
    c. maladaptive behavior
    d. self-determination

2. What is one reason why personality disorders can be difficult to diagnose?
    a. the fact that clients usually do not present for assistance with personality disorders
    b. the presence of maladaptive behaviors
    c. lack of reliable health history
    d. lack of emotional response from the client

3. What is one of the characteristics shared by most personality disorders?
    a. fear of attention
    b. short onset of duration
    c. a history of violence
    d. dysfunctional relationships

4. What type of personality disorder is characterized by eccentric, odd, or peculiar behavior, thinking, and beliefs?
    a. Cluster A
    b. Cluster B
    c. Cluster C
    d. General personality disorders

5. What personality disorder is characterized by magical thinking, or the idea that one can influence the outcome of specific events by doing something that has no bearing on the circumstances?
    a. obsessive-compulsive personality disorder
    b. schizoid personality disorder
    c. schizotypal personality disorder
    d. avoidant personality disorder

6. What personality disorder is most likely to be associated with illegal activity?
    a. antisocial personality disorder
    b. borderline personality disorder
    c. dependent personality disorder
    d. schizoid personality disorder

7. What common symptom of borderline personality disorder is described as alternating between extremes of idealization and devaluation of one's partner?
    a. body illusion
    b. dissociation

c. grandiosity
d. splitting

8. What personality disorder is characterized by a pervasive and excessive need to be taken care of by others?
   a. Dependent personality disorder (DPD)
   b. Histrionic personality disorder
   c. Narcissistic personality disorder
   d. Avoidant personality disorder

9. A client in treatment for obsessive-compulsive personality disorder (OCPD) is experiencing extreme anxiety after their therapy session. What is a good technique for de-escalating the client?
   a. immediately taking the client by the arm and directing them to a quiet place where they can decompress
   b. holding steady eye contact to establish empathy and trust
   c. employing active listening as a strategy
   d. taking control of the situation and instructing the client what to do next

10. What is a true statement regarding the treatment of personality disorders?
    a. Clients with a personality disorder can be cured of their condition forever.
    b. DBT was originally developed to helped cluster C clients improve their feelings of anxiety and need for control.
    c. There are multiple medications that are effective in treating personality disorders.
    d. Psychotherapy is only moderately helpful for clients diagnosed with a cluster A disorder.

11. The nurse is developing a care plan for a client with schizotypal personality disorder. The client has reported a recent history of magical thinking. What does the nurse note is the priority nursing diagnosis?
    a. anxiety
    b. risk for loneliness
    c. risk for self-harm
    d. disturbed thought process

Check Your Understanding Questions

1. Everyone has personality traits, some much stronger than others. When does a personality trait become a personality disorder?
2. Why is it so difficult to diagnose a personality disorder?
3. Describe the primary characteristics of borderline personality disorder.
4. What characteristics of paranoid personality disorder lead to difficulties in forming and maintaining trusting relationships?
5. Describe some effective strategies for de-escalating an aggressive or anxious client with a personality disorder.
6. What are some therapeutic strategies that clients with personality disorders can employ in the workplace?

Reflection Questions

1. Why do people with personality disorder struggle with emotional regulation?
2. How is obsessive-compulsive personality disorder (OCPD) different from obsessive-compulsive disorder (OCD)?
3. Antisocial personality disorder is the personality disorder most likely to be associated with illegal activity. What traits associated with antisocial personality disorder do you think contribute to this characteristic?
4. Why is the involvement of family/loved ones so important in the treatment of personality disorders?

What Should the Nurse Do?

1. Antonio, a twenty-eight-year-old male, seeks treatment at the outpatient mental health clinic due to interpersonal difficulties and ongoing emotional distress. He reports a history of strained relationships, frequent job changes, and a sense of emptiness. Antonio describes intense and unstable emotions, fearing abandonment, and engaging in impulsive behaviors, such as reckless spending and substance use. He reports episodes of anger and difficulty controlling his anger, often resulting in strained relationships. During the assessment, his vital signs are a blood pressure of 120/80 mmHg, heart rate of 90 bpm, respiratory rate of 18 breaths per minute, and temperature of 98.6°F (37°C). Antonio has a history of self-harm, including cutting, and has experienced several brief hospitalizations for suicidal ideation. He reports a history of traumatic experiences during his childhood but has not received consistent mental health treatment.
   What immediate actions should be taken during the initial assessment to ensure a thorough understanding of Antonio's symptoms and their impact on his daily life?

Robert, a thirty-five-year-old male, seeks treatment at the outpatient mental health clinic due to interpersonal difficulties and recurring conflicts at his workplace. He reports feeling misunderstood and isolated. He describes himself as socially anxious and uncomfortable in group settings. He mentions difficulty forming close relationships and often perceives others as untrustworthy. He reports occasional paranoid thoughts about colleagues plotting against him. Robert has a history of avoiding social situations and has experienced chronic feelings of inadequacy. He has never sought mental health treatment before and reports a generally healthy medical history. His vital signs are a blood pressure of 130/82 mmHg, heart rate of 78 bpm, respiratory rate of 16 breaths per minute, and temperature of 98.4°F (36.9°C).

2. What specific behaviors and statements made by Robert might be indicative of symptoms associated with cluster A personality disorders, especially paranoid personality disorder?
3. If there are indications of impulsivity or intense emotional reactions in Robert, how might this have impacted him socially?
4. How will you measure the effectiveness of interventions over time, and what indicators will suggest positive outcomes in terms of Robert's social functioning and reduction in paranoid thoughts?

Emma, a forty-year-old female, seeks treatment at the outpatient mental health clinic due to chronic difficulties in maintaining stable relationships. She reports intense feelings of emptiness, fear of abandonment, and frequent emotional outbursts. Emma describes patterns of impulsive behavior, including reckless spending and occasional substance use. She expresses a pervasive sense of unworthiness and struggles with self-identity. Emma has a history of interpersonal conflicts and brief hospitalizations related to suicidal ideation. She has engaged in self-harming behaviors, particularly during times of emotional distress. Emma has not received consistent mental health treatment in the past. Her vital signs are a blood pressure of 118/78 mmHg, heart rate of 92 bpm, respiratory rate of 20 breaths per minute, and temperature of 98.7°F (37°C).

5. What specific behaviors and statements made by Emma might be indicative of symptoms associated with a personality disorder, particularly one that involves fear of abandonment and impulsive behaviors?
6. What nursing interventions could be implemented to address Emma's fear of abandonment and impulsive behaviors? How can a nurse foster a therapeutic alliance to support her in developing healthier coping mechanisms?

Competency-Based Assessments

1. Outline key components of nursing care for a person with a personality disorder, emphasizing therapeutic communication and the establishment of trust. How can you collaborate with the interdisciplinary team to provide comprehensive care?

2. You are a nursing student who has been asked to evaluate a client who presents with suspiciousness, social detachment, and eccentric behaviors. How might you differentiate between paranoid, schizoid, and schizotypal personality disorders during the assessment, and what specific interventions could be tailored to address the unique challenges associated with each disorder?

3. A nurse is assessing a new client who reports engaging in a pattern of unstable relationships, impulsivity, and intense fear of abandonment. The nurse is aware that the client has which type of cluster B personality disorder?

4. When working with a client, the nurse finds it challenging to deal with his pervasive pattern of grandiosity, a need for admiration, and a lack of empathy. The nurse understands that this client has a particular form of personality disorder related to these behaviors. What disorder is this?
5. If you were caring for a socially isolated client who appears to be hypersensitive to criticism, you would suspect that this client has which of the cluster C personality disorders?
6. A client you are seeing with a personality disorder is resistant to medication. Write a dialogue (include nonverbal cues) of therapeutic communication to explore the client's concerns and collaboratively develop a treatment plan that incorporates their preferences and needs.
7. Think about the challenge of establishing rapport and trust with individuals with personality disorders. List some ways that a nurse can create an environment that encourages open communication and collaboration in developing coping strategies.

References

American Psychiatric Association. (2022a). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychiatric Association. (2022b). *What are personality disorders?* Psychiatry.org. https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

American Psychological Association. (n.d.-a). *APA dictionary of psychology*. https://dictionary.apa.org/

American Psychological Association. (n.d.-b). *What is cognitive behavioral therapy?* https://www.apa.org/ptsd-guideline/patients-and-familis/cognitive-behavioral

Bekelepi, N., & Martin, P. (2022). Support interventions for nurses working in acute psychiatric units: A systematic review. *Health SA = SA Gesondheid*, *27*, 1811. https://doi.org/10.4102/hsag.v27i0.1811

Cleveland Clinic. (2022, April 16). *Personality disorders: Types, causes, symptoms & treatment*. https://my.clevelandclinic.org/health/diseases/9636-personality-disorders-overview

Drescher, J. (Ed.). (2022, September). *What are personality disorders?* American Psychiatric Association. https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

Fariba, K. A., Gupta, V., & Kass, E. (2023, April 17). *Personality disorder*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK556058/

Job Accommodation Network. (2023). *Accommodation and compliance: Personality disorder*. https://askjan.org/disabilities/Personality-Disorder.cfm

Kasalova, P., Prasko, J., Kantor, K., Zatkova, M., Holubova, M., Sedlackova, Z., Slepecky, M., & Grambal, A. (2018). Personality disorder in marriage and partnership—A narrative review. *Neuro endocrinology letters*, *39*(3), 159–171.

Mayo Foundation for Medical Education and Research. (2016, September 23). *Personality disorders*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/personality-disorders/diagnosis-treatment/drc-20354468

Mayo Foundation for Medical Education and Research. (2022, March 2). *Worried about your child's mental health?* Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

Mayo Foundation for Medical Education and Research. (2023, February 24). *Antisocial personality disorder*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/antisocial-personality-disorder/symptoms-causes/syc-20353928

McKay, M. T., Clarke, M. C., Donnelly, P., & Percy, A. (2022). The McLean Screening Instrument for Borderline Personality Disorder: What, and why in a clinical cohort? *Psychiatry research*, *317*, 114868. https://doi.org/10.1016/j.psychres.2022.114868

NHS Oxford Health. (2021, June 21). *Personality disorders*. Oxford Health NHS Foundation Trust.

https://www.oxfordhealth.nhs.uk/health/mental-health/personality-disorders/

Substance Abuse and Mental Health Administration. (2024). *Setting goals and developing specific, measurable, achievable, relevant, and time-bound objectives.* https://www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf

The Joint Commission. (2019, January). *Quick safety: De-escalation in health care*. https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/qs_deescalation_1_28_18_final.pdf

The Joint Commission. (2023). *Quick safety 23: Implicit bias in health care*. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-23-implicit-bias-in-health-care/implicit-bias-in-health-care/

CHAPTER 19
Substance Use and Misuse

FIGURE 19.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Substance use and misuse disorders affect more than 40.3 million Americans (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020) although only one in ten people receive treatment for these disorders (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). Regardless of their specialty area, it is imperative that nurses recognize the signs and symptoms of substance use disorders, have a basic understanding of resources available, and are able to assess for the life-threatening effects of substance use in the clients under their care. Substance use disorders are often found comorbidly with mental health or trauma disorders and medical conditions, such as diabetes, hepatitis C, and HIV (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

19.1 Substance Use Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define substance use disorder
- Demonstrate an understanding of substance use disorder
- Outline the symptoms of substance use disorder
- Describe the role of the nurse in planning care and approaches to recovery for a client with substance use disorder

Chronic substance use disorders significantly impact individuals, families, communities, and society. Misuse of alcohol, drugs, and prescribed medications is estimated to cost the United States more than $400 billion annually in health-care expenses, law enforcement, criminal justice costs, lost workplace productivity, and losses from motor vehicle crashes (Substance Abuse and Mental Health Services Administration [SAMHSA] & Office of the Surgeon General, 2016). The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics estimates that 107,622 drug overdose deaths and 52,000 alcohol-induced deaths occurred in the United States in 2021 (National Center for Health Statistics, 2022).

UNFOLDING CASE STUDY

Substance Misuse: Part 1

The nurse is assessing a thirty-year-old female who has been admitted to the hospital psychiatric unit.

PMH	Client is a thirty-year-old female who works as a project manager at a construction firm. She has a medical-surgical history of lumbar disc herniation repair, GERD, and ovarian cysts. She is current on all vaccinations and reports a history of tobacco use but quit last year. Family History: Client reports a family history of depression. Maternal grandmother was a smoker and died of lung cancer four years ago. Mother has a history of depression. Father does not have a mental health diagnosis. Social History: Client is married and has one child, age three. She has worked as a project manager for the past six years and finds her job to be interesting but stressful at times. She struggles to balance motherhood, family, and her work, and this has resulted in her having a glass of wine to relax after work. Recently, she has started to refill her glass throughout the evening and states that her husband is starting to comment on the amount of wine she is drinking. She has difficulty sleeping and she has been prescribed medication to help her to sleep, which she also takes throughout the day to help with the anxiety since it is for "relaxation." Current Medication: Alprazolam 1mg HS and No Known Allergies.
Nursing Notes	**1020 Assessment** Physical Examination: Client clean and appropriately dressed, alert and oriented ×4, mild tremors noted. HEENT: Pupils equal, reactive to light (PERRL), mucus membrane dry, pharynx without lesions, palate intact. No thyroid enlargement. Complains of headache. Lymphatic: Tonsillar and cervical lymph nodes noted but not enlarged; no enlargement of right axillary or inguinal nodes, no pain or tenderness noted. Respiratory: Clear to auscultation bilaterally, no stridor, no crackles or murmur. Cardiovascular: Regular rate and rhythm, no edema, peripheral pulses 2+ Abdomen: Bowel sounds present in all four quadrants, no organomegaly or tenderness. Musculoskeletal: Within normal limits, full ROM Skin: Dry and intact. No skin injuries noted. Mental Assessment: Client appears anxious

Flow Chart	**1020 Admission Assessment** Client presents with irritability and anxiety, mild tremors, and headache. She reports that her last drink was the previous evening at 1900, which promoted an argument with her husband leading to her admitting herself to the hospital. She is concerned about her employer finding out she is on a psychiatric unit and is worried about losing her job and her child. She reports anxiety 10/10 and is visibly fidgeting and tense. Her husband reports that the client has increased her drinking over the past several months, and currently consumes at least one bottle to a bottle and a half of wine every night. He also reports that she has been taking her prescribed benzodiazepine and alprazolam throughout the day rather than just before bedtime as it was intended. He states that she has been increasingly more detached from their child and unable to participate in family activities at home, including dinner and bedtime routines that used to be important to her. The client reports symptoms of insomnia, and anxiety, usually related to her guilt over distancing from her family and child. She identifies her faith, spouse, and child as reasons for living. Blood pressure: 145/92 mmHg Heart rate: 109 beats/minute Respiratory rate: 18 breaths/minute Temperature: 98.5°F (36.9°C) Oxygen saturation: 99% on room air Pain: 3/10 (head)
Lab Results	Ethanol: 0.13 Urine Drug Screen: negative for all except Benzodiazepine (positive)
Diagnostic Tests/ Imaging Results	EKG within normal limits
Provider's Orders	Initiate Clinical Institute Withdrawal Assessment (CIWA) Close observation Vitamin B12 and Folic Acid daily

1. Highlight the cues that indicate what the nurse will evaluate further.
2. After close review of the client's signs and symptoms, what would the nurse expect to be priority actions in the plan of care?

Defining Substance Use Disorder

A **substance** is defined as a psychoactive compound with the potential for dependence and detrimental effects, including substance use disorder. According to Substance Abuse and Mental Health Services Administration (SAMHSA, 2022d), **substance use disorders (SUD)** happen when the repeated use of alcohol and/or other drugs significantly impairs a person's health and results in an inability for them to meet major responsibilities at work, school, or home. People who have an SUD may be dually diagnosed with a mental health disorder (National Institute of Mental Health, 2023). Conversely, some people with a mental health disorder may use substances as a coping mechanism and then develop an SUD.

Three regions of the brain play a critical role in the development and persistence of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex (SAMHSA & Office of the Surgeon General, 2016).

- The basal ganglia control the rewarding, pleasurable effects of substance use and are responsible for the formation of habitual substance taking. Two subregions of the basal ganglia are particularly important in substance use disorders: the nucleus accumbens, involved in motivation and reward; and the dorsal striatum,

involved in forming habits and other routine behaviors.
- The extended amygdala is involved in the stress response and the feelings of unease, anxiety, and irritability that typically accompany substance withdrawal.
- The prefrontal cortex is involved in executive function (e.g., the ability to organize thoughts and activities, prioritize tasks, manage time, and make decisions), including exerting control over substance use.

Changes in the brain from substance misuse persist long after substance use stops and are associated with a high incidence of relapse with substance use disorders. More specifically, when a person uses substances, the basal ganglia begin to react to those substances by producing pleasant surges of dopamine, a neurotransmitter, sending messages to the nerve cells in this reward center of the brain (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). If the person continues to use substances, the neurotransmitters adapt, and the person demonstrates a reduced response to the substance and requires more of the substance to feel an effect; this is called **tolerance** (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). The extended amygdala and the prefrontal cortex play against each other as the person continues to increase the amount of substance used. Just as the basal ganglia react in response to the good feeling that results from the burst of dopamine, pushing the person to use again, the extended amygdala responds to negative stimuli like stress by trying to get away from unpleasant feelings. When a person has a substance use disorder, these two areas no longer balance each other. The reward control center begins to take over and the person begins to feel physical or emotional upset when they are not using a substance; this is called **withdrawal**. The only way the person can begin to feel better is to use the substance once again. At this point, the person gets stuck in a cycle of a substance use disorder where they neglect other parts of their lives, family, work, and pleasurable activities (Figure 19.2).

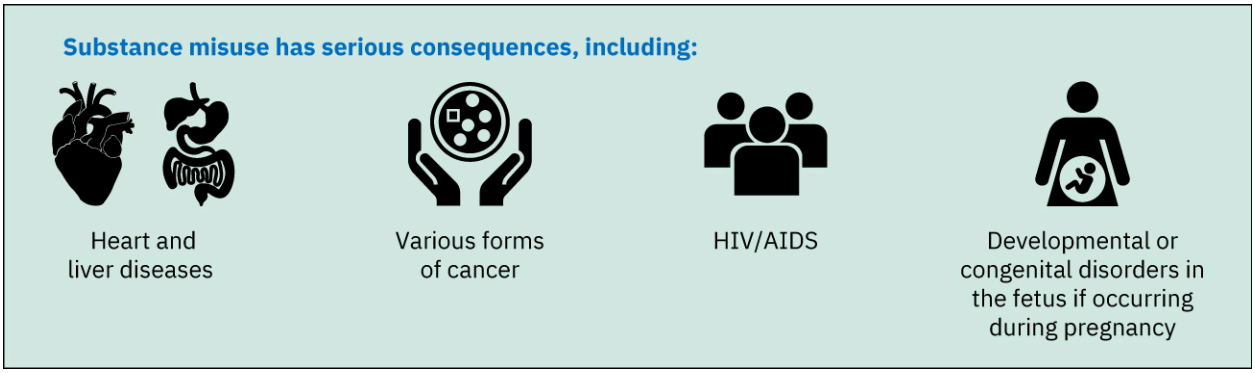


FIGURE 19.2 There are serious health consequences related to substance misuse (Office of the Surgeon General, 2023). (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

DSM-5 Diagnosis: Substance Use Disorder

Substance use disorders are diagnosed based on cognitive, behavioral, and psychological symptoms. To be diagnosed, a person meets with a health-care provider for a comprehensive evaluation to review substances used, patterns of use, effects on living, and range of symptom severity. After gathering and reviewing this information, the health-care provider will compare it with the *DSM-5* criteria, which includes degrees of substance use disorder but not addictive disorder. The most severe form of substance use disorder is categorized as addiction, and severe substance use disorder can be considered a neurological disorder and a mental illness (Partnership to End Addiction, 2023). Generally, according to the *DSM-5*, substance use disorder (SUD) is an illness caused by repeated misuse of substances such as alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants (amphetamines, cocaine, and others), and tobacco. These substances taken in excess have a common effect of directly activating the brain reward system and producing such an intense activation of the reward system that individuals may neglect normal life activities.

LINK TO LEARNING

The *DSM-5* diagnostic criteria for the diagnosis of substance use disorders (https://openstax.org/r/77DSM5SUD) is reproduced in the Clinical Guidelines Program published by Johns Hopkins University.

Addictive Disorders

Addictive disorders that are not substance-related include excessive behaviors that the person cannot control or stop, even if these behaviors pose risks or harm. The neurological aspects of addiction involving motivation and reward drive these behaviors, and stimulate the same addiction centers of the brain as addictive substances. The person's judgment may be impaired regarding consequences of the behaviors.

Behavioral addictions can include gambling, viewing pornography, compulsive sexual activity, internet gaming, overeating, shopping, overexercising, and overusing mobile phone technologies. Gambling disorder is the only nonsubstance use disorder with diagnostic criteria listed in the *DSM-5*. Additional research is being performed to determine the criteria for diagnosing other nonsubstance-related disorders (National Institute on Drug Abuse [NIDA] & National Institutes of Health, 2019).

LINK TO LEARNING

This news report effectively explains one example (https://openstax.org/r/77behavaddicton) of a behavioral addiction.

Understanding Substance Use Disorder

Chronic substance use disorders significantly affect individuals, families, communities, and society. According to the 2021 National Survey on Drug Use and Health (NSDUH), 46.3 million people in the United States aged twelve or older (16.5 percent) have a substance use disorder (SAMHSA, 2022c).

Prolonged, repeated misuse of substances can produce changes to the brain that can lead to a substance use disorder. Substance misuse (the term now used by professionals rather than substance abuse) is defined as the use of alcohol or drugs in a manner, situation, amount, or frequency that could cause harm to the user or to those around them (SAMHSA & Office of the Surgeon General, 2016). Misuse can be of low severity and temporary, but it can increase the risk for serious and costly consequences, such as motor vehicle crashes; overdose death; suicide; various types of cancer; heart, liver, and pancreatic diseases; HIV; and unintended pregnancies. Substance use during pregnancy can cause complications for the baby, such as fetal alcohol spectrum disorders (FASDs) or neonatal abstinence syndrome (NAS). Substance misuse is also associated with intimate partner violence, child abuse, and neglect (SAMHSA & Office of the Surgeon General, 2016).

Legal and Illegal Substances That Can Be Misused

There are many types of substances that can be misused and not all of them are illegal or classified as medications. Legally obtained substances include alcohol, tobacco, and caffeine. In the United States, tobacco use disorder is the second most common substance use disorder, following alcohol (Cleveland Clinic, 2023). Even though electronic cigarettes or "e-cigarettes" are advertised as being safer than cigarettes, they also contain nicotine, the addictive ingredient in cigarettes.

Legal substances that are medication and can be misused include inhalants, sedatives, opioids, and stimulants. In 2020, 2.4 million (0.9 percent) of people aged twelve or older in America misused inhalants. Inhalants are various products easily bought or found in the home, such as spray paints, markers, glue, gasoline, and cleaning fluids. Unlike other drugs, the percentage of inhalant use was highest among adolescents aged twelve to seventeen (NIDA & National Institutes of Health, 2020). People who use inhalants breathe in the fumes through their nose or mouth, usually by sniffing, snorting, bagging, or huffing. Although the high that inhalants produce usually lasts just a few minutes, people often try to make it last by continuing to inhale again and again over several hours (NIDA & National Institutes of Health, 2020). Prescription medications can also be misused as inhalants. For example, amyl nitrate is a prescription medication administered via inhalation to relieve chest pain. It can be misused by individuals to cause a high. It is referred to as the street drug, "poppers." Inhalant intoxication causes problematic behavioral or psychological changes, such as belligerence, being assaultive, apathy, and impaired judgment.

Other commonly misused prescription medications include those in the sedative, opioid, and stimulant classes. Sedatives include both anxiolytic hypnotics for sleep (like Ambien) and anxiolytic benzodiazepines (like Xanax, Valium, Ativan, and Klonopin). Prescriptions misused in the opioid class (used for pain) include codeine and

oxycodone (OxyContin). Frequently misused stimulants include ADHD drugs like amphetamine/dextroamphetamine (Adderal) and methylphenidate (Ritalin).

Chronic use of benzodiazepines causes changes in the gamma-aminobutyric acid (GABA) receptor, resulting in decreased GABA activity and the development of tolerance. A person can go through withdrawal after stopping or lowering the dose of benzodiazepines. Sedatives, hypnotics, and anxiolytic intoxication cause behavioral or psychological changes similar to alcohol intoxication, such as inappropriate sexual or aggressive behavior, mood lability, and impaired judgment. Symptoms of intoxication include slurred speech, lack of coordination, unsteady gait, nystagmus, impaired attention and memory, and stupor or coma (American Psychiatric Association, 2013).

Opioid misuse has been and continues to be a major cause of death in the United States with the number of overdose deaths in 2021 being six times the number in 1999 (CDC, 2023). While most people follow their health-care provider's directions on how and when to take their medications, others use prescribed medications in nonprescription ways: sharing medications with friends or family members, taking medications more frequently or in higher doses than what has been prescribed, combining medications with alcohol or other drugs, and taking medications in a form other than what is prescribed (snorting or injecting) (Alcohol and Drug Foundation, 2021). In an effort to reduce the number of opioid prescription medications being used, most states have monitoring systems in place to track how many opioid prescriptions individuals are receiving. With the help of the Drug Enforcement Agency (DEA), prescribers can review the registry to see if there is a pattern for abuse (Jahan & Burgess, 2023).

A person may use stimulants for the psychological and physical effects of euphoria, excitement, appetite suppression, and wakefulness. Misuse of stimulants can result in paranoia, hallucinations, and agitation, along with elevated body temperature, cardiac dysrhythmias, altered blood pressure, and seizures (Mayo Clinic, 2022).

Also legal, cold medications containing the cough suppressant dextromethorphan, decongestants, and antihistamines are also misused due to the potential for narcotic effects. Heart rate, body temperature, and blood pressure may be altered to the point of life-threatening (Connecticut Poison Control Center, 2024).

Illegal substances used include hallucinogens (PCP and LSD), stimulants (amphetamines, methamphetamine, cocaine), nonprescription opioids (heroin), and cannabis, where not legalized. See the table for a more descriptive list of both legal and illegal substances Table 19.1.

Substance Category	Examples
Alcohol	Beer, malt liquor, wine, and distilled spirits
Illicit drugs (including prescription drugs used nonmedically)	• Opioids, including heroin • Cannabis (may be legalized by state laws) • Sedatives, hypnotics, and anxiolytics • Hallucinogens • Stimulants, including methamphetamine-like substances, cocaine, and crack • Dextromethorphan and other cold medications
Over-the-counter drugs (used nonmedically)	Dextromethorphan, pseudoephedrine, and other cold medications
Other substances	Inhalants, such as spray paint, gasoline, and cleaning solvents; Delta-8 THC

TABLE 19.1 Categories and Examples of Substances

Controlled Substances

The Controlled Substances Act is a federal law that places all substances regulated by the U.S. Drug Enforcement Agency into one of five categories called schedules. This placement is based on the substance's medical use or lack of, its potential for abuse or dependency, and related safety issues. For example, Schedule I drugs have a high

potential for abuse and potentially cause severe psychological and/or physical dependence, whereas Schedule V drugs represent the least potential for abuse (U.S. Drug Enforcement Administration, 2020; Table 19.2).

Cannabis has been classified as a Schedule 1 drug since the 1970 Controlled Substances Act. However, more than half of the states in the nation have decriminalized the substance, with some permitting medical usage and others both medical and recreational usage. As of May 2024, the Drug Enforcement Agency has recommended that cannabis be reclassified as a Schedule III drug, which would support wider medical usage and scientific research but not permit recreational usage on a national level. Formal reclassification will require additional steps.

Schedule	Definition	Examples
Schedule I	No currently accepted medical use and a high potential for abuse.	Heroin, LSD, MDMA (Ecstasy), and cannabis (marijuana)
Schedule II	High potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. They can be used for treating pain, anxiety, insomnia, and ADHD.	Hydrocodone, cocaine, methamphetamine, methadone, hydromorphone, meperidine, oxycodone, fentanyl, amphetamine/dextroamphetamine salts (Adderall), methylphenidate (Ritalin), and phencyclidine (PCP)
Schedule III	Moderate to low potential for physical and psychological dependence. Abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV.	Acetaminophen with codeine, ketamine, anabolic steroids, and testosterone
Schedule IV	Low potential for abuse and low risk of dependence.	Alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), zolpidem (Ambien), and tramadol (Ultram)
Schedule V	Lower potential for abuse than Schedule IV and consists of preparations containing limited quantities of certain narcotics. Generally used for antidiarrheal, antitussive, and analgesic purposes.	Cough medications with codeine, diphenoxylate/atropine (Lomotil), and pregabalin (Lyrica)

TABLE 19.2 **DEA Controlled Substances by Schedule** (U.S. Drug Enforcement Administration, 2020)

Symptoms of Substance Use Disorder

Substance use disorder can be mild, moderate, or severe, with severe being considered addiction (Cleveland Clinic, 2023). Examples of symptoms seen in someone who is developing a substance use disorder include the following: using a prescribed substance for longer than intended and in amounts beyond its prescribed directions; being unable to stop using a substance; problems with relationships, work, and school; and development of a tolerance so that more of the substance needs to be used to get the same effects. There are over twenty million people in the United States who have an SUD that involves one substance, and 12 percent of those people have an SUD that includes using a drug and alcohol (Cleveland Clinic, 2023).

Intoxication

The term **intoxication** refers to a disturbance in behavior or mental function during or after the consumption of a substance. Generally, it is understood that saying someone is intoxicated is the same as saying they are drunk or high. A person using alcohol may experience a feeling of euphoria or excitement, which can become confusion, stupor, coma, or death (LaHood & Kok, 2023). As the level of intoxication increases so does the severity of the symptoms. Signs of intoxication may differ slightly depending on the substance being used. A person using heroin will also have a sense of euphoria along with drowsiness and nodding. A person using cocaine will experience more energy, but also experience paranoia, fatigue, and decreased appetite. A person using cannabis will experience a

state of relaxation, increased appetite, and sensory enhancement, which can progress to impaired perception (National Academies Press, 2017).

Tolerance versus Habituation

A person develops a tolerance the more they use a substance because the neurotransmitters adapt to the substance and no longer produce the same pleasurable feelings that occurred when the person first began to use the substance. When this occurs, the person may need to increase the amount used to reach the same "high."

Very simply, **habituation** is the process of getting used to doing something—such as using a substance—and then not wanting to stop. Habituation is a cycle that is difficult to break. Physical dependence often follows habituation.

Dependence

A person has a **dependence** on a substance when the lack of the substance causes physical symptoms. When a person suddenly stops using a substance, if they have developed a dependence, their body goes through withdrawal, a group of physical and mental symptoms that can range from mild to life-threatening. Dependence can be further broken down into psychological dependence and physical dependence although, according to American Addiction Centers (2021), psychological and physical dependence are intertwined.

Psychological Dependence

Psychological dependence stands for the emotional developments and changes that accompany substance misuse (American Addiction Centers, 2021). When most people think of psychological dependence, they think of cravings, the anxiety and/or depression that can occur when a person does not use the substance, denial that there is even a substance use problem, obsessing over the substance, and cognitive decline (American Addiction Centers, 2021). Substances that are associated with stronger psychological dependence are stimulants, cannabis, inhalants, psychotropic medications, and hallucinogens.

Physical Dependence

Physical dependence is related to the symptoms that a person experiences with tolerance and withdrawal (American Addiction Centers, 2021). Examples of these symptoms include nausea, vomiting, stomach upset, hallucinations, tremors, and headaches. Examples of certain substances that have stronger physical dependence are alcohol, opioids, benzodiazepines, and barbiturates. A person who is experiencing physical dependence will also have psychological symptoms as they go through withdrawal from the substance. Thinking holistically, the mind and body are inextricably connected, so it makes sense that these two types of dependence often accompany one another.

Addiction

Compulsive or uncontrolled use of one or more substances, **addiction** is a chronic condition that has the potential for both relapse and recovery. The addiction process involves a three-stage cycle of symptoms that become more severe as a person continues to misuse substances, causing neuroadaptations in brain function that reduce a person's ability to control their substance use. Each stage is associated with one of the brain regions previously described (i.e., basal ganglia, extended amygdala, and prefrontal cortex). This three-stage model provides a useful way to understand the symptoms of addiction, the ways it can be prevented and treated, and the steps for recovery.

1. Binge/intoxication: The stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects.
2. Withdrawal/negative affect: The stage at which an individual experiences a negative state in the absence of the substance.
3. Preoccupation/anticipation: The stage at which one seeks substances again after a period of abstinence (SAMHSA & Offices of the Surgeon General, 2016).

LIFE-STAGE CONTEXT

The Cycle of Addiction

Research has shown that a person who first tries drugs in their teens is more apt to develop an SUD than a person who first tries drugs as an adult (NIDA, 2022). Conduct problems and delinquent behaviors, such as vandalism and

violence, are usually precursors to the initiation of substance use in teenagers. Substance use is also higher in teens who have drug-using friends. Important to consider are the psychosocial factors of education, employment, relationships, and involvement with the legal system. A study by Arria et al. (2020), which evaluated continuous abstinence over a two-year period, found that teens with long-term SUD treatment program completion had greater improvements in relationships with significant others and in relapse avoidance. The authors acknowledged the value of supportive resources after treatment to improve education and employment outcomes.

Overdose

The biological response of the human body when it has ingested lethal or toxic amount of a substance is **overdose**. Signs of intoxication and overdose differ for categories of psychoactive substances.

Poison control centers are available 24/7, every day of the year to consult about toxic ingestion of substances and overdoses; just call 1-800-222-1222. Some hospitals also have toxicologists available for bedside consultation for overdoses (Rosenbaum & Boyer, 2021).

Approaches to Recovery from Substance Use Disorder

The first step is admitting there is a problem. In addition to medications and behavioral therapies, effective treatment of SUD includes recovery support services (RSS). Recovery support services provided by substance use disorder treatment programs and community organizations provide support to individuals receiving treatment for SUD, as well as ongoing support after treatment. These supportive services are typically delivered by trained case managers, recovery coaches, and/or peers. Specific RSS include assistance in navigating systems of care, removing barriers to recovery, staying engaged in the recovery process, and providing a social context for individuals to engage in community living without substance use. RSS can be effective in promoting healthy lifestyle techniques to increase resilience skills, reduce the risk of relapse, and help achieve and maintain recovery. Individuals who participate in RSS typically have better long-term recovery outcomes (SAMHSA & Office of the Surgeon General, 2016).

Recovery goes beyond abstinence and the remission of substance use disorder to include a positive change in the whole person. There are many paths to recovery. People choose their individual pathway based on their cultural values, socioeconomic status, psychological and behavioral needs, and the nature of their substance use disorder (SAMHSA & Office of the Surgeon General, 2016). In a study by Kaskutas et al. (2014) of over 9,000 individuals with previous substance use disorders, three themes emerged when asked how they defined recovery:

- Abstinence: 86 percent viewed abstinence as part of their recovery, but the remainder did not think abstinence was required. Abstinence was considered “essential,” however, by those affiliated with twelve-step mutual aid groups.
- Personal growth: “Being honest with myself” was endorsed as part of recovery by 98 percent of participants. Other almost universally endorsed elements included “handling negative feelings without using alcohol or drugs” and “being able to enjoy life without alcohol or drugs.” Almost all study participants viewed their recovery as a process of growth and development, and about two-thirds saw it as having a spiritual dimension.
- Service to others: Engaging in service to others was another prominent component of how study participants defined recovery. This is perhaps because during periods of heavy substance misuse, individuals may damage interpersonal relationships, which they later regret doing and attempt to resolve during recovery. Evidence exists that providing service to others helps individuals maintain their own recovery (SAMHSA & Office of the Surgeon General, 2016).

LINK TO LEARNING

This SAMHSA information sheet explains how to start a conversation with a family member (https://openstax.org/r/77talkaboutprob) who is using or having mental health problems. This sheet could be used as a handout for client/family education.

Overlap Between SUD and Mental Health Disorders Causes Treatment Challenges

In 2020, seventeen million adults (6.7 percent) had both a substance use disorder (SUD) and a mental health illness

(SAMHSA, 2021b). The relationship between SUDs and mental disorders is known to be bidirectional, meaning the presence of a mental health disorder may contribute to the development or exacerbation of an SUD, or an SUD may contribute to the development or exacerbation of a mental health disorder. The combined presence of SUDs and mental health disorders results in greater functional impairment; worse treatment outcomes; higher morbidity and mortality; increased treatment costs; and higher risk for homelessness, incarceration, and suicide.

The reasons why substance use disorders and mental health disorders often occur together are not definitive, but there are three possible explanations. One reason may be that certain substances may temporarily mask the symptoms of mental health disorders (such as anxiety or depression). A second reason may be that certain substances trigger a mental health disorder that otherwise would not have developed. For example, research suggests that alcohol use increases risk for post-traumatic stress disorder (PTSD) by altering the brain's ability to recover from traumatic experiences. A third possible reason is that both substance use disorders and mental health disorders are caused by overlapping factors, such as particular genes, neurobiology, or exposure to traumatic or stressful life experiences (SAMHSA & Office of the Surgeon General, 2016).

Mental health disorders and substance use disorders have overlapping symptoms, making diagnosis and treatment planning challenging. For example, people who use methamphetamine for a long period of time may experience paranoia, hallucinations, and delusions that can be mistaken for symptoms of schizophrenia (SAMHSA & Office of the Surgeon General, 2016).

Planning Nursing Care for a Client with Substance Use Disorder

Initial treatment begins with the health-care provider ordering laboratory testing, such as urine and blood tests. A urine drug screen and blood alcohol level can determine what substance the person has been using. Complete blood count (CBC), basic metabolic panel (BMP), liver function test (LTF), hepatitis panel, and pancreatic enzymes can determine the health of the client (Jahan & Burgess, 2023). Female clients may receive a urine pregnancy test (HCG). The CBC will show anemia or infection that may be occurring due to substance use. The BMP will identify any comorbidities and electrolyte imbalances. A liver function test (LFT), hepatitis panel, and, possibly a screen for human immunodeficiency virus (HIV), will check for any problems with the liver due to alcohol/substance consumption or HIV infection due to IV drug use. Lastly, a pancreatic enzyme serum level will show if there is any damage to the pancreas. The results of these tests form the basis for the medical part of the treatment plan (Jahan & Burgess, 2023).

The health-care provider may also look at data from the prescription drug monitoring program (PDMP) to see if the person is obtaining medications from multiple sources (NIDA, 2020a). A PDMP is an electronic database capable of tracking prescriptions for controlled substance. This monitoring can alert providers to clients at risk for overdose or other concerns about inappropriate medication use (Centers for Disease Control and Prevention [CDC], 2022).

The nurse must assess for past or current history of mental health disorders, because SUD and mental health disorders can overlap and affect treatment. The nurse should ask the client what substance they have been using, how much/how often, last use, and the form (pills, snorting, injection). The nurse should check with the client about any current legal problems, their support systems and living situation, and any cultural or religious needs for care. The nurse may administer Clinical Institute Narcotic Assessment (CINA), Clinical Institute Withdrawal Assessment for Alcohol (CIWA), or Clinical Opiate Withdrawal Scale (COWS) scales to determine if the client is experiencing any withdrawal symptoms. All the information from the initial assessment is combined to form the foundation of the nursing plan of care.

Nurses' Attitudes toward Addiction

According to Tierney (2017), nurses can hold stigmatizing views toward people with substance use disorders and the behaviors caused by substance use. The author continues by saying that nurses sometimes experience feelings of anger, anxiety, powerlessness, and frustration when caring for these clients. Nurses report that many of these feelings come from not having enough training or education about substance use disorders.

Nurse as Client with Substance Use Disorder

Health-care professionals are not immune to developing SUD. SUD is a chronic illness that can affect anyone regardless of age, occupation, economic circumstances, ethnic background, or gender. The National Council of State Boards of Nursing (NCSBN) created a brochure called *A Nurse's Guide to Substance Use Disorder in Nursing*. This brochure states that many nurses with SUD are unidentified, untreated, and may continue to practice when their

impairment may endanger the lives of their clients. Because of the potential safety hazards to clients, it is a nurse's legal and ethical responsibility to report a colleague's suspected SUD to their manager or supervisor. It can be hard to differentiate between the subtle signs of SUD and stress-related behaviors, but three significant signs include behavioral changes, physical indicators, and drug diversion (NCSBN, 2018). Nurses are in an excellent position to notice **drug diversion**, which occurs when medication is redirected from its intended destination for personal use, sale, or distribution to others. It includes drug theft, use, or tampering (adulteration or substitution). Drug diversion is a felony that can result in criminal charges.

Behavioral changes include less satisfactory job performance, absences from the unit for extended periods, frequent trips to the bathroom, arriving late or leaving early, and making an excessive number of mistakes, including medication errors (NCSBN, 2018). Other evidence includes increasing isolation from colleagues; inappropriate verbal or emotional responses; and diminished alertness, confusion, or memory lapses. Physical signs include subtle changes in appearance that may escalate over time. Signs of diversion look like frequent discrepancies in opioid counts, unusual amounts of opioid wastage, numerous corrections to medication records, frequent reports of ineffective pain relief from clients, offers to medicate coworkers' clients for pain, and altered verbal or phone medication orders (NCSBN, 2018).

LINK TO LEARNING

Watch this short video that discusses the problems and solutions for substance use disorder in nurses (https://openstax.org/r/77SUDinNurses) from the NCSBN.

All fifty states have boards of nursing (BON) that promulgate, regulate, and enforce their own rules and guidelines. These BON provide disciplinary action to nurses who practice while impaired (Boehning & Haddad, 2022). The National Council of State Boards of Nursing (NCSBN) website provides alternatives to discipline programs in their "Find a Program" (https://openstax.org/r/77FindAProgram) page in which programs are listed by state (NCSBN, n.d.). An individual can click on the link, choose their state, and receive a list of available programs in that state.

The earlier a nurse is diagnosed with SUD and receives treatment, the sooner client safety improves, and the better the chances for the nurse to recover and return to work. In most states, a nurse diagnosed with an SUD enters a nondisciplinary program designed by the board of nursing for treatment and recovery services. When a colleague treated for an SUD returns to work, nurses should create a supportive environment that encourages their continued recovery (NCSBN, 2018).

An example of one such BON program is the Texas Peer Assistance Program for Nurses (TPAPN). This program is funded by the fees paid for nursing licenses (TPAPN, n.d.). According to the Texas Nurse Practice Act, employers are required to report nurses who are suspected of being impaired at work. A recovery plan is set up for nurses who participate in TPAPN. Peer supports meet with participants to provide guidance, support, and mentorship so that they can eventually return to work.

LINK TO LEARNING

Read this analysis of state boards of nursing nurse monitoring programs (https://openstax.org/r/77NurseMonitor) that revealed individualized program components. Each nurse participant is contracted for their specifics, such as length in the program, required toxicology testing or therapies. The *DSM-5* is used to determine mild, moderate, or severe levels of SUD to determine appropriate referrals case by case.

19.2 Alcohol Use Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define and recognize how to diagnose alcohol use disorder
- Outline approaches to treating alcohol use disorder
- Plan nursing care for a client with alcohol use disorder
- Comprehend the risks a client in alcohol withdrawal might have to overcome

Alcohol is a legal drug that many people misuse. As of 2022, the lifetime statistics for alcohol use are that 221.3 million people aged twelve or older have used alcohol in their lifetime (SAMHSA, 2023a). Nurses provide care to individuals with alcohol use disorders, including performing assessments and offering treatment. Both alcohol and substance use have increased since the COVID-19 pandemic. Per the CDC, the number of Americans who reported either starting or increasing use of a substance to help them cope with the pandemic was at 13 percent (Chacon et al., 2021). Note that in the clinical setting, nurses may see the abbreviation ETOH. This stands for the chemical name for ethyl alcohol and is commonly used in documentation for alcohol and alcohol use.

Diagnosis and Definition of Alcohol Use Disorder

The *DSM-5* recognizes **alcohol use disorder (AUD)** as a chronic medical condition that is categorized by difficulty stopping or controlling alcohol use, and by using alcohol to relieve or avoid withdrawal symptoms, even when it is causing negative social, occupational, or health-related consequences (SAMHSA, 2022c). Most people who have an alcohol use disorder will seek care from their primary care provider regarding an alcohol-related medical problem instead of for their drinking (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2023a).

An alcohol use disorder is considered a brain disorder that can be mild, moderate, or severe (National Institute on Alcohol Abuse and Alcoholism, 2023c). The misuse of alcohol causes many health concerns, including high blood pressure, gastroenteritis and pancreatitis, cirrhosis, cancer, and mental health problems. Violence and crime, fatal and nonfatal vehicle accidents, and death—more than 140,000 per year in the United States—are also connected to alcohol misuse (SAMHSA, 2022a).

Symptoms of Alcohol Use Disorder

The 2021 National Survey on Drug Use and Health reports that 47.5 percent (133.1 million) of Americans aged twelve or older use alcohol, 21.5 percent are binge drinkers, and 5.8 percent are heavy alcohol users (SAMHSA, 2022c). Consumption of eight or more drinks per week for women and fifteen or more drinks per week for men or binge drinking on five or more of the previous thirty days is considered **heavy drinking**. Consuming several standard drinks on one occasion in the past thirty days is considered **binge drinking**; for men, this refers to drinking five or more standard alcoholic drinks on one occasion, and for women, this refers to drinking four or more standard drinks on one occasion (SAMHSA, 2022c). Based on the 2015–2020 Dietary Guidelines for Americans, a standard drink is defined as 14 grams (0.6 ounces) of pure alcohol. Examples of a standard drink are one 12-ounce beer, 8 to 9 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces of distilled spirits (Figure 19.3).

FIGURE 19.3 A standard drink contains 14 g (0.6 oz) of pure alcohol, but the overall volume of the drink varies by type. (credit: "US Standard Drink Sizes" by Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion/Centers for Disease Control and Prevention, Public Domain)

The term **alcohol intoxication** refers to problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, or impaired judgment) that develop during or shortly after alcohol ingestion. Signs and symptoms of alcohol intoxication are as follows: slurred speech, lack of coordination, unsteady gait, nystagmus, and impairment in attention or memory (American Psychiatric Association, 2013). The CDC's recommendations on alcohol intake are limited to one to two drinks per day (Figure 19.4).

FIGURE 19.4 The CDC recommends limiting alcohol intake. (credit: "Dietary Guidelines for Americans on Alcohol" by Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion/Centers for Disease Control and Prevention, Public Domain)

Symptoms of Alcohol Overdose

An alcohol overdose, also called alcohol poisoning, occurs when there is so much alcohol in the bloodstream that areas of the brain controlling autonomic nervous system functions (e.g., breathing, heart rate, and temperature control) begin to shut down. Signs of alcohol overdose include mental confusion, difficulty remaining conscious, vomiting, seizures, trouble breathing, slow heart rate, clammy skin, dulled gag reflex, and extremely low body temperature. Alcohol intoxication while also taking opioids or sedative-hypnotics (such as benzodiazepines or sleep medications) increases the risk of an overdose. Alcohol overdose can cause permanent brain damage or death (NIAAA & National Institutes of Health, 2021). Anyone who consumes too much alcohol too quickly is in danger of an alcohol overdose. As blood alcohol concentration (BAC) increases, so does the risk of harm. When BAC reaches high levels, blackouts (gaps in memory), loss of consciousness (passing out), and death can occur. BAC can continue to rise even when a person stops drinking or is unconscious because alcohol in the stomach and intestine continues to enter the bloodstream and circulate throughout the body.

Risk Factors in Developing Alcohol Use Disorder

Whether an individual ever uses alcohol or another substance and whether that initial use progresses to a substance use disorder of any severity depends on several factors, including the following:

- genetic and biological factors
- the age of substance use onset
- psychological factors related to a person's unique history and personality
- environmental factors, such as the availability of alcohol, family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support (Substance Abuse and Mental Health Services Administration (SAMHSA) & Office of the Surgeon General, 2016).

A person who binge drinks or has heavy alcohol use has an increased risk of developing alcohol use disorder (AUD) (NIAAA, 2023c). Genetics influence development of AUD by approximately 50 percent, though environmental factors are also significant (Deak & Johnson, 2021). Parents' drinking patterns can influence a child later in

developing an alcohol use disorder. Drinking at an early age can increase the risk of developing an AUD. This risk is increased in females as compared to males. A person with mental illness or trauma history is also at higher risk for an AUD, as these factors are common comorbidities of AUDs. Continuing research in genetics and ancestry will further inform the science as to causation of all substance use disorders (Deak & Johnson, 2021).

CULTURAL CONTEXT

Alcohol Use among the Asian Community

Genetics are a component of alcohol use disorder (AUD). Genetics influence a person's risk of developing AUD. Some individuals of Asian descent are affected by a gene variant that changes their ability to metabolize alcohol. When they drink, they have flushing, nausea, and a rapid heartbeat. These side effects cause many to abstain from drinking alcohol.

(American Addiction Centers, 2023b)

Approaches to Treatment of Alcohol Use Disorder

There are many approaches that can be used to treat alcohol use disorder. Keeping in mind that cravings will remain after an individual stops drinking, some of the things that the treatment team might offer are medications, behavioral therapies, and support groups. The care plan is individualized to meet the needs of the client.

Medications

The U.S. Food and Drug Administration (FDA) has approved three medications for treating alcohol dependence: naltrexone, acamprosate, and disulfiram. A health-care provider must first assess the client's "motivation for treatment, potential for relapse, and severity of co-existing conditions" (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016, p. 4-24). Research has shown that most clients who are prescribed medication to treat their alcohol use disorders do see positive benefits.

Naltrexone is an opioid antagonist that blocks opioid receptors. Just as it counteracts the pleasurable parts of using opioids, it also blocks the pleasurable parts of drinking. Compliance with taking Naltrexone in the oral form is necessary to avoid relapse. For clients who have difficulty with adherence, there is an extended-release injectable, given once a month (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

Acamprosate reduces the cravings to drink. Research has shown that this medication works well when used with behavioral interventions. Acamprosate has been found to be effective for reducing instances of relapse and maintaining abstinence.

The third medication is Disulfiram. It works by stopping the metabolism of alcohol. When a client uses alcohol and takes Disulfiram, they feel nauseous, have flushed skin, and experience heart palpitations, sweat, dizziness, and headaches. Teach clients taking this medication to check labels of products or foods—such as fragrance, astringents, dyes, paints, cough syrup, vinegar, sauces, or flavorings—that may contain alcohol and could cause a reaction. This medication should only be used if the person wants to stop drinking, not just reduce their drinking (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

Behavioral Treatments

Behavioral treatments help the client identify the triggers for their drinking. These treatments take place in a variety of settings—individual, group, and family. Trained providers teach the client how to change their behaviors through various methods, such as CBT, motivational enhancement therapy (MET), and family therapy. Each of these treatments can work individually or in combination with one another to help the client develop the skills they need to decrease/stop drinking, work on goal-setting, and build a support system.

CBT is a short-term therapy approach that involves twelve to twenty-four weekly sessions. During these sessions, participants are taught techniques to help recognize the thoughts and emotions that lead to the behaviors they hope to change and implement better coping skills as a way of reducing/quitting their drinking habits (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). DBT is similar to CBT, though the approach is to accept and manage feelings of distress without engaging in high-risk behaviors (Brice, 2024). MET uses motivational

interviewing to assist clients with determining any questions they have about stopping drinking/substance use. This therapy has been shown to have good results in combination with CBT in adolescents who use multiple substances (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

Family therapy helps the client by engaging the spouse, partner, and other family members to support reduction of the substance use and talk about other issues that may be occurring within the family unit. The family works together with the guidance of a therapist to learn better communication skills, bolster the individual's recovery, and improve family relationships (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

Mutual Support Groups

Twelve-step groups are one type of **mutual aid (support) group**. Members reveal their substance use problem and value learning from each other's experiences as they focus on personal-change goals. The groups are voluntary associations that charge no fees and are member-led.

Alcoholics Anonymous

Alcoholics Anonymous (AA) is a mutual aid support group that employs a twelve-step approach. It has been in existence since 1935 when two men, Bill W. and Dr. Bob S., met after both had been part of a nonalcoholic fellowship that shared the importance of living by spiritual values. Together they held the first AA meeting with a man they helped at Akron's City Hospital (Alcoholics Anonymous, n.d.). Its philosophy, approach, and format have been adopted and adapted by groups focusing on recovery from other substances, such as Narcotic Anonymous, Cocaine Anonymous, Marijuana Anonymous, and Crystal Meth Anonymous. AA and derivative programs share two major components: social fellowship and a twelve-step program of action formulated based on members' experiences of recovery from severe alcohol use disorders. These twelve steps are ordered in a logical progression, beginning with accepting that one cannot control one's substance use, followed by abstaining from substances permanently, and transforming one's spiritual outlook, character, and relationships with other people (SAMHSA & Office of the Surgeon General, 2016).

Research studying alcohol twelve-step mutual aid groups has shown that participation in the groups promotes an individual's recovery by strengthening recovery-supportive social networks; increasing members' abilities to cope with risky social contexts and negative emotions; augmenting motivation to recover; reducing depression, craving, and impulsivity; and enhancing psychological and spiritual well-being (SAMHSA & Office of the Surgeon General, 2016).

Al-Anon and Alateen

Friends and family members often suffer when a loved one has a substance use disorder. This can include worrying about their loved one or experiencing verbal or physical abuse, among other issues. Mutual aid groups provide emotional support to concerned significant others to help them systematically and strategically cope with the problems related to their loved one (SAHMSA & Office of the Surgeon General, 2016).

Al-Anon is a mutual aid group for family members dealing with substance misuse by a loved one. Like AA, Al-Anon is based on a twelve-step philosophy and provides support whether or not members' loved ones seek help or achieve remission or recovery. More than 80 percent of Al-Anon members are women. The principal goal of Al-Anon is to foster emotional stability and "loving detachment" from the loved one rather than coaching members to "get their loved one into treatment or recovery." Al-Anon includes Alateen, which focuses on the specific needs of adolescents affected by a parent's or other family member's substance use. Research studies regarding the effectiveness of Al-Anon show that participating family members experience reduced depression, anger, and relationship unhappiness at rates comparable to those of individuals receiving psychological therapies (SAMHSA & Office of the Surgeon General, 2016).

Screening/Assessment Tools for Withdrawal from Alcohol Use

Initial assessment of a client being seen for possible AUD should begin with an examination for withdrawal symptoms. There are scales to determine the amount of alcohol consumed by the client. The first is the Alcohol Use Disorders Identification Test (AUDIT-C). This test has three simple questions that are scored using a Likert scale. The higher the score, the more likely that the person will have negative health consequences due to their drinking habits (NIAAA, 2022). The second assessment tool is called CAGE (https://openstax.org/r/77CAGE), which stands for "Cut down, Annoyed, Guilty, Eye-opener." It consists of four questions with yes/no answers. A score of two or

more yes answers is considered significant (Ewing, 1984).

The Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) is the most widely used scale to determine the need for medically supervised withdrawal management. It is used in a variety of settings, including outpatient, emergency, psychiatric, and general medical-surgical units when there is a clinical concern regarding a client's alcohol withdrawal. The CIWA-Ar scale is typically utilized in association with a protocol containing medications to guide symptom-triggered treatment. Clients with an alcohol use disorder who have a CIWA-Ar score of less than 10 do not typically require medical management (Pace, 2022). There are ten questions on the CIWA-Ar related to nausea/vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and level of orientation.

CLINICAL JUDGMENT MEASUREMENT MODEL

Recognizing Cues: Using the CIWA-Ar for Alcohol Withdrawal

The CIWA-Ar assesses the withdrawal symptoms of a client with alcohol use disorder. The nurse has the client sit in a chair with their feet flat on the floor, then takes and records vital signs. The nurse proceeds to go down the form's checklist choosing answers on a Likert scale based on the scale's directions to either observe symptoms or ask the client a question about certain symptoms. The CIWA-Ar is a vital tool for gathering assessment data for the care of a person with alcohol use disorder.

(MDCalc, n.d.)

Treatment for Withdrawal from Alcohol Use

Benzodiazepines treat the psychomotor agitation many clients experience during alcohol withdrawal and prevent progression from minor symptoms to severe symptoms of seizures, hallucinations, or delirium tremens. Diazepam (Valium), lorazepam (Ativan), and chlordiazepoxide (Librium) are the drugs used most frequently to treat or prevent alcohol withdrawal symptoms (Hoffman, 2022). Anticonvulsants may be used concurrently or instead of benzodiazepines. Anticonvulsants decrease the probability of withdrawal seizures.

Delirium tremens (DT), a rapid-onset, fluctuating disturbance of attention and cognition, can include hallucinations and autonomic hyperactivity, with fever, tachycardia, hypertension, and diaphoresis. DTs typically begin between forty-eight and ninety-six hours after the client's last drink, reinforcing the necessity for accurate assessment data.

Chronic alcohol use depletes thiamine and magnesium. Clients receiving alcohol withdrawal treatment typically receive intravenous thiamine, along with dextrose, to prevent Wernicke's encephalopathy. Wernicke's encephalopathy is an acute, life-threatening neurological condition characterized by nystagmus, ataxia, and confusion caused by thiamine (B1) deficiency associated with alcohol use disorder. If untreated, Wernicke's encephalopathy can progress to Korsakoff's syndrome, a chronic, irreversible memory disorder resulting from thiamine deficiency (National Institute of Neurological Disorders and Stroke, 2023). Other electrolyte deficiencies may require treatment during alcohol withdrawal.

UNFOLDING CASE STUDY

Substance Misuse: Part 2

See Substance Misuse: Part 1 for a review of the client data.

Nursing Notes	**1240 Ongoing Assessment** The client is seen in the dayroom, pacing near the windows. She appears to be anxious and has tremors that are visible in her extremities. You complete a CIWA-Ar and her score is 12, scoring for anxiety, tremors, headache, and mild sweating. She denies hallucinations and appears oriented, but increasingly anxious and difficult to redirect. **1255 Intervention** MD notified of increased CIWA-Ar scoring and client symptoms.
Flow Chart	**1245 Ongoing Assessment** Blood pressure: 154/97 mmHg Heart rate: 110 beats/minute Respiratory rate: 20 breaths/minute Temperature: 99.1°F (37.2°C) Oxygen saturation: 98% on room air Pain 6/10 (head)
Lab Results	No additional labs
Diagnostic Tests/ Imaging Results	No additional diagnostic tests
Provider's Orders	CIWA-Ar with protocol Close observation Seizure precautions

3. Based on the findings, the nurse prioritizes the hypothesis. The client is at highest risk for [1] due to [2]. Select the most appropriate options to complete the statement(s).

Options for 1	Options for 2
Delirium tremens	Increased BP and HR
Physiological changes	CIWA-Ar score 12
Increased anxiety	Anxiety

4. The nurse generates solutions to the priorities for this client. Through use of the CIWA protocol, what is one solution?

Planning Nursing Care for a Client with Alcohol Use Disorder

Considering that only one in six people ever talks to their health-care professional about their drinking, nurses need to know how to start the conversation; after all, this important step can reduce drinking by 25 percent (CDC, 2020). Nurses and other health-care professionals must collaborate to help these clients.

Every facility should have a policy to ask all clients, including pregnant clients, about their drinking. Talking with the client about their drinking by asking for their thoughts on the good and bad of drinking is the first step toward beginning screening and counseling. Determine if the client is interested in making changes to their drinking—cutting back or quitting—or planning to continue their current drinking. Then begin to work with the client on a treatment plan (CDC, 2020). This type of screening and counseling can happen anywhere that health-care

professionals are seeing clients. Screening will identify potential concerns while providing the opportunity to begin talking about the treatment resources available. It is important for health-care professionals to know that the federal Affordable Care Act (2010) mandates that insurance policies cover this service and to share this information with clients. The treatment plan must be individualized and person-centered, keeping in mind age, race, religion/spirituality, culture, sexual orientation, trauma history, any co-occurring physical or mental health problems, language, and health literacy (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). The development of an individualized treatment plan increases client engagement and retention.

Nurses can educate clients about the dangers of drinking excessive amounts of alcohol and advise all women not to drink alcohol if they are pregnant. Treatment options are based on the severity of the client's drinking (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). If the client's alcohol use is mild, then counseling services of one to two visits per week may be appropriate. A client with a more severe alcohol use disorder may require inpatient treatment. The nurse caring for a client in an inpatient setting would use evidence-based practice to determine the client's motivation for change, triggers, help the client to increase their belief in themselves, and educate on changing thinking patterns (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016).

LINK TO LEARNING

The CDC (2017) produced this one-minute public service announcement (https://openstax.org/r/77AlcoholPSA) to share the importance of screening and counseling clients on alcohol use.

Overcoming Risks of Developing AUD

Many factors influence the development of substance use disorders, including growth and development, environment, social, genetics, and co-occurring mental health disorders. Genetics play a 60 percent role in a person developing an AUD, and a child who sees their parents drinking may also be influenced to begin drinking. Mental health and trauma histories can have an effect on the likelihood that an individual will develop an AUD (NIAAA, 2023a).

Other conditions called **protective factors** shield people from developing a substance use disorder or addiction. Protective factors are things like cultural or religious beliefs, having supportive friends and family, and having healthy coping mechanisms. The relative influence of these factors varies across individuals and the lifespan.

Educating the public about the significance of AUD by providing programs in schools, community centers, and media public service announcements decreases the risks of people developing AUDs. Nurses have the potential to effect positive change through their educational endeavors.

19.3 Stimulant Use Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify stimulants that can be misused
- Describe the symptoms of stimulant use disorder
- Outline the role of the nurse in treating stimulant use disorder

Amphetamine-type substances, cocaine, and crack are **stimulants**; they cause the release of dopamine in the brain and are highly addictive because the flood of dopamine in the brain's reward circuit strongly reinforces drug-taking behaviors. With continued drug use, the reward circuit adapts and becomes less sensitive to the drug. As a result, people take stronger and more frequent doses in an attempt to feel the same high and to obtain relief from withdrawal symptoms. Because the high from stimulants starts and fades quickly, people often take repeated doses in a form of binging, often giving up food and sleep while continuing to take the drug every few hours for several days. Both the use and withdrawal from amphetamines can cause psychosis with symptoms of hallucinations and paranoia (NIDA & National Institutes of Health, 2019).

Stimulants That Can Be Misused

Legal stimulants are most commonly prescribed to address attention-deficit hyperactivity disorder (ADHD) and include the medications Ritalin and Adderall, among others (NIDA, 2020a). These medications enhance cognition and focus in clients with ADHD. When used by a person who does not have ADHD, these substances can become addictive and cause a dangerous rise in body temperature, irregular heartbeat, anger, psychosis, and paranoia. It is estimated that 1.5 million people, aged twelve or older, misused prescription stimulants in 2021 (NIDA, 2020a). Also frequently misused, and often more easily accessible, are over-the-counter cold/allergy medications containing pseudoephedrine, a stimulant.

Illegal stimulants, on the other hand, such as cocaine and methamphetamine, are highly addictive substances that cause a sense of euphoria and increased energy. When used in combination with alcohol, the person has a higher risk of cardiac toxicity.

LIFE-STAGE CONTEXT

Nonmedical Prescription Stimulant (NMPS) Use among College Students

Increased academic performance is the number one reason for college students obtaining and misusing prescription stimulants, such as Adderall and Ritalin. Fairman et al. (2020) report that 45.7 percent of 219 students responding used a NMPS without their own prescription and without a diagnosis for attention-deficit disorder. Most users wanted to improve concentration for studying and thereby improve academics. Students who have lower grade point averages are more likely to use NMPS. Rates of use in the United States are higher than in any other part of the world. Health concerns for this practice include adverse reactions, risk for dependence, and polydrug use (using more than one drug at a time).

(Fairman et al., 2020)

Amphetamines

Amphetamines are prescription stimulant drugs and many are classified as Schedule II controlled substances due to the potential for misuse. Amphetamines were first used in the 1930s in an inhaler called Benzedrine (Department of Justice/Drug Enforcement Administration, 2022) after which prescriptions for the pill form of amphetamines became available to treat narcolepsy and ADHD. Today, these drugs have a high rate of misuse and have street names, such as crank, speed, and ice. Ice is the crystallized form of methamphetamine that is used for smoking. The effect is like cocaine but is slower and lasts longer in the body. Side effects include insomnia, loss of appetite, increased heart rate and blood pressure, and feeling exhausted (Department of Justice/Drug Enforcement Administration, 2022).

Methamphetamines

Methamphetamines are illegal stimulant drugs with no recognized medical use. Methamphetamines are unregulated and addictive and are classified as Schedule II drugs. Approximately two million Americans use methamphetamine in any given year, according to SAMHSA (2023b). The National Institute on Drug Abuse data reveals that overdose death rates involving methamphetamine quadrupled from 2011 to 2017 (NIDA & National Institutes of Health, 2019). Methamphetamine comes in many forms and can be ingested by smoking, swallowing a pill, snorting, or injecting a powder that has been dissolved in water or alcohol. Methamphetamine can be easily made in small, clandestine laboratories with relatively inexpensive over-the-counter ingredients, such as pseudoephedrine, a common ingredient in cold medications. To curb this illegal production, federal law requires pharmacies take steps to limit sales and obtain photo identification from purchasers. Methamphetamine production also involves a number of other very dangerous chemicals. Toxic effects from these chemicals can remain in the environment long after the lab has been shut down, causing a wide range of health problems for people living in the area. These chemicals can also result in deadly lab explosions and house fires (NIDA & National Institutes of Health, 2019).

Long-term use of methamphetamine has many negative consequences, including extreme weight loss, severe dental problems, intense itching leading to skin sores from scratching, involuntary movements (dyskinesia), anxiety, memory loss, and violent behavior (NIDA & National Institutes of Health, 2019).

Cocaine

Cocaine is another powerfully addictive stimulant drug. The drug is made from the leaves of the coca plant native to South America. Estimates indicate that 4.8 million people aged twelve or older used cocaine in 2021 (SAMHSA, 2022c). Those who have used the drug may snort cocaine powder through the nose, rub it into their gums, or dissolve the powder and inject it into the bloodstream. Cocaine processed to make a rock crystal is called "crack." People heat the crystal (making crackling sounds) to produce vapors that they inhale into their lungs (American Psychiatric Association, 2013; Boyer & Hernon, 2019). In the short-term, cocaine use can result in increased blood pressure, restlessness, and irritability. In the long-term, severe medical complications of cocaine use include heart attacks and seizures (NIDA & National Institutes of Health, 2019).

MDMA

A synthetic, psychoactive drug, **MDMA**, is more commonly known by the names Molly or Ecstasy (NIDA, 2020b). It is like amphetamine and the hallucinogen mescaline in that it makes its users feel like they have more energy, pleasure, and a distorted sense of time (NIDA, 2020b). MDMA affects three chemicals in the brain—dopamine, norepinephrine, and serotonin—by increasing their activity. People using MDMA commonly take it in pill or capsule form or by snorting it. The pleasurable effects usually last three to six hours. Because this drug lowers inhibitions, people may engage in risky behaviors, such as unsafe sex, thus increasing their chances of contracting a sexually transmitted infection or becoming pregnant. Other side effects are chills, nausea, teeth clenching, and extremely high body temperature that can cause kidney, liver, or heart failure, and ultimately lead to death (NIDA, 2020b).

REAL RN STORIES

Nurse: Shannan
Years in Practice: Sixteen
Clinical Setting: ER
Geographic Location: Unknown

In *From Impaired to Inspired: One Nurse's Story of Addiction and Recovery* (2018), Shannan F. shares her story of recovery. She and her husband met when she was eighteen, married when she was twenty-two, and had their first baby at twenty-seven. As an ER nurse married to a firefighter, she had what looked like a great marriage. They had three boys together. Yet Shannan's husband began to have affairs. In 2010, he asked for a divorce. Shannan began drinking socially over the next couple of years. As the pressures of being a single parent rose, Shannan was soon drinking every night after her boys went to bed. In 2014, Shannan was given a prescription of Norco (a combination of hydrocodone and acetaminophen) for a kidney stone. This drug, combined with the alcohol she was still drinking, was a dangerous combination. After the prescription ran out, she began buying Norco from a drug dealer and eventually stole Dilaudid from the Pyxis at work to support what had become a habit. On Easter of 2015, Shannan blacked out and can only remember her boys trying to wake her up. Two days later, she called her state's board of nursing (BON) and was put into a diversion program; her nursing license was suspended.

Shannan's story doesn't end there. She was eventually charged with twenty-eight felony charges for diverting drugs. She had no money for a lawyer, but had a good public defender who got the charges reduced. She was put on ninety days of house arrest and her sons went to live with their dad. During that period, she grew spiritually. She got her sons back after the ninety days were over. She also had to face BON disciplinary proceedings at the end of her diversion program. She made the decision to give up her nursing license. She currently works as a life coach to nurses and first responders to help them in their recovery journeys.

(F, 2018)

Symptoms of Stimulant Use Disorder

Stimulant intoxication causes problematic behavioral or psychological changes, such as euphoria or blunted affect; changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension, or anger; and impaired judgment. Other symptoms of stimulant intoxication include tachycardia, hypertension, pupillary dilation, elevated or decreased blood pressure, perspiration or chills, nausea or vomiting, weight loss, psychomotor agitation or retardation, muscular weakness, respiratory depression, chest pain or cardiac dysrhythmias, confusion, seizures,

coma, psychosis/hallucinations, dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs, or trunk) and dystonia (involuntary muscle contractions that result in slow repetitive movements) (American Psychiatric Association, 2013; Boyer & Hernon, 2019).

Approaches to Treating Stimulant Use Disorder

Treatment begins with detoxing from the stimulant, which is when the client stops taking the stimulant and allows all traces to leave their body. During withdrawal, the client may experience muscle tension, headaches, stomach cramps, increased appetite, insomnia, depression, and slower thinking (Cleveland Clinic, 2019). These withdrawal symptoms can begin within a few hours of the most recent use and last for up to seven days. The next part of treatment is for the client to participate in therapy, which can be in group format, individual counseling, or attend a twelve-step program. The support offered through these treatment options can increase the chances of the client maintaining sobriety.

Planning Nursing Care for a Client in Stimulant Withdrawal/Detoxification

The nurse initially assesses the client for withdrawal symptoms. Nurses commonly use the Clinical Institute Narcotic Assessment (CINA) or Clinical Opiate Withdrawal Scale (COWS) to determine the level of discomfort the client is experiencing. The higher the score, the higher the level of symptoms that need to be managed by medication administration. Although there is no medication specifically for treating stimulant withdrawal, there are medications that can be used to treat individual symptoms (Cleveland Clinic, 2019). As the client's symptoms decrease, the nurse should invite the client to attend group sessions to learn more about positive coping methods. Discharge planning can include obtaining a bed in a residential recovery facility or the use of outpatient sobriety programs, such as Narcotic Anonymous, Cocaine Anonymous, or looking at a list of treatment options located on the SAMHSA website.

Collaborative Care for Clients in Stimulant Use Recovery

It is important for health-care systems to work together to assess and provide treatment to individuals who are experiencing all substance use disorders. There have been improvements to access to care brought about by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act, which work together to require that substance use disorder treatment be covered by insurance (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). Implementing screening of all clients at each appointment is one of the first steps of early intervention. If a provider identifies a substance use disorder, they can initiate treatment within the primary care office or refer to more intense treatment for detox and recovery. Nurses, and other health-care professionals who complete client screenings, should receive training. According to the U.S. Department of Health and Human Services, Office of the Surgeon General (2016), each dollar that is spent on treatment saves four dollars in related health-care costs.

Collaborative care achieves the best results in client recovery. It is important that all the members of the interprofessional team work together to recognize possible substance use disorders in their clients, determining the best treatment options for each individual and recognizing signs of relapse (Jahan & Burgess, 2023).

19.4 Opioid Use Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define opioid use disorder
- Outline methods used to treat opioid use disorder

From 1999 to 2021, over 600,000 people died in the United States from an overdose involving prescription or illicit opioids (CDC, 2023). This rise in opioid overdose deaths happened in three distinct waves. The first wave of overdose deaths began with the increased prescription rate and misuse of opioids in the 1990s. The second wave began in 2010 with rapid increases in overdose deaths involving heroin. The third wave began in 2013 with significant increases in overdose deaths involving synthetic opioids, particularly illicitly manufactured fentanyl (CDC, 2023).

Defining Opioid Use Disorder

Even though health-care providers prescribe opioids legally to address pain, the use of these medications can lead

to opioid use disorder (John Hopkins Medicine, 2023b). Among the 2021 U.S. population, 8.7 million people misused prescription pain relievers, and 1.1 million people used illegal opioids such as heroin (SAMHSA, 2022c). Misuse of a prescription pain reliever is described as either using a prescription medication that is prescribed to another person or overuse (either in quantity or number of doses) of a medication prescribed to the user (SAMHSA, 2022c).

Opioids are substances that act on opioid receptors in the central nervous system. Opioid receptors in the brain are part of the body's internal system to regulate pain. A receptor is like a lock that the opioid (similar to a key) fits into (Medline Plus, 2017). Medically, they are used for anesthesia and relief of moderate to severe pain. When misused, opioids cause a person to feel relaxed and **euphoric**, meaning they experience an intense feeling of happiness. Opioid prescription medications include Schedule II medications, such as morphine, oxycodone, hydrocodone, fentanyl, and hydromorphone. Heroin, an illegal street drug, is also an opioid, but it is classified as a Schedule I drug (A.D.A.M. Medical Encyclopedia, 2022). Injected opioid misuse is a risk factor for contracting HIV, hepatitis B, hepatitis C, and bacterial endocarditis. The CDC reports that people who inject drugs accounted for 9 percent of HIV diagnoses in the United States in 2016 (SAMHSA, 2022a).

Behaviors Associated with Opioid Use Disorder

People often begin using opioids legitimately for pain that is caused by surgery, traumatic injury, or disease. When taken as prescribed by the health-care provider, most people do not end up with an opioid use disorder (John Hopkins, 2023a). Some people who take opioids enjoy a sense of euphoria when taking these drugs, however. For these people there is a risk of abuse as they try to continue to replicate that euphoric feeling.

Once an opioid use disorder develops, the person may begin to have financial problems due to the expense of buying the drugs. They may start to steal other people's opioids, belongings, or cash in order to support their habit (John Hopkins Medicine, 2023a). Along with their interpersonal relationships beginning to deteriorate as they continue to use, they may also have difficulty staying employed. According to the National Institute on Drug Abuse (2018), only a small percentage of people who have an opioid use disorder will go on to use heroin. Data collected to examine heroin use suggests that those who go on to start heroin are more often polydrug users to begin with.

Opioid Intoxication

Opioid intoxication causes problematic behavioral or psychological changes, such as initial euphoria followed by apathy, dysphoria, psychomotor retardation or agitation, and impaired judgment. Some other signs of opioid intoxication include pupillary constriction (or dilation from severe overdose), drowsiness or coma, slurred speech, and impairment in attention or memory (American Psychiatric Association, 2013). An initial assessment includes a physical examination of the skin to look for the presence of needle track marks.

The typical signs of opioid overdose are referred to as the opioid overdose triad and include pinpoint pupils, respiratory depression, and decreased level of consciousness (Jahan & Burgess, 2023). Naloxone (Narcan) reverses the effects of an opioid overdose. A single-step nasal spray delivery of naloxone is the easiest and most successful route of administration for members of the community and first responders. Also available is naloxone intramuscular injection (Eggleston et al., 2018) (Figure 19.5).

FIGURE 19.5 Take these steps to begin helping others to prevent opioid misuse. (credit: modification of "What can you do to Prevent Opioid Misuse?" by U.S. Department of Health and Human Services/www.hhs.gov, Public Domain)

CLINICAL JUDGMENT MEASUREMENT MODEL

Take Action: Administering Naloxone

After recognizing the signs of opioid overdose, there are five steps nurses and other health-care providers should take:

1. Obtain emergency assistance—when in a facility, gather team members, and, if not in a facility, call 911.
2. Provide rescue breathing, chest compressions, and oxygen as needed and if accessible. Use a barrier device when giving breaths to protect yourself from transmissible diseases.
3. Administer the first dose of naloxone. This medication should be given to anyone suspected of an opioid overdose, including pregnant women.
4. Administer a second dose of naloxone if the person does not respond within two to three minutes of the first dose.
5. Monitor the person's response. Naloxone should work within two to three minutes of being administered, but it is short-acting and the person's overdose symptoms can return; thus, the person should be taken to the ED if they are not already in a facility with medical care available.

Health Risks Associated with Illegal Use of Opioids

According to Jahan and Burgess (2023), opioid use can affect many body systems and cause the following side effects:

- stroke, seizures
- cardiac failure with chronic use
- memory loss and overall cognitive deficits
- psychosis
- nasal septal perforation
- respiratory depression
- muscle breakdown from overuse, leading to rhabdomyolysis

- hepatitis B and C infections, HIV, sepsis, and gangrene
- coma and death

Some of the side effects are associated with the form in which a person uses the substance. For instance, snorting can cause nasal septal perforation. Use of IV forms of the substance can lead to blood-borne infections—Hep B and C and HIV—if people are sharing needles (Cleveland Clinic, 2022b). The more that a person uses a substance, the higher their risk for overdose, suicide, or death.

LINK TO LEARNING

This article debates a needle exchange program (https://openstax.org/r/77needleexchnge) in rural Kentucky. As you read this article, weigh the pros and cons presented and think about how such programs might work in your own community.

Approaches to Treating Opioid Use Disorder

There are several approaches to treating opioid use disorder. These methods include outpatient counseling, intensive outpatient treatment, short-term residential treatment, long-term therapeutic communities (sober living), and medication-assisted treatment (MAT) (Cleveland Clinic, 2022b). The most effective treatment combines the use of medication with counseling and behavioral therapy.

Three FDA-approved medications for the treatment of opioid use disorder exist: buprenorphine, methadone, and naltrexone (Cleveland Clinic, 2022b). Buprenorphine is a medication that blocks the euphoria produced by opioids and reduces withdrawal symptoms and cravings. This medication must be given in the provider's setting in either oral form or by monthly injection. Methadone is available in specific clinics designated to administer this medication. It prevents the symptoms of withdrawal and reduces cravings. Naltrexone blocks the euphoria of opioids. It is only available in provider settings in oral form or monthly injections.

CBT helps clients adjust their thinking and behavior in relation to using opioids. This therapy helps the client to act in a healthier manner by examining their thoughts and reactions when they were using. Self-help programs, such as **Narcotics Anonymous**, also provide behavior modification using the support and guidance of others with lived experience.

Planning Nursing Care for a Client in Opioid Withdrawal/Detoxification

When caring for a client enduring opioid withdrawal/detoxification, the nurse's initial concerns revolve around symptom management. Part of the assessment process involves the use of the CINA or COWS to determine the level of withdrawal symptoms the client is having at set intervals throughout the day. The scoring on this scale assists the nurse with determining medication administration to help manage symptoms. Withdrawal/detoxification length and severity depend upon the opioid that the client has been taking and when their last use was prior to coming in for treatment. The goal is to minimize withdrawal symptoms to the point that the client can begin working on discharge planning.

Planning Nursing Care for a Client with Opioid Use Disorder

Once detox is complete, the nurse and other health-care professionals will begin to talk to the client about their expectations for further treatment, motivation to change, and desire to stay sober. These important conversations help to pave the way for continuing treatment as the client begins to feel better. Nurses spend this time educating their clients on the seriousness of OUD, the negative effects it has on physical and emotional health, and on available resources to support them once they leave inpatient treatment.

Collaborative Care for Clients in Opioid Use Recovery

In both the inpatient and community health settings, collaborative care provides the highest efficacy for clients with OUD. Clinicians work together to plan individualized interventions, treatment plans, and outcomes. For instance, the physician or psychiatrist may suggest the use of medications to assist with sobriety. The social worker will provide a list of resources (outpatient services, short-term recovery services, sober living houses) that the client can review. The nurse provides support and additional education to assist the client in determining the best course of action for their life circumstances. Together, the team takes a **harm reduction** approach, which focuses on meeting the client

where they are and helping to prevent overdose, reducing transmission of infectious diseases (such as HIV), and improving the overall health of the client (SAMHSA, 2022b). Harm reduction supplies and services can be funded by grants and can offer naloxone kits, health-care supplies, vitamin supplements, snacks, educational materials, and public health referrals and services. Using this approach, the team works with the client to set their own goals (SAMHSA, 2022b). The CDC partners with SAMHSA to provide more intensive harm reduction services, such as needle exchange programs and care to vulnerable populations through the National Harm Reduction Technical Assistance Center (NHRTAC).

19.5 Dealing with Addiction

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the approaches used to treat addiction
- Recall the principles used to treat an overdose
- Review management of a client who is in withdrawal
- Plan collaborative care for a client who has an addiction

Substance use disorder treatment is designed to help individuals stop or reduce harmful substance misuse, improve their health and social function, and manage their risk for relapse. For example, mild substance use disorders can be identified quickly in many medical settings and often respond to brief motivational interventions and/or supportive monitoring, referred to as guided self-change. In contrast, severe and chronic substance use disorders often require specialty substance use disorder treatment and continued posttreatment support to achieve full remission and recovery. To address the spectrum of problems associated with substance use disorders, it is necessary to plan and implement a continuum of care based on an individual's needs, including early intervention, treatment, and recovery support services (SAMHSA & Office of the Surgeon General, 2016).

PSYCHOSOCIAL CONSIDERATIONS

Culturally Sensitive Prevention Programs for Substance Use among Adolescents of Color

This systematic review analyzed substance use prevention programs for adolescents of color in the United States. The study found that when culturally sensitive assessment addressed factors specific to certain populations and communities, effectiveness of the prevention efforts was increased.

Adolescents of color are overrepresented in adverse consequence and involvement with the legal system and less likely to receive substance use treatment than White teens. The study found that culturally sensitive substance use prevention programs can address factors that contribute to these disparities.

Delivered in home and in community, culturally sensitive programs can address positive aspects for adolescent psychosocial development such as racial and ethnic identity, problem-solving, and refusal skills. Further, these programs aim to strengthen the family dynamic as a protective strategy and educate on substance use.

(Bo et al., 2023)

Approaches to Treating Addiction

The use of substances has a staggering cost of approximately $442 billion in the United States each year in health care costs, lost productivity, and criminal justice costs (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). Research shows that integration of substance use treatment in primary health-care settings can greatly improve outcomes. Many people in the United States with a substance use disorder also have a mental health disorder, further complicating treatment. Traditionally, health-care providers have separated substance use treatment from other health-care practices (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). This separation appears counter to the similar goals of treating substance use disorder and other chronic health conditions, which are reduce symptoms of the substance use, increase overall health, monitor motivation to change, and manage possible relapse.

The U.S. Department of Health and Human Services, Office of the Surgeon General (2016) suggests that screening

for substance misuse begin in health-care organizations by training health-care teams, including nurses, to recognize the signs and symptoms of substance misuse. Screening should follow with training and the use of therapeutic communication skills to engage the client in brief interventions for mild substance use problems or referral to more intense therapies and use of medications for more severe cases.

LINK TO LEARNING

SAMHSA has developed a short booklet called "Faces of Change. Do I have a Problem with Alcohol or Drugs?" It covers the case studies (https://openstax.org/r/77alcdrugprob) of five people who have problems with either drugs or alcohol.

Steps for Quitting Addiction

As health-care professionals struggle to support their clients who have substance use disorders, Harvard Medical School (2021) suggests a basic five-step process that can be introduced in any office visit. The first step is the client setting a quit date. Step two is the client agreeing to change their environment, removing any triggers to the addiction. This could mean separating oneself from other people who are involved in the object of the addiction, and removing items from their environment (alcohol, wine glasses). Step three is learning to use distraction as a technique when feeling the urge to use. This could be as simple as going outside for a walk or calling a friend. Step four is to review what worked and what did not work in past attempts to quit. The final step is to create a support network of people who can help to encourage them.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment, or MAT, combines the use of medication and behavioral therapy to prevent opioid overdose and treat substance use disorder (Food and Drug Administration [FDA], 2023). This type of treatment takes a holistic approach that has been shown to improve outcomes for people using substances, help people get jobs and work, increase clients staying in treatment, and increase positive outcomes of babies born to women who were using substances while pregnant (FDA, 2023). Depending upon the substance that the client has used, medications may either help block the cravings and good feelings produced by the substance or decrease withdrawal symptoms.

Medications to Combat Drug Use

Medications that have been approved by the FDA for use during MAT include methadone, buprenorphine, and naltrexone (FDA, 2023). Methadone is taken once a day under the supervision of a nurse at a methadone clinic. It comes in tablet, liquid, and wafer forms. It works by blocking the effects of the opioid and reducing cravings. Buprenorphine gives the same euphoric feelings as the opioids without the side effects. It helps to decrease cravings and withdrawal symptoms. Naltrexone blocks the euphoria associated with opioids. If a person relapses while taking naltrexone, they will not get "high." One concern is that when a person discontinues naltrexone and relapses, they will have a lower tolerance to opioids and may overdose if they take the same opioid doses previously taken.

Using Medications for Detoxification

The amount of time it takes for the body to get rid of the substances (**detoxification**) differs based on the substance consumed. Likewise, the medications prescribed to help with detox differ based on the substance consumed. Nurses closely monitor the use of medication during withdrawal/detoxification, including performing withdrawal assessment scales. These scales have symptom items that are scored by the observation of the nurse or provider or through direct questioning of client (Prunty & Prunty, 2016). The data collected on these forms is used to help determine the medication to manage withdrawal symptoms.

Much of the medication that is used is based on the symptoms that the client is experiencing, such as stomach upset, runny nose, headache, diarrhea, anxiety, and increased blood pressure. For example, it is common practice to have orders for acetaminophen (Tylenol) for headache, dyphenhydramine (Benadryl) for runny nose, Maalox for stomach upset, and Imodium for diarrhea. Clonidine (Catapres) is commonly prescribed to reduce the high blood pressure seen during some detoxes. Nursing management is indicated with Catapres, as renal impairment and rapidly dropping blood pressure can result.

UNFOLDING CASE STUDY

Substance Misuse: Part 3

See Substance Misuse: Part 2 for a review of the client data.

Nursing Notes	**1445 Ongoing Assessment** The client is seen in her bedroom, lying on her bed. She appears to be more relaxed. Currently, you repeat her vitals. She reports feeling less anxious. She denies hallucinations and appears oriented, yet still shifts frequently in the bed as you talk with her. She reports that she would like to try to take a nap. **1445 Intervention** You offer her an additional blanket and make sure she has a full water cup at her bedside. You tell her you will return in two hours to repeat her vitals and reassess her withdrawal.
Flow Chart	**1445 Ongoing Assessment** Blood pressure: 145/90 mmHg Heart rate: 100 beats/minute Respiratory rate: 20 breaths/minute Temperature: 99.1°F (37.2°C) Oxygen saturation: 98% on room air Pain 4/10 (head)
Lab Results	No additional laboratory tests results
Diagnostic Tests/ Imaging Results	No additional diagnostic tests
Provider's Orders	CIWA-Ar with protocol Close observation Seizure precautions

5. Based on the current assessment, what actions does the nurse decide to take?
6. How are outcomes of nursing actions evaluated for this client?

Hospital and Residential Treatment

Inpatient treatment for substance use disorder at a hospital typically runs overnight to a few weeks. Some programs are short-term three- to five-day inpatient hospital programs that assist the client in the initial detox while supporting them with medications and milieu therapy. During their stay, a case manager/social worker will assist the client with discharge planning that could include admission to a long-term recovery center (SAMHSA, 2014).

Residential treatment entails a client living at a treatment center for a period of time. This allows the client to live in a supportive environment aimed at helping them to stay sober, learn about substance use disorders and healthier coping mechanisms, receive therapy to help them stay motivated, and get life skills training (SAMHSA, 2014). This time depends upon the facility, insurance coverage, and/or the severity of the person's substance use disorder. This type of treatment may cost the client, so it is important to understand which types of insurances the program takes, if it has a low-cost or free option, and if there are other program alternatives (SAMHSA, 2023a).

Community Treatment

Community treatment takes place through community health centers, mental health facilities, and hospitals. Groups

and educational options are often listed on these facilities' websites or can be obtained by calling them directly. Community treatment gives individuals the option to be supported while continuing to live and work in their communities (SAMHSA, 2014).

An intensive outpatient program (IOP) is a treatment option that involves meeting at a facility for both individual and group therapy, three to five days a week for approximately three hours a day. These types of programs are used to treat depression, dual diagnosis, substance use, and eating disorders (Blanchfield, 2022). IOPs are considered a "step down" type of treatment that helps individuals transition from inpatient care back to their normal lives.

Peer Support Services

Peer support services provide an individual with the option to attend groups at times that are flexible and convenient to them. These groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), The National Alliance on Mental Illness (NAMI), and cultural, religious, or social networks (SAMHSA, 2023a), include face-to-face and virtual options. There are also groups such as Nar-Anon, Al-Anon, and NAMI for families of those with substance use or mental health problems. Veterans can reach out to their local VA to find out more information about self-help groups specifically available to them.

Many apps are available for those with smartphones. These apps offer 24/7 support that is easy to take anywhere you want to go. In times of crisis, individuals or family members can call 988 to talk with a trained crisis counselor.

Recognizing and Treating Overdose

Overdoses happen when people misuse their prescription medications, consume illegal drugs, and relapse after abstinence. Symptoms observed in the person who has taken an overdose depend upon the substance taken (Hartney, 2023). In opioid overdoses, the symptoms include clammy skin, slowed breathing, pinpoint pupils, vomiting, and becoming unconscious. Naloxone aids people who have overdosed on opioids. It works by blocking the effects of opioids and it can reverse the overdose.

In stimulant overdoses, the symptoms include rapid breathing, increased heart rate, convulsions, paranoia, and even coma. Medication can be used for symptom management once the person is taken to the hospital. Benzodiazepines are usually the most used medication for cardiovascular symptoms. Nitroglycerin might be used for the client who complains of chest pain. There is no specific medication for stimulant overdoses comparable to the use of naloxone for opioid overdoses (SAMHSA, 2021a).

Alcohol overdose is a medical emergency that can result in death. A person who overdoses on alcohol should be taken to a hospital, monitored closely, and medicated to prevent further physical decline. One potential danger of alcohol overdose is choking on one's vomit and dying from lack of oxygen because high levels of alcohol intake hinder the gag reflex, resulting in the inability to protect the airway. Asphyxiation can occur due to an obstructed airway or from aspiration of gastric contents into the lungs. For this reason, do not leave a person alone who has passed out due to alcohol misuse. Keep them in a partially upright position or roll them onto one side with an ear toward the ground to prevent choking if they begin vomiting (NIAAA & National Institutes of Health, 2021).

Critical signs and symptoms of an alcohol overdose include mental confusion or stupor, difficulty remaining conscious or inability to wake up, vomiting, seizures, slow respiratory rate (fewer than eight breaths per minute), irregular breathing (ten seconds or more between breaths), slow heart rate, clammy skin, no gag reflex, extremely low body temperature, and bluish skin color or paleness (NIAAA & National Institutes of Health, 2021). If you suspect someone has overdosed on alcohol, seek emergency assistance or call 911. While waiting for help to arrive, be prepared to provide information to the responders, such as the type and amount of alcohol the person drank and any other drugs they ingested, current medications, allergies to medications, and any existing health conditions (NIAAA & National Institutes of Health, 2021).

Overdoses of certain medications, such as Tylenol, require medical intervention, including the use of activated charcoal to leech the medication out of the system. Many people do not realize that Tylenol overdose can result in permanent liver damage.

Issues in Withdrawal Management

Nurses working in medical-surgical hospital settings or emergency departments commonly provide care for clients receiving withdrawal treatment for alcohol, opioids, or other substances. Withdrawal symptoms vary among

substances, length, and frequency of use. Clients frequently underreport alcohol and substance use, so nurses must be aware of signs of withdrawal in clients receiving medical care for other issues and notify the health-care provider (Sellers, n.d.). Withdrawal management, also considered detoxification, is highly effective in preventing immediate and serious medical consequences associated with discontinuing substance use, although alone it is not an effective treatment for any substance use disorder. It is considered **stabilization**, which is assisting a client through a period of acute detoxification and withdrawal so that they are medically stable and substance-free. Stabilization often prepares the individual for treatment. During stabilization, the client has become medically stable and is prepared for the recovery process and treatment plan. It is considered a first step toward recovery, similar to the acute management of a diabetic coma as a first step toward managing the underlying illness of diabetes. Similarly, acute stabilization and withdrawal management work best when followed by evidence-based treatments and recovery services (SAMHSA & Offices of the Surgeon General, 2016).

Unfortunately, many individuals who receive withdrawal management do not become engaged in treatment. Studies have found that, among individuals with substance use disorders who receive withdrawal management services, up to three-quarters of them do not enter treatment (Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General, 2016). The client needs to be ready to make the necessary changes in order to enter into recovery long-term. This is often the most difficult step.

Nurses can use the Motivation to Change Model to assess clients and educate them about the resources available to help them stay sober. This model is a therapeutic process wherein the professional supports positive behavior change. Support includes identifying the client's existing motivation, empowering the client to choose, recognizing that resistance is part of the change process, and matching helping strategies to the client's readiness to change. Stages of readiness include precontemplation, contemplation, preparation, action, and maintenance of the change.

One of the most serious consequences when individuals do not continue care after withdrawal management is overdose. Because withdrawal management reduces acquired tolerance, those who attempt to reuse their former substance in the same amount or frequency may overdose, especially those with opioid use disorders (SAMHSA & Offices of the Surgeon General, 2016).

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Teamwork and Collaboration

One part of working with clients who are withdrawing from substance use is teaching them about relapse prevention. During this interaction, the nurse will:

- treat clients holistically with no judgment toward their substance use
- discuss the danger of using again at the same amount used prior to withdrawal
- encourage the client to share their feelings about withdrawal, working with them to devise a plan if craving is pushing them toward relapse

(QSEN Institute, n.d.)

Alcohol Withdrawal

The prevalence of alcohol use disorder is estimated to be as high as 40 percent among hospitalized U.S. clients. Approximately half of clients with alcohol use disorder experience alcohol withdrawal when they reduce or stop drinking, with as many as 20 percent experiencing serious manifestations, such as hallucinations, seizures, and delirium tremens (Pace, 2022). Severe alcohol withdrawal is considered a medical emergency that is best managed in an intensive care unit.

Symptoms of early or mild alcohol withdrawal include anxiety, minor agitation, restlessness, insomnia, tremor, diaphoresis, palpitations, headache, and alcohol craving. Clients often experience loss of appetite, nausea, vomiting, and diarrhea. Their risk for falls often increases when they try to go unassisted to the bathroom with these gastrointestinal symptoms. Physical signs include sinus tachycardia, systolic hypertension, hyperactive reflexes, and tremor. Without treatment, symptoms of mild alcohol withdrawal generally begin within six to thirty-six hours after the last drink and resolve within one to two days (Pace, 2022).

Some clients develop moderate to severe withdrawal symptoms that can last up to six days. Hallucinations, for example, mostly occur within twelve to forty-eight hours after the last drink. They are typically visual and commonly involve seeing insects or animals in the room, although auditory and tactile phenomena may also occur (Pace, 2022). Moreover, alcohol withdrawal-related seizures can occur within six to forty-eight hours after the last drink. Risk factors for seizures include concurrent withdrawal from benzodiazepines or other sedative-hypnotic drugs (Pace, 2022). Importantly, delirium tremens (DT) is a rapid-onset, fluctuating disturbance of attention and cognition that is sometimes associated with hallucinations. In its most severe manifestation, DTs are accompanied by agitation and signs of extreme autonomic hyperactivity, including fever, severe tachycardia, hypertension, and drenching sweats. DTs typically begin between forty-eight and ninety-six hours after the client's last drink. Mortality rates from withdrawal delirium have been historically as high as 20 percent, but with appropriate medical management, the mortality rate is between 1 and 4 percent. Death is attributed to cardiovascular complications, hyperthermia, aspiration, and severe fluid and electrolyte disorders (Pace, 2022).

Benzodiazepine Withdrawal

Rapid recognition and treatment of benzodiazepine withdrawal is critical because it can be life-threatening. Signs and symptoms of benzodiazepine withdrawal include tremors, anxiety, general malaise, perceptual disturbances, psychosis, seizures, and autonomic instability. Withdrawal is treated with a long-acting benzodiazepine (such as diazepam) and titrated to prevent withdrawal symptoms without causing excessive sedation or respiratory depression. The dose is then tapered gradually over a period of months (SAMHSA, 2022a).

Opioid Withdrawal

Medically supervised opioid withdrawal, also known as detoxification, involves administering medication to reduce the severity of withdrawal symptoms that occur when an opioid-dependent client stops using opioids. Supervised withdrawal alone does not generally result in sustained abstinence from opioids, nor does it address reasons the client became dependent on opioids (Sevarino, 2022). Clients may undergo detoxification for several reasons (Sevarino, 2022):

- Initiating the process to "get clean and stay clean" from opioids. Some clients may follow up with inpatient or outpatient treatment after completing the detoxification process.
- Treating withdrawal symptoms when a client dependent on opioids or heroin becomes hospitalized and lacks access to the misused substance.
- Beginning the first step in treating opioid use disorder and transitioning to medication-assisted treatment like methadone or suboxone treatment.
- Establishing an abstinent state without withdrawal symptoms as required for the client's setting or status (e.g., incarceration, probation, or a drug-free residential program).

Withdrawal symptoms commonly encountered after prolonged use of opioids include runny nose, watering eyes, yawning, extremely high body temperature, muscle pain, nausea/vomiting, and anxiety (Cleveland Clinic, 2022a).

Stimulant Withdrawal

As soon as a person stops using a stimulant, the symptoms of withdrawal begin. These include feeling depressed, having a lack of energy, and feeling lethargic (American Addiction Centers, 2023). While this withdrawal is not typically life-threatening, the depression can cause suicidal ideation.

There are three phases to this withdrawal (American Addiction Centers, 2023). The first is the emotional feelings of sadness, anxiety, and intense craving. During the second phase, the person begins to feel physically and mentally exhausted as well as experience insomnia and depression. The third phase begins about twelve hours after the initial withdrawal symptoms and the person may notice much stronger symptoms and cravings that can last for ninety-six hours to several weeks.

Collaborative Care for a Client with an Addiction

The care of an individual with an addiction is collaborative in nature. It includes the client, family members, treatment team members such as the provider, nurse, social worker, case manager, and addiction/mental health counselors. Individual treatment plans are developed based on the individual needs and concerns of the client.

Summary

19.1 Substance Use Disorders

Chronic substance use disorders significantly impact individuals, families, communities, and society. Misuse of alcohol, drugs, and prescribed medications is estimated to cost the United States more than $400 billion in health-care expenses (SAMHSA & Office of the Surgeon General, 2016), law enforcement and criminal justice costs, lost workplace productivity, and losses from motor vehicle crashes.

Substance use disorders (SUD) occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. People who have an SUD may also have a mental health disorder. Three regions of the brain are the key components in the development and persistence of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex. Prolonged, repeated misuse of substances can produce changes to the brain that can lead to a substance use disorder. Substances that are abused can be both legal and illegal in nature (Substance Abuse and Mental Health Services Administration & Office of the Surgeon General, 2016).

Nurses also struggle with substance use disorders. Many state boards of nursing have programs designed to assist nurses with substance use disorders recover so that they can provide safe care to their clients.

19.2 Alcohol Use Disorder

Alcohol use disorder occurs in all ages, cultures, and socioeconomic groups. Risk factors for developing an alcohol use disorder include the age at which a person starts drinking, genetics, psychological factors, and environmental factors. There are several FDA-approved medications to help treat alcohol use disorders. In addition to medication, examples of behavioral treatments include CBT, DBT, motivational enhancement therapy (MET), and family therapy. Each of these treatments can work individually or in combination to help the client develop the skills they need to decrease/stop drinking, work on goal setting, and build a support system. Mutual support groups include Alcoholics Anonymous and Al-Anon. As part of the standard of care, nurses should assess all clients for alcohol use.

19.3 Stimulant Use Disorders

Stimulants include amphetamine-type substances, cocaine, and crack. Stimulants cause the release of dopamine in the brain and are highly addictive because the flood of dopamine in the brain's reward circuit strongly reinforces drug-taking behaviors. Legal stimulants are most commonly prescribed to mitigate the symptoms of ADHD and include the medications Ritalin and Adderall, among others. Over-the-counter cold/allergy medications containing pseudoephedrine are easily accessible stimulants that are prone to misuse. Illegal stimulants, such as cocaine and methamphetamine, are highly addictive substances that cause a sense of euphoria and increased energy.

Stimulant intoxication causes problematic behavioral or psychological changes, such as euphoria or blunted affect; changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension, or anger; and impaired judgment. It is important for health-care systems to work together to assess and provide treatment to individuals who are experiencing all substance use disorders. Nurses and any health-care professionals who complete client screenings need extensive training.

19.4 Opioid Use Disorder

Even though many opioids are legally prescribed by physicians to address pain, the use of these medications can lead to opioid use disorder. Opioid intoxication causes problematic behavioral or psychological changes, such as initial euphoria followed by apathy, dysphoria, psychomotor retardation or agitation, and impaired judgment. When misused, opioids cause a person to feel relaxed and euphoric or to overdose. Naloxone reverses the effects of an opioid overdose. Outpatient counseling, intensive outpatient treatment, short-term residential treatment, long-term therapeutic communities (sober living), and medication-assisted treatment (MAT) are all recovery methods for OUD. One main nursing goal with respect to detox is to minimize withdrawal symptoms to the point that the client can begin working on discharge planning.

19.5 Dealing with Addiction

The U.S. Department of Health and Human Services, Office of the Surgeon General (2016) suggests that screening

for substance misuse begin in health-care organizations by training health-care teams, including nurses, to recognize the signs and symptoms of substance misuse, and then using therapeutic communication skills to engage the client in brief interventions for mild substance use problems or referral to more intense therapies and use of medications for more severe cases.

There are several medications that can be used to either block cravings or decrease withdrawal symptoms. MAT uses a holistic approach that has been shown to improve outcomes for people with SUD. Treatment settings include inpatient, outpatient, and self-help groups. Unfortunately, many individuals who receive withdrawal management do not become engaged in treatment. Studies have found that half to three-quarters of individuals with substance use disorders who receive withdrawal management services do not enter treatment.

Key Terms

addiction associated with compulsive or uncontrolled use of one or more substances
alcohol intoxication refers to problematic behavioral or psychological changes that develop during or shortly after alcohol ingestion
alcohol use disorder (AUD) chronic medical condition that is categorized by difficulty stopping or controlling alcohol use, and by using alcohol to relieve or avoid withdrawal symptoms, even when it is causing negative social, occupational, or health-related consequences
Alcoholics Anonymous (AA) offers social fellowship and a twelve-step program of action that was formulated based on members' experiences of recovery from severe alcohol use disorders
binge drinking consuming several standard drinks on one occasion in the past thirty days
dependence characterized by the lack of the substance causing physical symptoms
detoxification period of time during which the body rids itself of the substances
drug diversion when medication is redirected from its intended destination for personal use, sale, or distribution to others; includes drug theft, use, or tampering (adulteration or substitution)
euphoric experiencing an intense feeling of happiness
habituation getting used to doing something—such as using a substance—and then not wanting to stop
harm reduction focuses on meeting the client where they are and helping to prevent overdose, reduce transmission of infectious diseases, and improve the overall health of the client
heavy drinking consumption of eight or more drinks per week for women and fifteen or more drinks per week for men or binge drinking on five or more of the previous thirty days
intoxication disturbance in behavior or mental function during or after the consumption of a substance
MDMA synthetic psychoactive drug more commonly known by the names Molly or Ecstasy
mutual aid (support) group recovery supports in which members share their substance use problem and value learning from each other's experiences as they focus on personal-change goals
Narcotics Anonymous provides behavior modification with the support of others with lived experience
overdose biological response of the human body when it has ingested a lethal or toxic amount of a substance
protective factors shield people from developing a substance use disorder or addiction
stabilization assisting a client through a period of acute detoxification and withdrawal so that they are medically stable and substance-free
stimulant type of drug that causes the release of dopamine in the brain and is highly addictive because the flood of dopamine in the brain's reward circuit strongly reinforces drug-taking behaviors
substance psychoactive compound with the potential to cause health and social problems, including substance use disorder
substance use disorder (SUD) repeated use of alcohol and/or drugs that significantly impairs a person's health and results in the inability for them to meet major responsibilities at work, school, or home
tolerance as a person continues to use substances, the neurotransmitters adapt and the person demonstrates a reduced response to the substance and requires more of the substance to feel an effect
withdrawal when the reward control center begins to take over and the person begins to feel physical or emotional upset when they are not using a substance

Assessments

Review Questions

1. What is a description of tolerance that shows a misunderstanding about substance use disorder?
    a. not having any bad side effects from periods of not using a substance
    b. needing to use more of a substance in order to reach a "high"
    c. no longer feeling the same sense of pleasure from the substance
    d. feeling better after using the substance again

2. Nurse Gina is caring for a twenty-three-year-old client who is being admitted to a behavioral health unit for treatment of her substance use disorder. Nurse Gina notes that lab values have not yet populated. When considering the age and gender of this client, what is a priority lab result needed before Nurse Gina can administer any medications?
    a. blood alcohol level (BAL)
    b. complete blood count (CBC)
    c. urine pregnancy test (HCG)
    d. urine drug screen (UDS)

3. A client makes an appointment to see their primary care provider (PCP) for sleep problems. What statement by the client regarding their sleep problems leads the PCP to suspect the client may have an alcohol use disorder?
    a. "Work has been really busy and I am working long hours. I am tired but can't fall asleep."
    b. "The only way I can fall asleep is to have three to four beers before going to bed."
    c. "I have one-year-old twins who are not yet sleeping through the night."
    d. "I work nights and have difficulty sleeping during the day."

4. Alcohol withdrawal can be life-threatening. Nurses caring for a client who is detoxing from alcohol use must be able to identify what signs and symptoms of serious withdrawal?
    a. anxiety
    b. nausea and vomiting
    c. delirium tremens
    d. palpitations

5. A psychiatric-mental health nurse is giving a talk to college students about substance use disorder. Understanding that college students frequently use stimulants to help them study, the nurse makes sure to talk about what commonly prescribed medication?
    a. Benzedrine
    b. Ritalin
    c. MDMA
    d. Vicodin

6. Nurse Jorge is completing an assessment of withdrawal symptoms for one of his clients. This client has been using cocaine for the past six months and is now detoxing. What scale would Nurse Jorge use as part of his assessment?
    a. CIWA
    b. Beck's
    c. COWS
    d. PHQ-9

7. Nurse Tony has just come on shift and has been assigned to a new client diagnosed with opioid overdose. Nurse Tony recognizes the opioid overdose triad by what signs and symptoms?
    a. profuse sweating, dilated pupils, and motor agitation
    b. pinpoint pupils, respiratory depression, and decreased level of consciousness

c. nausea and vomiting, hypertension, and hallucinations
d. dilated pupils, anxiety, and hypertension

8. Lucy is a fifteen-year-old who lives with her mother. She frequently takes care of her eight-year-old brother when their mother is intoxicated on the pain pills she takes for an injury that was the result of a motor vehicle accident. How does Lucy recognize her mother as intoxicated?
   a. She is drowsy and has slurred speech.
   b. She is hyperactive and cannot stop talking.
   c. She is happy and able to go to work.
   d. She has insomnia and eats a lot.

9. Withdrawal management is important in treating substance use disorders. Why is it is considered the first step in recovery?
   a. It provides stabilization.
   b. It provides resources.
   c. It provides increased tolerance.
   d. It provides decreased dependence.

10. A primary care provider's office is seeing more and more clients come to appointments with symptoms that could be attributed to substance use disorder. In order to use evidence-based practice, the office decides to institute a new practice of assessing all clients at each visit. For this to be effective, what is the first step that needs to be put into place?
    a. asking each client if they are using any substances
    b. sending out a letter to each client to let them know of this new policy
    c. training all staff who will be completing client assessments
    d. posting lists of community resources on the waiting room wall

11. Nurses frequently caring for clients who use substances understand that treatment options vary depending upon the substance used. When caring for a client who is actively detoxing, the first step is helping the client get through the withdrawal process safely. Medications can help relieve some of the symptoms of withdrawal. What is the best way for the nurse to determine what medications to administer?
    a. Wait for the doctor's order.
    b. Ask the client what they have used in the past that worked for those symptoms.
    c. Rate the client's symptoms according to CIWA, CINA, or COWS.
    d. Review the client's chart for allergies.

Check Your Understanding Questions

1. What are some symptoms you would expect to see in a client with substance use disorder?
2. Define substance use disorder.
3. Describe the steps you would use to approach treating a client with alcohol use disorder.
4. Describe the symptoms that a person might exhibit if they have stimulant use disorder.
5. Give one example of how a nurse would use harm reduction in providing care to a client in recovery for opioid use.

Reflection Questions

1. As a nurse caring for a client with a substance use disorder, what are some important questions to ask during an initial assessment?
2. What are some important factors to consider when thinking about what may have contributed to a client developing alcohol use disorder?
3. Consider the client's perspective in treatment for substance use disorder. How would these considerations

influence your nursing practice?

4. What would be most challenging for the nurse in care of the client in treatment for addiction? How could these challenges be met?

Critical-Thinking Questions about Case Studies

1. Refer to Substance Misuse: Part 1.
The client identified some personal strengths of her faith, spouse, and child as reasons for living. What is one nursing strategy to assist the client to utilize these strengths now?

2. Refer to Substance Misuse: Part 1.
What do you think the prescriber's rationale was for ordering folic acid and vitamin B12 for this client?

3. Refer to Substance Misuse: Part 1.
Which statement by a client demonstrates an accurate understanding of the nurse's use of the CIWA scale?

    a. "It's to see when I am ready to go home."
    b. "It's to find out if I really drink too much."
    c. "It's so the social worker can decide if this is all my fault."
    d. "It's to know where I am in the withdrawal process."

4. Refer to Substance Misuse: Part 1.
The nurse recognizes the greatest risk related to which of the client's vital signs elevations?

    a. oxygen saturation
    b. blood pressure
    c. temperature
    d. respirations

5. Refer to Substance Misuse: Part 2.
Based on the recognized cues, the nurse determines the client has symptoms that could indicate moderate withdrawal. Designate which condition the cue is associated with.

Cue	ETOH Withdrawal	Anxiety
Anxiety		
Tremors		
Sweating		
Headache		
Restlessness		
Altered vitals		

6. Refer to Substance Misuse: Part 2.
The client is anxious, pacing, and difficult to redirect. From prior learning about nursing interventions for anxiety, what could improve the client's experience?

7. Refer to Substance Misuse: Part 3.
Identify something you learned about nursing evaluation in care of this client.

8. Refer to Substance Misuse: Part 3.
In what ways were you able to integrate learning from this chapter to process this case study?

9. Refer to Substance Misuse: Part 3.
   When assessing a client in alcohol withdrawal, what does the nurse expect to find?

   a. elevated vital signs
   b. cyanosis
   c. bradypnea
   d. drowsiness

Competency-Based Assessments

1. In a scenario where a client denies having a substance use issue but exhibits signs of withdrawal during hospitalization, create a plan for a nurse to approach the situation without compromising trust and therapeutic rapport.
2. As a nurse, you have a role in planning care for a client with substance use disorder. Talk about how a collaborative approach involving the client, health-care team, and community resources can contribute to successful outcomes.
3. A client with alcohol use disorder is resistant to pharmacological interventions. Outline alternative nonpharmacological approaches a nurse can incorporate into the client's care plan.
4. As a nurse, you are working with a client who is at risk for delirium tremens during alcohol withdrawal. Outline the nursing interventions you would take to prevent and manage delirium tremens.
5. A client is admitted with symptoms of stimulant intoxication. Do some research to determine how a nurse can differentiate between the effects of cocaine and amphetamine intoxication during the assessment.
6. You are examining a client who expresses difficulty maintaining abstinence from stimulants. Outline the strategies you would use to support relapse prevention and promote long-term recovery.
7. A client with chronic pain is prescribed opioids but shows signs of misuse. Develop a nursing care plan to address the client's pain while minimizing the risk of opioid use disorder.
8. A client expresses fear and ambivalence about starting medication-assisted treatment (MAT) for opioid use disorder. Develop a nursing approach to address the client's concerns and promote engagement in MAT.
9. You are a nursing student who is working with a client who has been admitted to the emergency room with symptoms of stimulant intoxication. How can you differentiate between the effects of cocaine and amphetamine intoxication during the assessment?
10. A client with a history of opioid addiction is prescribed pain medication for postoperative pain. Develop a nursing plan to address the client's pain while minimizing the risk of relapse and misuse.

References

A.D.A.M. Medical Encyclopedia. (2022, February 18). *Opioid intoxication*. A.D.A.M., Inc.; c1997–2022. https://medlineplus.gov/ency/article/000948.htm

Alcohol and Drug Foundation. (2021, April 22.) *Pharmaceuticals*. https://adf.org.au/reducing-risk/pharmaceuticals/

Alcoholics Anonymous. (n.d.) *The start and growth of A.A.* https://www.aa.org/the-start-and-growth-of-aa

American Addiction Centers. (2021, October 9). *What is psychological dependence?* https://americanaddictioncenters.org/the-addiction-cycle/psychological-dependence

American Addiction Centers. (2023a, March 27). *Stimulant detox, withdrawal symptoms, and addiction treatment*. Drugabuse.com. https://drugabuse.com/stimulants/detox-withdrawal/

American Addiction Centers. (2023b, September 7). *Alcohol use and recovery among the Asian community*. https://alcohol.org/alcoholism-and-race/asian/

American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

Arria, A. M., Bugbee, B. A., Mader, J., Smith, J. M., & Winters, K. C. (2020). Postdischarge outcomes of adolescents attending a long-term addiction treatment program. *Addictive Disorders & Their Treatment, 20*(2), 117–126. https://doi.org/10.1097/ADT.0000000000000227

Blanchfield, R. (2022, August 30). *How an intensive outpatient (IOP) works*. Verywell mind. https://www.verywellmind.com/what-is-an-iop-intensive-outpatient-program-5521766

Bo, A., Goings, T. C., Evans, C. B. R., Sharma, A., Jennings, Z., Durand, B., Bardeen, A., & Murray-Lichtman, A. (2023). Culturally sensitive prevention programs for substance use among adolescents of color: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review, 99*, 102233. https://doi.org/10.1016/j.cpr.2022.102233.

Boehning, A. P., & Haddad, L. M. (2022, July 18). *Nursing Practice Act*. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559012/

Boyer, E. W., & Hernon, C. (2019, December 24). *Methamphetamine: Acute intoxication*. UpToDate. https://www.uptodate.com/contents/methamphetamine-acute-intoxication

Brice, M. (2024). *Dialectical behavior therapy (DBT) for addiction treatment*. American Addiction Centers. https://americanaddictioncenters.org/therapy-treatment/dialectical-behavioral-therapy

Centers for Disease Control and Prevention. (2020, January 31). *Alcohol screening and counseling*. https://www.cdc.gov/vitalsigns/alcohol-screening-counseling/

Centers for Disease Control and Prevention. (2022). *Prescription drug monitoring programs (PDMPs)*. https://www.cdc.gov/opioids/healthcare-professionals/pdmps.html

Centers for Disease Control and Prevention. (2023, August 8). *Understanding the opioid overdose epidemic*. https://www.cdc.gov/opioids/basics/epidemic.html

Chacon, N. C., Walia, N., Allen, A., Sciancalepore, A., Tiong, J., Quick, R., Mada, S., Diaz, M. A., & Rodriguez, I. (2021). Substance use during COVID-19 pandemic: Impact on the underserved communities. *Discoveries (Craiova, Romania), 9*(4), e141. https://doi.org/10.15190/d.2021.20

Cleveland Clinic. (2019, October 11). *Cocaine (Crack) addiction*. https://my.clevelandclinic.org/health/drugs/4038-cocaine-crack

Cleveland Clinic. (2022a, May 27). *Opioids*. Retrieved June 2, 2023, from https://my.clevelandclinic.org/health/articles/21127-opioids

Cleveland Clinic. (2022b, October 4). *Opioid use disorder*. Retrieved June 4, 2023, from https://my.clevelandclinic.org/health/diseases/24257-opioid-use-disorder-oud

Cleveland Clinic. (2023). *Substance use disorders (SUD)*. https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud

Connecticut Poison Control Center. (2024). *Cold medicine abuse*. https://health.uconn.edu/poison-control/about-poisons/medications/cold-medicine-abuse/

Deak, J. D., & Johnson, E. C. (2021). Genetics of substance use disorders: A review. *Psychol Med, 51*(13), 2189–2200. https://doi.org/10.1017/S0033291721000969. Epub 2021 Apr 21. Erratum in: Psychol Med. 2022 Mar 02;:1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8477224/

Department of Justice/Drug Enforcement Administration. (2022). *Drug fact sheet: Amphetamines*. https://www.dea.gov/sites/default/files/2023-02/Amphetamines%202022%20Drug%20Fact%20Sheet_0.pdf

Drug Enforcement Association. (2023, March 6). *Medication-assistance treatment (MAT)*. https://www.getsmartaboutdrugs.gov/medication-assisted-treatment-mat

Eggleston, W., Podolak, C., Sullivan, R. W., Pacelli, L., Keenan, M., and Wojcik, S. (2018). A randomized usability assessment of simulated naloxone administration by community members. *Addiction, 113*(12), 2300–2304. https://doi.org/10.1111/add.14416

Ewing, John A. (1984). Detecting alcoholism: The CAGE questionnaire. *JAMA* 252, 1905–1907.

F., S. (2018, October 23). *From impaired to inspired: One nurse's story of addiction and recovery*. Heroes in Recovery. https://heroesinrecovery.com/stories/from-impaired-to-inspired-one-nurses-story-of-addiction-and-recovery/

Fairman, R. T., Vu, M., Haardorfer, R., Windle, M., & Berg, C. J. (2020). Prescription stimulant use among young adult college students: Who uses, why, and what are the consequences? *Journal of American College Health*, https://doi.org/10.1080/07448481.2019.1706539. https://www.loyola.edu/-/media/department/sswp/documents/info-partnerships/adderall-stimulant-use.ashx?la=en

Hartney, E. (2023, May 25). *Drug overdose signs and treatment*. Verywell mind. https://www.verywellmind.com/what-is-an-overdose-22061

Harvard Medical School. (2021, January 14). *5 action steps for quitting an addiction*. Harvard Medical School. https://www.health.harvard.edu/diseases-and-conditions/five-action-steps-for-quitting-an-addiction

Hoffman, R. (2022). *Management of moderate and severe alcohol withdrawal symptoms*. UpToDate. Retrieved May 5, 2022, from www.uptodate.com https://www.ncsbn.org/SUD_Brochure_2014.pdf

Jahan, A. R., & Burgess, D. M. (2023, April 9). *Substance use disorder*. In StatPearls [Internet]. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK570642/

John Hopkins Medicine. (2023a) *Opioids*. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/opioids

John Hopkins Medicine. (2023b). *Opioid use disorder*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/opioid-use-disorder

Johns Hopkins Medicine. (n.d.). *CAGE substance abuse screening tool*. https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/CAGE%20Substance%20Screening%20Tool.pdf

Kaskutas, L. A., Borkman, T. J., Laudet, A., Ritter, L. A., Witbrodt, J., Subbaraman, M. S., & Bond, J. (2014). Elements that define recovery: The experiential perspective. *Journal of Studies on Alcohol and Drugs, 75*(6), 999–1010. Cited in https://www.ncbi.nlm.nih.gov/books/NBK424846/

LaHood, A. J., & Kok, S. J. *Ethanol toxicity*. [Updated 2023 Jun 21]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK557381/

Mayo Clinic.org. (2022). *Prescription drug abuse - Symptoms and causes*. https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/symptoms-causes/

MDCalc. (n.d.) *CIWA-Ar for alcohol withdrawal*. https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal#why-use

Medline Plus. (2017, November 1). *OPRM1 gene*. https://medlineplus.gov/genetics/gene/oprm1/

Minkove, J. F. (2022). *New research and insights into substance use disorder*. John Hopkins Medicine. https://www.hopkinsmedicine.org/news/articles/new-research-and-insights-into-substance-use-disorder

National Academies Press. (2017). *The current state of evidence and recommendations for research: Cannabis*. https://www.ncbi.nlm.nih.gov/books/NBK425762/

National Center for Health Statistics. (2022, May 11). *U.S. overdose deaths in 2021 increased half as much in 2020 - but are still up 15%* [Press release]. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

National Council of State Boards of Nursing. (2018). *A nurse's guide to substance use disorder in nursing* [Brochure].

National Council of State Boards of Nursing. (n.d.). *Alternative to discipline programs for substance use disorder*. https://www.ncsbn.org/nursing-regulation/discipline/board-proceedings/alternative-to-discipline.page

National Institute of Mental Health. (2023). *Substance use and co-occurring mental disorders*.

https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

National Institute of Neurological Disorders and Stroke. (2023). *Wernicke-Korsakoff syndrome*. https://www.ninds.nih.gov/health-information/disorders/wernicke-korsakoff-syndrome?search-term=wernicke

National Institute on Alcohol Abuse and Alcoholism & National Institutes of Health. (2021, May). *Understanding the dangers of alcohol overdose*. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose

National Institute on Alcohol Abuse and Alcoholism. (2022). *Strategies for prevention and treatment*. Retrieved June 1, 2023, from https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods#pub-toc0

National Institute on Alcohol Abuse and Alcoholism. (2023a, December). *Alcohol's effects on health*. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder

National Institute on Alcohol Abuse and Alcoholism. (2023b). *Alcohol treatment in the United States: Age groups and demographic characteristics*. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-treatment-united-states-age-groups-and-demographic-characteristics

National Institute on Alcohol Abuse and Alcoholism. (2023c). *Understanding alcohol use disorder*. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder

National Institute on Alcohol Abuse and Alcoholism. (2024). *Get the facts about underage drinking*. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/underage-drinking

National Institute on Drug Abuse, & National Institutes of Health. (2019, May). *Methamphetamine drug facts*. https://nida.nih.gov/publications/drugfacts/methamphetamine

National Institute on Drug Abuse, & National Institutes of Health. (2020). *Misuse of prescription drugs research report*. https://nida.nih.gov/publications/research-reports/misuse-prescription-drugs/how-can-prescription-drug-misuse-be-prevented

National Institute on Drug Abuse. (2018, January). *Prescription opioids and heroin research report: Heroin use is rare in prescription drug users*. https://nida.nih.gov/publications/research-reports/prescription-opioids-heroin/heroin-use-rare-in-prescription-drug-users

National Institute on Drug Abuse. (2020a, June). *Misuse of prescription drugs research report*. National Institutes of Health. https://nida.nih.gov/publications/research-reports/misuse-prescription-drugs/what-scope-prescription-drug-misuse

National Institute on Drug Abuse. (2020b, August 20). *Commonly used drug charts*. https://nida.nih.gov/research-topics/commonly-used-drugs-charts#mdma

National Institute on Drug Abuse. (2020c). *Marijuana research report*. https://nida.nih.gov/publications/research-reports/marijuana/letter-director

National Institute on Drug Abuse. (2022, April 1). *Drug use severity in adolescence affects substance use disorder risk in adulthood*. https://nida.nih.gov/news-events/news-releases/2022/04/drug-use-severity-in-adolescence-affects-substance-use-disorder-risk-in-adulthood

Office of the Surgeon General. (2023). *Addiction and substance misuse reports and publications*. https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/index.html

Pace, C. (2022). *Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis*. UpToDate. https://www.uptodate.com/contents/alcohol-withdrawal-epidemiology-clinical-manifestations-course-assessment-and-diagnosis

Partnership to End Addiction. (2023). *Substance use disorder vs. addiction*. https://drugfree.org/article/substance-use-disorder-vs-addiction/

Prunty, L. M., & Prunty, J. J. (2016). Acute opioid withdrawal: Identification and treatment strategies. *U.S.*

Pharmacist, 41(11), HS2-HS6.

QSEN Institute. (n.d.) QSEN competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Rosenbaum, C., & Boyer, E. (2021, January 20). *Dextromethorphan abuse and poisoning: Clinical features and diagnosis*. UpToDate. https://pro.uptodatefree.ir/Show/6488

Schiller, E. Y., Goyal, A., & Mechanic, O. J. (2023). *Opioid overdose*. In StatPearls [Internet]. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK470415/

Sellers, E. M. (n.d.). *CIWA-AR for alcohol withdrawal*. MDCalc. https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal#why-use

Sevarino, K. A. (2022). *Medically supervised opioid withdrawal during treatment for addiction*. UpToDate. https://www.uptodate.com/contents/opioid-withdrawal-medically-supervised-withdrawal-during-treatment-for-opioid-use-disorder

Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016).*Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK424857

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2023). 2022 National Survey on Drug Use and Health. Table 2.25B—Alcohol use in lifetime: among people aged 12 or older; by age group and demographic characteristics, percentages, 2021 and 2022. [cited 2023 Dec 8]. https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabsSect2pe2022.htm#tab2.25b

Substance Abuse and Mental Health Services Administration. (2006). Detoxification and substance abuse treatment. *Treatment Improvement Protocol Series, No. 45*. https://www.ncbi.nlm.nih.gov/books/NBK64114/

Substance Abuse and Mental Health Services Administration. (2014). *What is substance abuse treatment? A booklet for families*. https://store.samhsa.gov/sites/default/files/sma14-4126.pdf

Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Substance Abuse and Mental Health Services Administration. (2021a). Treatment for stimulant use disorders: Updated 2021 [Internet]. *Treatment Improvement Protocol (TIP) Series, No. 33*. https://www.ncbi.nlm.nih.gov/books/NBK576550/

Substance Abuse and Mental Health Services Administration. (2021b). *Evidence-based resource guide series: Implementing community-level policies to prevent alcohol misuse*. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-01-006.pdf

Substance Abuse and Mental Health Services Administration. (2022a, March 2). *Alcohol, tobacco, and other drugs*. U.S. Department of Health & Human Services. https://www.samhsa.gov/find-help/atod

Substance Abuse and Mental Health Services Administration. (2022b, August 16). *Harm reduction*. Retrieved June 6, 2023, from https://www.samhsa.gov/find-help/harm-reduction

Substance Abuse and Mental Health Services Administration. (2022c, December). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Publication* PEP22-07-01-005. https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

Substance Abuse and Mental Health Services Administration. (2022d). *Mental health and substance use disorders*. https://www.samhsa.gov/find-help/disorders

Substance Abuse and Mental Health Services Administration. (2023a, April 24). *Find support*. U.S. Department of Health & Human Services. https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment

Substance Abuse and Mental Health Services Administration. (2023b, September 6). *Learn about methamphetamine*. https://www.samhsa.gov/meth

Texas Peer Assistance Program for Nurses (TPAPN). (n.d.). *About*. https://www.texasnurses.org/mpage/TPAPN-About

Tierney, M. (2017, April 12). *Improving nurses' attitudes towards patients with substance use disorders*. American Nurse. https://www.myamericannurse.com/improving-nurses-attitudes-toward-patients-substance-use-disorders/

U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. HHS. https://www.ncbi.nlm.nih.gov/books/NBK424857/pdf/Bookshelf_NBK424857.pdf

U.S. Drug Enforcement Administration. (2020). *The Controlled Substance Act*. U.S. Department of Justice. https://www.dea.gov/drug-information/csa

U.S. Food and Drug Administration. (2023, May 23). *Information about medication-assisted treatment (MAT)*. https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat

University of Melbourne. (2017, December 27). *Why do people with East Asian heritage get flushed after drinking alcohol?* https://findanexpert.unimelb.edu.au/news/5911-why-do-people-with-east-asian-heritage-get-flushed-after-drinking-alcohol

CHAPTER 20
Eating Disorders

FIGURE 20.1 Neuroimaging can be an important part of a psychological diagnosis. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Eating disorders are a growing concern in nursing because they affect millions of people. It is estimated that approximately 5 percent of the United States population experiences eating disorders with the highest prevalence seen in women ages twelve to thirty-five (American Psychiatric Association [APA], 2023a), though these conditions affect all genders. Eating disorders have high morbidity and mortality rates and are considered serious mental health illnesses (Davis & Attia, 2019). Clients with eating disorders may seek health-care services that require nurses to play an essential role. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*) lists the following under the category of feeding and eating disorders: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant/restrictive food intake disorder (ARFID), pica, and rumination (APA, 2023b).

20.1 Psychological, Social, and Physiological Factors

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss psychological factors associated with eating disorders
- Discuss social factors associated with eating disorders
- Relate physiological, hereditary, and environmental factors to the development of eating disorders
- Determine nursing interventions for identified problems related to eating disorders

According to the American Psychological Association, an **eating disorder** is an illness where there is an abnormal disturbance in attitudes and behaviors related to food (APA, 2023c).

Eating disorders can affect people of all ages and backgrounds though they occur more often during the adolescent period. Eating disorders are complex and involve many psychological and behavioral factors, though these factors may interact differently in different people (National Eating Disorders Association [NEDA], 2023a). Studies are still evaluating the effects psychological, social, physiological, genetic, and environmental factors all have on eating disorders, but the current evidence demonstrates that all of these factors play a role in the development of these disorders (NEDA, 2023a).

Individuals with eating disorders may have certain rituals and habits related to their disorder. These can include things like cutting up food into small pieces, counting pieces of food, hiding food, eating slowly, and taking long breaks (Calugi et al., 2019). Assessing clients for rituals and habits is essential during history taking. Tools like the Self Report Habit Index can be used to help assess habits and behavior (Verplanken & Orbell, 2003).

PSYCHOSOCIAL CONSIDERATIONS

Statistics around Eating Disorders

The National Eating Disorders Association has published statistics on eating disorders (https://openstax.org/r/77eatngdisorder) across all genders and groups, military, students, and athletes, and addresses comorbidities, pregnancy, mental health challenges, and caregiver concerns.

The Center for Women's Health at Oregon Health and Science University (OHSU) (2023) found twice the prevalence among females as among males for eating disorders, while noting that Transgender and nonbinary persons also show an increase in these conditions. There are reports that eating disorders are increasing globally for all people, with an uptick from 3.4 percent to 7.8 percent from 2000 to 2018 (OHSU, 2023).

Psychological Factors

Studies reveal that psychological factors, such as having a history of anxiety disorder, can increase an individual's chance of developing an eating disorder (NEDA, 2023a). Other psychological factors—displeasure with body image and behavioral rigidity, meaning that the person may have habits that are inflexible, compulsive, and resistive to change—have also been associated with eating disorders. The National Eating Disorders Association states that people with eating disorders are more likely to be dissatisfied with their bodies and report inflexible behaviors in childhood (NEDA, 2023a). Personality traits, parenting, and childhood trauma also may contribute psychologically to the development of an eating disorder.

Personality Development

Personality traits can play a key role in the development and progression of eating disorders. For instance, studies have shown that individuals with eating disorders tend to have high levels of perfectionist traits that can cause things like obsession with weight, rigidity around eating, and unusually high expectations (Holland et al., 2013). In fact, perfectionism has been implicated as one of the strongest risk factors associated with eating disorders (NEDA, 2023a).

Family Dynamics and Parenting

Family dynamics and parenting can influence the development of eating disorders. Studies have shown that family dynamics that include conflict, poor communication, and issues with boundaries can impact some disorders

(Zanella & Lee, 2022). Several studies conducted in children also found a connection with parenting styles and eating disorders. Authoritarian (very strict) and permissive (less strict) parenting styles have been shown to have a significant effect on eating patterns leading to behaviors like calorie restriction (Ramsewak et al., 2022). For example, people who grow up in a very permissive household may find it easier to engage in disordered eating behaviors if they are not being monitored as much.

Adverse Events of Childhood

Adverse events that occur in childhood have been discovered as a risk factor for eating disorders. Adverse events include things such as child abuse, neglect, or households where substances are abused (Yoon et al., 2022). Because adverse childhood events can be common in people with eating disorders, screening for adverse childhood events should be a standard part of any plan of care. Screening tools like the ten-item Adverse Childhood Experiences (ACE) Questionnaire can screen for exposure to abuse, neglect, and other household dysfunction that can influence the development of eating disorders (Kovács-Tóth et al., 2022; Kovács-Tóth et al., 2023).

Social Factors

Social factors can impact the development and progression of eating disorders. Being teased or bullied and/or having a limited social network have been linked to the development of eating disorders (NEDA, 2023a). For example, 60 percent of those with eating disorders reported that being teased about weight led to the development of their eating disorder (NEDA, 2023a). Similarly, lack of social supports, which can lead to isolation and loneliness, is also associated with the development of eating disorders (NEDA, 2023a).

Peer Influence

Peer and social factors can have an effect on eating disorders. As children grow and develop, peers become more influential in their lives. Studies have shown that influence from peers can lead to disordered eating patterns such as excessive dieting, fasting, and binge eating (Keel et al., 2013). There are also several social factors associated with a higher risk of developing eating disorders. These include things such as weight stigma, bullying, loneliness, and generational cultural trauma (NEDA, 2023a). Generational cultural trauma starts when one generation endures a distressing event and then the effects of that trauma pass to the next generation.

Societal pressure to achieve an "ideal body" can also influence behaviors seen with eating disorders, such as excessive dieting and exercising. Social media and television can increase a person's risk for developing an eating disorder and can lead to stress and issues with body image (NEDA, 2023a).

Physiological, Hereditary, and Environmental Factors

Eating disorders are complex and involve the interplay of several factors. Physiological, hereditary, and environmental factors can increase the risk for developing eating disorders (Treasure et al., 2022). Interventions to promote healthy eating and exercise habits in clients with risk factors associated with eating disorders may be beneficial as a preventative strategy (Treasure et al., 2022). One good example of a healthy eating initiative is the U.S. Department of Agriculture's MyPlate, which provides information on balancing each meal with healthy options from each food group (U.S. Department of Agriculture [USDA], 2023).

LINK TO LEARNING

The USDA offers tips and resources to help people learn how to eat healthy (https://openstax.org/r/77healthyeating) in its MyPlate campaign. Users can personalize it to create a healthy eating plan.

Biological and Genetic Factors

There are several biological factors that can increase the risk of developing eating disorders. For example, the hypothalamus regulates appetite in the brain, and contributes to neurotransmitter function, specifically involving serotonin and norepinephrine. Neurotransmitter dysfunction may contribute to eating disorders (Riva, 2016). Studies also have found that growth spurts, illness, athletic training, and having type 1 diabetes can lead to the development of eating disorders (NEDA, 2023a). These conditions/situations often require that clients check their weight frequently, focus on food labels and content, and report on weight at doctor's visits, which shines a light on weight and body that increases the frequency of eating disorders.

Another risk factor associated with eating disorders is **heritability**, defined as how much genes influence differences in traits. Twin studies have found heritability as high as 58 percent in anorexia nervosa, 57 percent in binge eating disorder, and as high as 83 percent in bulimia nervosa (Thornton et al., 2011). Family studies have shown an increase in the lifetime risk of developing some eating disorders if there is a first-degree relative with the disorder (Thornton et al., 2011). Having a first-degree relative with a mental health condition, such as anxiety, depression, or addiction, can also increase an individual's chances of developing an eating disorder (NEDA, 2023a). Because genetic factors can influence eating disorders, it is important to obtain a thorough family history during nursing assessment.

Environmental Factors

Environment can play a role in the development of eating disorders, particularly exposure to media. Studies in adolescents have revealed a correlation between an increase in technology use like social media, the internet, TV, and video games with an increase in eating disorders (Mora et al., 2022). Other environmental factors, such as experiencing stress, have also been shown to influence eating disorders. In twin studies, stress experienced by one twin has been proven to be highly influential in that twin developing an eating disorder (Steiger & Booij, 2020). There have also been studies conducted on the prenatal environment related to eating disorders. These studies found that exposure to things like natural disasters experienced by mothers during the third trimester showed an increase of children who later exhibited symptoms for eating disorders due to maternal stress (Steiger & Booij, 2020). Assessing prenatal history and environmental factors like technology use are essential when caring for clients at risk of developing eating disorders.

Nursing Implications

Nurses are essential members of the health-care team who will assess clients with eating disorders. Positive experiences with nurses have been associated with improved outcomes in clients treated for eating disorders, so it is important to build a therapeutic relationship (Zugai et al., 2013). When performing their assessments, nurses should be aware of risk factors associated with eating disorders. An example would be inquiring about family history of an eating or mental health disorder or screening for adverse childhood events. It is also important for nurses to inquire about things like internet and social media usage.

Nursing Assessment

Nursing assessments should be holistic and not only focus on caring for physical needs but on the whole person. Assessing clients' psychological, emotional, and social needs is essential to the management of eating disorders (Corral-Liria et al., 2022). Clients with eating disorders may have experienced trauma or have poor family dynamics that may be revealed during a nursing assessment. Clients with eating disorders may also have other underlying mental health disorders like depression and anxiety, so it is important to identify any mental health symptoms. Nurses should assess psychological factors like perfectionism, body image dissatisfaction, and inflexible behaviors. Examples that may be revealed during an assessment include:

- having unrealistic expectations for themselves
- reporting high levels of dissatisfaction with their body
- feeling like there is only one right way to do things

Nurses should also assess emotional factors and history of anxiety disorders. Common anxiety disorders associated with eating disorders are:

- generalized anxiety disorder
- social phobia
- obsessive-compulsive disorder

Nurses should also be sure to assess social factors that can influence eating disorders, such as bullying, social isolation, and history of generational trauma.

Collaborative Care

Caring for clients with eating disorders requires a collaborative approach. There are several disciplines that will be involved in care, including nurses, dietitians, social workers, and other specialists like psychiatrists. Some clients with eating disorders will require medications to manage their mental health comorbidities. Medications used may

include antidepressants, antipsychotics, anti-nausea medications, antianxiety medications, and stimulants (Himmerich et al., 2021). Some medications like benzodiazepines and lisdexamfetamine are controlled substances that require special care to ensure safety and prevent misuse. Nurses who administer controlled medications to clients will need to ensure that they follow agency-specific protocols, which can include keeping the medication in a locked area.

Nursing Process and Plan of Care

Caring for clients with eating disorders requires nurses to use clinical reasoning to competently work with clients and involve them in their plan of care. Consider this example of using clinical reasoning when caring for clients with eating disorders:

- Recognizing cues: Nurses should be able to recognize cues that may indicate the need for immediate medical attention. Nurses can obtain helpful data from multiple sources to help assess clients with eating disorders. An example would be getting a history of the clients' disordered eating and collecting height and weight measurements that reveal abnormalities. It could also include collecting vital signs that may reveal abnormalities, like hypotension, in clients who are severely malnourished.
- Analyzing cues: If a nurse sees a cue that is concerning, they need to be able to determine what requires further evaluation. This process involves connecting cues with possible concerns. For example, they could correlate inadequate nutrition with the low body weight obtained during admission. It could also include relating findings like inadequate cardiac output as evidenced by low blood pressure that can occur with malnourishment.
- Prioritizing hypotheses: After analyzing cues, the nurse can determine which cues need to be addressed first or immediately. For example, if a client is severely malnourished and has a very low blood pressure, addressing the low blood pressure would be a priority.
- Generating solutions: Once the nurse determines the priority, they can begin to plan interventions needed to manage the client. Examples of actions that could be taken for a severely malnourished client with a low blood pressure are administering fluids that may be ordered for blood pressure or nutritional supplements to address the low body weight.
- Taking action: The nurse can take action by implementing interventions or contacting providers who are needed for orders to address the clients' health concerns. For example, if there is no order for fluids or medications to address the low blood pressure, the nurse could contact the attending provider.
- Evaluating outcomes: After implementing interventions or actions, the nurse can determine if the actions helped the situation and if they achieved the intended outcome. For example, if the intended outcome of giving fluids was to increase the client's blood pressure, the nurse would assess the client's blood pressure and document the findings. The nurse collaborates with the client and the health-care team throughout the process.

LINK TO LEARNING

This video demonstrates a nursing simulation experience (https://openstax.org/r/77eatdisvideo) on a client with an eating disorder.

20.2 Anorexia Nervosa

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- List risk factors associated with and etiology of anorexia nervosa
- Plan nursing care for clients in treatment for anorexia nervosa
- Discuss nursing implications for the therapeutic relationship and milieu management in care of clients diagnosed with anorexia nervosa

The self-induced restriction of food, due to fear of weight gain, that results in weight lowering to below the normal parameters for age and height is called **anorexia nervosa** (APA, 2023a). The disorder is characterized by extreme restriction of food intake below the daily requirements causing very low body weight. In adults, this typically

presents with a **body mass index (BMI)**, a value that is calculated from an individual's height and weight (Figure 20.2), under 18.5 (APA, 2023a). In children, this would present as notable deficits in height and weight compared with children in their age group with a BMI under the fifth percentile (Costandache et al., 2023). The height and weight with the lowest risk for mortality is called **ideal body weight**. It has been used as a method of risk assessment by dietitians and researchers, calculated using height-weight tables (Chichester et al., 2021). Though widely used in sports and health statistics, some variances, such as body measurements and musculature, may require further exploration, according to Chichester et al. (2021).

BMI parameters may not apply to athletes, body builders, or people who exercise a lot because a BMI may be higher in athletes due to their increased muscle mass. Also, BMI measurements are based on anthropometric measurements of White people. Body fat distribution differs by race and ethnicity, such as among Hispanic, Black, East Asian, and South Asian populations. Furthermore, the American Medical Association indicates that BMI should not be used as a sole determinant of health and risk. Rather, it should be used in conjunction with measurements of body adiposity index, relative fat mass, waist circumference, and visceral fat, as well as considerations of body composition, genetic factors, metabolic factors, and other measures (American Medical Association, 2023).

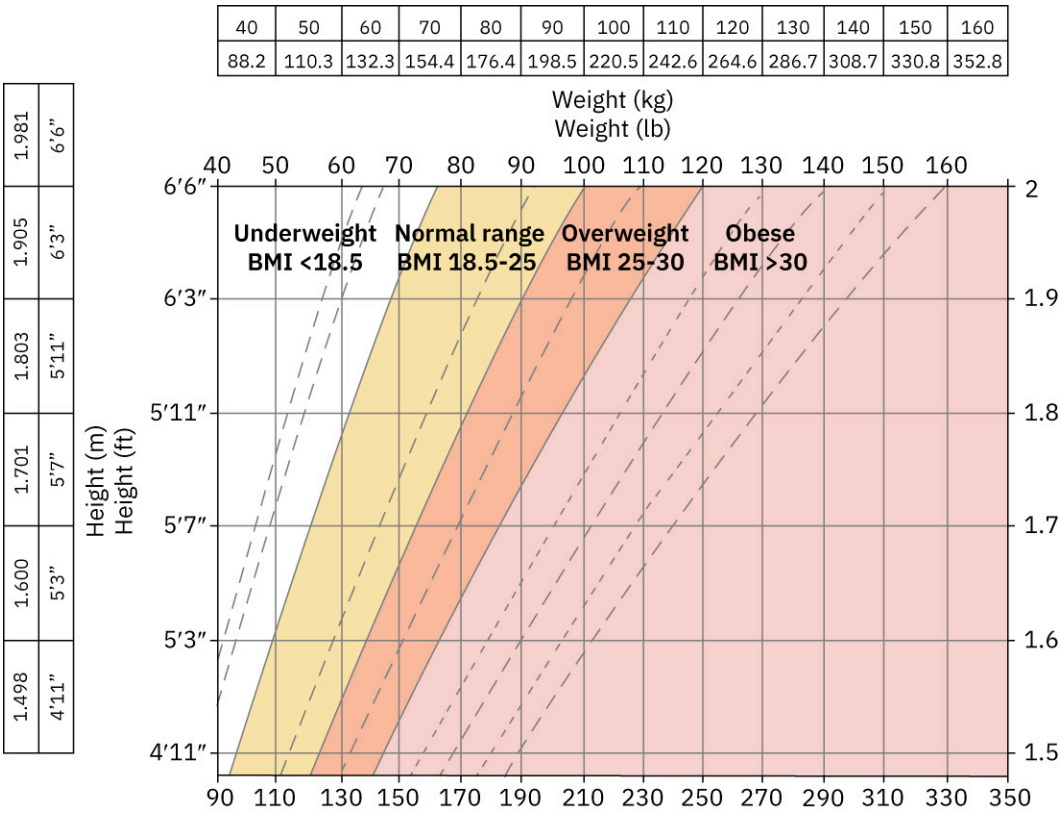


FIGURE 20.2 Body mass index is a ratio of height to weight that can be used as one piece of data to determine healthy body weight. (credit: modification of work from Psychology 2e; attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Anorexia is divided into two categories: **restricting type anorexia**, where weight loss is achieved by dieting, fasting, or extreme exercise; or **binge eating/purging type anorexia**, where binge eating is followed by purging through self-induced vomiting or misuse of laxitives, diuretics, or enemas to achieve weight loss. To distinguish the binge eating/purging seen with anorexia from bulimia, there must be low body weight where the BMI is <18 (Jain & Yilanli, 2023).

Clients with anorexia have an extreme fear of gaining weight and have disruptive issues with their body image that may be caused by **cognitive distortions**, or negatively biased errors in thinking patterns (Rnic et al., 2016). A type of distortion seen with eating disorders like anorexia is called **thought-shape fusion**, where there are altered beliefs about food, weight, and shape (Wyssen et al., 2017). For example, people with anorexia may change their estimates of how much they weigh or how big they are just because they thought about a particular food.

Clients with anorexia may present with symptoms affecting several body systems. For example, a common symptom

seen with clients with anorexia is the presence of soft, fine hair that typically covers the face and back of newborns called **lanugo**. It can be found on the skin of clients with anorexia and is caused by the body's attempt to conserve heat during starvation (Mehler & Brown, 2015). Other symptoms associated with anorexia can be found in Table 20.1.

Body System	Symptom(s)
Integumentary	Lanugo, hair loss, dry skin, pruritus
Neurological	Mood changes like irritability
HEENT	Abnormal closure of the eyelids
Gastrointestinal	Constipation, bloating, pancreatitis, hepatitis dysphagia, delayed gastric emptying
Cardiac	Edema, bradycardia, cool peripheries, hypotension, mitral valve prolapse, arrhythmias
Pulmonary	Pneumonia, respiratory failure, emphysema, spontaneous pneumothorax
Hematologic/ Electrolyte	Pancytopenia, hypokalemia, hyponatremia
Musculoskeletal	Osteopenia/osteoporosis
Endocrine	Infertility, amenorrhea, growth delays, delayed puberty, thyroid dysfunction, hypoglycemia, increased cortisol levels, neurogenic diabetes insipidus

TABLE 20.1 Symptoms Associated with Anorexia (Mehler & Brown, 2015; Kit Tan et al., 2022)

Risk Factors for Anorexia Nervosa

Anorexia nervosa most commonly affects persons AFAB aged thirteen to twenty-five and has a prevalence of approximately 0.5 to 1 percent (Sim et al., 2010). The etiology of anorexia nervosa involves the complex interplay of psychological, environmental, and genetic factors that are often precipitated by stressful life events during adolescence or early adulthood (APA, 2023b). Having personality traits like perfectionism or being obsessive-compulsive is associated with the development of anorexia nervosa and can increase the risk for developing the eating disorder.

CULTURAL CONTEXT

Anorexia Nervosa in Persons Assigned Male at Birth

Eating disorders are one of the most gendered mental health disorders, so eating disorders in persons assigned male at birth (AMAB) were not recognized until recently (Gorrell & Murray, 2019). Anorexia nervosa has a lifetime prevalence in persons AMAB of 0.1 to 0.3 percent in community-based samples, but though anorexia is more commonly seen in persons assigned female at birth (AFAB) populations, it still affects persons AMAB populations (Gorrell & Murray, 2019). Physiological differences in persons AMAB can affect the way that they present with anorexia nervosa. For example, persons AMAB typically have less body fat with higher lean muscle mass, so protein breakdown can occur more quickly in persons AMAB who have less weight loss, resulting in ketosis (Mehler & Brown, 2015).

Persons AMAB can also present with findings like small testes, decreased sexual drive, and declines in testosterone levels that may differ from common findings seen in persons AFAB. It is important to consider these factors when caring for clients with eating disorders to ensure provision of inclusive care.

Genetics and Physiological Factors

Anorexia nervosa is a complex eating disorder that involves several factors. Genetic factors, such as having a first-degree relative with anorexia nervosa and/or having a first-degree relative with a mental health disorder, have been found to be risk factors. Twin studies have also shown an increased risk of developing anorexia nervosa (APA, 2023b). Paolacci et al. (2020) found a strong genetic component for anorexia nervosa due to gene sharing. Therefore, monozygotic twins who may share 100 percent of genetic material have a higher likelihood of developing anorexia than dizygotic twins.

Social Factors

There are several social factors associated with anorexia nervosa. Societal emphasis on being thin can place unreasonable standards related to body image that can lead to disordered eating. What is portrayed in the media plays an essential role in establishing beauty standards that promote thin bodies. This has been found to be a factor in body dissatisfaction that can lead to anorexia (Aparicio-Martinez et al., 2019).

Negative beliefs about eating disorders can even occur with health-care providers like nurses. Body shaming can be detrimental to people with eating disorders, leading to challenges such as poor treatment compliance and low self-esteem (Brelet et al., 2021).

A history of trauma has also been associated with the development of anorexia. The incidence of post-traumatic stress disorder in individuals with anorexia is estimated to be between 10 percent and 47 percent, indicating that traumatic experiences can be common with anorexia (Sjögren et al., 2023).

Mental Health Comorbidities

Clients with anorexia nervosa often have other comorbid mental health conditions. The *DSM-5* lists several common conditions seen with anorexia nervosa that include bipolar disorder, depression, anxiety, obsessive-compulsive disorder, alcohol use disorder, and substance use disorder (APA, 2013b). Anxiety and obsessive disorders are also risk factors that increase the risk for developing anorexia nervosa in the first place (APA, 2013b).

Nursing Care Planning

Nurses can encounter clients with anorexia in various treatment settings, including psychiatric units for stabilization, or in the community. Nurse care planning for anorexia should focus on restoring body weight, replacing needed nutrition/electrolytes, and treating any underlying mental health issues to help establish a healthy relationship with food.

CLINICAL JUDGMENT MEASUREMENT MODEL

Clinical Judgment Measurement Model Sample Care Plan for a Client with Anorexia Nervosa

This sample care plan uses the steps of the CJMM.

CJMM Step	Notes
Assessment	• BMI=17.5 • Excessive weight loss • Amenorrhea • Lanugo • Hypokalemia
Priority problem	• Imbalanced nutrition
Outcomes	• Client will increase BMI to ≥18.5 • Client will verbalize understanding of daily recommended calorie goal

CJMM Step	Notes
Interventions	• Daily weights • Dietitian consult • Ensure replacements between meals
Rationale	• To ensure adequate weight gain • To assist with daily caloric needs and healthy eating habits/choices • To help increase weight and restore nutrients
Evaluation	• Client's BMI increased to 19 during admission

Nurses should be aware that anorexia nervosa can have life-threatening complications and has a high mortality rate. Estimates show that 10 percent of people with anorexia nervosa die within ten years of its onset (Rikani et al., 2013). Starvation and suicide are the two leading causes of death in people with anorexia nervosa (National Institute of Mental Health [NIMH], 2023). Starvation can cause severe electrolyte imbalances in addition to dehydration, renal dysfunction, and cardiac issues. Suicide is the second leading cause of death in anorexia nervosa clients, so it is important to screen people with anorexia for suicidal thoughts (NIMH, 2023). Nurses can use tools like the nineteen-item Beck Scale for Suicide Ideation (BSI) to screen for suicide risk and measure the severity of their ideations and/or plan (Andreotti et al., 2020). Nurses can also provide clients with crisis information that includes the 988 and 911 emergency numbers.

Assessments

Early detection of anorexia nervosa is essential and screening tools can be helpful in identifying clients with this eating disorder. Two common tools are the Sick Control One Fat and Food (SCOFF) questionnaire and the Eating Disorder Diagnostic Scale (EDDS). The SCOFF is a five-item questionnaire used to screen for eating disorders and has been proven to be effective in screening for anorexia nervosa (Kutz et al., 2020). It contains questions related to beliefs about weight and overeating that can be helpful in assessing clients with anorexia. The EDDS is a twenty-two-item self-report questionnaire that contains specific questions, using criteria from the *DSM-5* to assess symptoms of eating disorders, including anorexia nervosa. It has also been proven to be effective in evaluating anorexia nervosa clients (Schaefer et al., 2019).

Interventions

Sometimes referred to as weight restoration, **refeeding** is the starting of oral intake for clients with anorexia. Enteral or parenteral nutrition are not the first efforts unless the client is seriously ill or cannot tolerate oral intake. Refeeding is accomplished with slow, measured meals, snacks, and fluids with careful monitoring and ongoing emotional support. Clients may be physically uncomfortable consuming food during nutritional rehabilitation. Hospitalization is necessary if medical monitoring is required. Clients who are malnourished are also at risk for **refeeding syndrome** where rapid changes in their fluid volume and electrolytes cause complications like cardiac arrhythmias, delirium, coma, and even death (Sim et al., 2010).

Psychological treatment can be effective in treating clients with anorexia nervosa. Specialist Supportive Clinical Management (SSCM) and The Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) are commonly used as modalities (Costandache et al., 2023). SSCM is a treatment approach that involves both clinical management along with supportive individual psychotherapy. MANTRA is a treatment approach where people with anorexia can be supported by a therapist and other people with anorexia in a group setting.

Family-based therapies are considered first-line for children and adolescents with anorexia where the family takes an active role to support the client's recovery (Sim et al., 2010). CBT has also been shown to be an effective approach that involves exploring cognitive processes that influence behaviors.

Pharmacology

There are no FDA-approved medical treatments for anorexia nervosa. Medications used in anorexia nervosa help to manage symptoms and other comorbidities. For example, SSRIs, like fluoxetine, can assist clients with anorexia

nervosa to manage underlying anxiety or depression. Antipsychotic medications like olanzapine may be used to promote weight gain and help manage obsessional thinking (Davis & Attia, 2017). Medications like laxitives can be used to manage symptoms of constipation, and potassium supplements can be used in clients with hypokalemia. Because clients with anorexia can have decreased bone density due to malnutrition, medications like alendronate can improve bone health (Davis & Attia, 2017). There is also promising research on using synthetic cannabinoid agonists like dronabinol to manage symptoms like nausea, vomiting, and decreased appetite (Davis & Attia, 2017).

Client's Self-Help

The use of online, guided self-help interventions has been studied with anorexia nervosa and has been found to be a feasible way to help clients with the disorder (Cardi et al., 2020). There are a variety of online options available, but all online tools are not created equally, so it's important to review sites to ensure that they are a good fit for the client. Evidence supports that personal guidance from an expert, such as a nurse, can help clients find the best self-help resources and increase compliance with interventions (Rohrbach et al., 2022). This may also be a way to reach out to those who are suffering with anorexia nervosa but may be reluctant to seek care. The National Eating Disorders Association provides information on eating disorders, including treatment options, support opportunities, and screening tools to assess risk (NEDA, 2023a).

Nursing Implications

Nurses play a vital role in managing clients with anorexia nervosa. Clients who are severely malnourished are at risk for fatal complications that the nurse must quickly assess. Nurses in the outpatient setting can help screen and assess clients for eating disorders and determine if they need additional evaluation or interventions. The American Psychological Association provides an interactive screening/assessment tool for eating disorders that can be used in clinical decision making (APA, 2023a). Nurses caring for clients in the treatment setting will closely monitor for things like refeeding syndrome, cardiac arrhythmias, and other complications that can occur in clients with anorexia nervosa. Suicide risk is also high in clients with anorexia, so nurses must be sure to assess for suicidal ideations.

LINK TO LEARNING

The American Psychiatric Association provides clinical practice guidelines, screening tools, and a toolkit (https://openstax.org/r/77APAeating) that can be used to assess eating disorders.

Therapeutic Relationship

Establishing a therapeutic relationship with clients with anorexia nervosa is essential to help facilitate their recovery and provide support. The nurse must establish an alliance with the client to confront the disease process. Lev Ari et al. (2024) and Hartley et al. (2022) acknowledged the therapeutic relationship is key to the best outcomes in mental health care. Nurses can establish a therapeutic relationship by establishing rapport with the client, being nonjudgmental, and ensuring that they are competently implementing interventions to help improve the clients' health status and provide client-centered care.

Nurses' reactions can affect therapeutic relationships with clients who suffer from eating disorders like anorexia. It may be difficult and even frustrating for nurses to care for complex clients with anorexia who engage in self-starvation that can lead to fatal complications. It is important for nurses to provide nonjudgmental care and to adequately assess each client's mental health status. An example of providing nonjudgmental care can be when a client with anorexia who appears emaciated talks about the desire to lose more weight. Instead of telling the client that they do not need to lose weight, nurses can encourage them to talk about their feelings related to their weight. An essential part of recovery from anorexia is receiving support that includes managing comorbid mental health conditions like anxiety and depression along with body image issues. It is important for nurses to remember that anorexia nervosa involves an abnormal disturbance in attitudes and behaviors related to food so these clients will need support to help reorder their thought processes and behaviors to healthy patterns.

Nurse Mentoring

Finding support from colleagues through nurse mentorship has been proven to be effective in increasing nurse competence in managing clients with complex health conditions (Hookmani et al., 2021). Nurses with experience managing clients with eating disorders can offer knowledge and demonstrate skills to other nurses who may have

less experience to help increase their competence. For example, preceptors can provide their clinical experience on how to manage clients with eating disorders. Nurse educators who teach about eating disorders can mentor nurses working with these clients and provide current and relevant information.

Milieu Management

The American Nurses Association's essential standards for psychiatric nursing includes the responsibility of nurses to maintain a therapeutic milieu for clients to help aid in their recovery (Belsiyal et al., 2022). Milieu therapy involves clients practicing everyday activities like eating, in a structured environment that is facilitated by the nurse. Providing a safe, structured, healing environment can be beneficial for clients with anorexia who may need to implement behavioral changes to help restore their health.

Safe Environment

Treatment of eating disorders can require different levels of care ranging from community treatment, day programs, residential facilities, or hospitalization (Peckmezian & Paxton, 2020). Clients with severe complications from anorexia nervosa may require hospital care. They may deprive themselves of food and nutrients and engage in purging that can lead to severe malnutrition and starvation that can be fatal. These clients are also at high risk for suicide, so it is important to help maintain a safe environment, both in a treatment setting, and, in the community (NIMH, 2023). Clients should be screened for suicide risk, followed by the implementation of interventions to ensure safety, such as removing harmful objects that can be used for self-harm, providing one-on-one care for clients at high risk, and having clients at high risk monitored carefully. Behaviors that need to be watched for in suicidal clients include self-injurious behaviors, like cutting, reporting suicidal thoughts, and attempting suicide (Mereu et al., 2022). At discharge, it is important that clients are provided with resources to help them if they have suicidal thoughts. Transitional and residential treatment options are also available to manage clients who are at risk for self-harm.

Delegation

Caring for clients with anorexia requires teamwork. Delegation of tasks by nurses is essential to providing quality care and can help decrease the workload. Tasks like obtaining weight and vital signs can be delegated to assistive personnel. This can allow more time for the nurse to focus on tasks like medication administration and care planning. Nurses can also coach assistive personnel on providing nonjudgmental care by showing compassion.

20.3 Avoidant/Restrictive Food Intake Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Differentiate between anorexia nervosa and avoidant/restrictive food intake disorder
- Plan nursing care for clients in treatment for avoidant/restrictive food intake disorder

Formery known as *feeding disorder of infancy and childhood*, **avoidant/restrictive food intake disorder (ARFID)** is a newer eating disorder characterized as a disturbance with eating or feeding where nutritional or energy needs are continuously not met (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016) and may be present into adulthood. The *DSM-5* provides three ways that clients present with ARFID: sensory sensitivity, low appetite/interest in foods, or avoidance due to trauma (Thomas et al., 2017). Clients with sensory sensitivity may avoid certain foods like meats and fruits due to texture while clients with low appetite or interest may restrict food due to not feeling hungry or interested in the foods. Clients who have experienced trauma with eating may avoid specific food(s) that caused the problem.

It is important to note that ARFID is more than being a picky eater. It is characterized by restriction of food that can lead to issues with growth and development along with significant deficiencies that can affect the client's health (Thomas et al., 2017). ARFID can lead to a complication like a **nutritional deficiency** where there is a reduction in essential nutrients needed to maintain adequate bodily functions. Common nutrient deficiencies seen in ARFID include zinc, potassium, iron, and vitamins C, K, and multiple B vitamins (Białek-Dratwa et al., 2022). In some cases, clients with ARFID may require artificial nutrition to meet their nutritional needs. Clients with ARFID can present with symptoms that include significant weight loss, abdominal pain, and other gastrointestinal issues (NIMH, 2023).

Comparison with Anorexia Nervosa

ARFID and anorexia are eating disorders that have similarities and differences. They both involve restriction of food that can lead to unmet nutritional or energy needs of the body and are characterized by low body weight. Both ARFID and anorexia can cause vitamin deficiencies that can become severe and require medical intervention. On the other hand, anorexia typically affects adolescents and young adults, and while ARFID can occur during these times, it is also seen in infancy and early childhood. Anorexia also includes issues with body image. ARFID does not involve disturbances with body image and typically involves sensory sensitivity, low appetite/interest in food, and/or avoidance due to food-related experiences. In other words, the psychological drivers of the behaviors differ between the two eating disorders.

Psychological Drivers of Behaviors

Though the etiology of ARFID is unknown, the disrupted eating behaviors seen with ARFID can have psychological influences (Brigham et al., 2018). Mental health disorders such as anxiety, autism spectrum disorder, obsessive-compulsive disorders, and attention-deficit disorder have been found to increase the risk for behaviors associated with ARFID (APA, 2023b). For example, if a client has anxiety and has a bad experience with a food (i.e., a stressful event that took place while eating a certain food), they may worry about and avoid eating that particular food again. Another example is with individuals with autism spectrum disorders. They may have sensory sensitivity issues and strict behaviors related to eating (APA, 2023b). If these behaviors become extreme, they can lead to the disordered eating seen in ARFID.

The avoidance of food seen in ARFID may be due to a history of trauma related to food. Individuals who have had negative experiences with food like vomiting or choking may ultimately avoid or restrict food (APA, 2023b). They may avoid the food or foods that caused the negative experience and even avoid other foods that are similar (Brigham et al., 2018).

Nursing Care

Nurses play an important role in caring for clients with ARFID, including obtaining a thorough history from clients who present with symptoms of ARFID. Questions related to eating habits, food aversions, and history of traumatic experiences related to food should take place along with an assessment of nutritional status. Severe cases of malnutrition may include lanugo, also seen with anorexia nervosa. Other symptoms can include bradycardia, hypothermia, pallor, orthostatic tachycardia, and hypotension, which require prompt medical attention (Brigham et al., 2018). In addition to developing and nurturing the therapeutic relationship, nursing care may include managing severe symptoms along with nutritional replacements to reverse vitamin deficiencies.

Age-Specific Treatment

Treatment for ARFID varies based on the age of the client being treated and should be age appropriate. Young children with nutritional deficiencies are often treated with oral formula supplements, tube feedings, and intensive behavior therapies (Thomas et al., 2017). Though there are no FDA-approved medications for ARFID, off-label use of medications has shown efficacy in infants and young children with ARFID. Studies in children ages seven months to six years old have revealed benefits from medications like cyproheptadine to increase appetite (Brigham et al., 2018). Other medications, such as mirtazapine and olanzapine, have also been used to promote weight gain in children. Children also benefit from cognitive behavioral therapies and behavioral interventions to help stabilize their weight (Thomas et al., 2017).

Collaborative Care and Partnership with Family

A collaborative approach works best for clients with ARFID. Nurses will work with other key members of the health-care team, including dietitians, therapists, clinicians, and behavioral specialists. The collaborative team will work together with the client and/or their family to restore health.

Partnering with families to treat individuals with ARFID is important because ARFID can disrupt family interactions. Partnering with the client's families in care planning and decision making, called **family-based care**, is a treatment approach that can be effective. With ARFID, the parents typically take control of their child's eating and work with a therapist to help decrease disrupted eating behaviors and restore healthy weight. Family-based therapies have been effective with eating disorders, including ARFID (Białek-Dratwa et al., 2022).

Behavioral Therapies

Behavioral therapies can be effective in managing ARFID. Food chaining is a behavioral feeding method that aims to broaden a client's food selections by introducing safe foods that are similar to avoided foods (Białek-Dratwa et al., 2022). Young children may also benefit from play therapy to help introduce new foods. Play therapy has been found to help reduce anxiety and help prepare the child for the food that will be eaten (Białek-Dratwa et al., 2022). The Feeling and Body Investigators is another behavioral therapy that is used with ARFID. This modality involves exposure therapy that focuses on reframing negative body sensations (Białek-Dratwa et al., 2022).

Cognitive Behavioral Therapy

CBT is an effective modality for treating individuals with ARFID. There are various forms of CBT that are used with ARFID, but most contain elements like consistent eating, exposure to prevent negative responses, relaxation training, and monitoring food intake (Thomas et al., 2018). An example of a CBT for ARFID is the CBT-AR. It has four stages that involve psychoeducation about ARFID and its impact on health: regular eating, which involves creating meal plans with a variety of foods; exposure therapy, which means gradually having individuals try avoided foods and food situations; coping skills training; and relapse prevention (Thomas et al., 2018).

LINK TO LEARNING

This webinar discusses cognitive behavioral therapy (https://openstax.org/r/77ARFIDinfo) used for ARFID. It describes its uses for clients ages ten to older adults and clinical practice information along with ongoing treatment of ARFID.

Dialectal Behavior Therapy

DBT can be effective in managing eating disorders like ARFID (Reilly et al., 2020). DBT is a psychotherapy modality that provides skills to help cope with strong emotions and can be modified to focus on disrupted eating behaviors, food intake, and nutritional skills (Pennell et al., 2019).

Goals of Treatment

The goals of treatment for ARFID are to restore nutritional balance, stabilize weight, and modify disrupted eating behaviors and thought processes. Restore nutritional balance by monitoring lab values like electrolytes, blood count, and metabolic function. Abnormalities in essential nutrients values may require nutritional replacement. Weight stabilization may require nutritional supplements to help restore weight. Modifying disrupted eating behaviors and thought processes will involve a collaborative effort of nurses working with members of the health-care team, the client, and their family to establish healthy eating behaviors.

20.4 Bulimia Nervosa

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- List risk factors associated with bulimia nervosa
- Plan nursing care for clients in treatment for bulimia nervosa
- Discuss nursing implications for the therapeutic relationship in care of clients diagnosed with bulimia nervosa

Recurrent episodes of binge eating that are followed by behaviors to prevent weight gain like purging is called **bulimia nervosa** (APA, 2023b). It occurs most often in adolescent females with an estimated prevalence of 0.5 percent to 1.5 percent in the United States (Jain & Yilanli, 2023). Individuals with bulimia shift from calorie restriction to binge eating where they consume large amounts of food in a short period of time. During binges, there is a loss of control, and the portions are larger than most people would consume in the same time frame. The episodes of binging are followed by recurrent weight control measures that can include extreme exercise, fasting, purging, or abuse of laxatives and diuretics (Jain & Yilanli, 2023). This cycle of out-of-control consumption of large amounts of food in a short period of time followed by methods to prevent weight gain is also known as a **binge-purge cycle**.

Risk Factors for and Etiology of Bulimia

Though bulimia is seen in females and males, it is significantly more common in females. The median age of the onset of bulimia is around twelve (Jain & Yilanli, 2023). The etiology of bulimia is unknown, but it is thought to include several biological, psychological, environmental, and temperamental factors that can predispose individuals to bulimia. Alterations in the brain structure and function have been found to contribute to binging behaviors (Jain & Yilanli, 2023).

Biological Factors

Biology is thought to play a significant role in the development of bulimia. Puberty and childhood obesity increase the risk for bulimia nervosa, and childhood physical and sexual abuse also lead to an increase in incidence (APA, 2023b). Appetite has been known to be a factor in bulimia. Studies of appetite hormones like ghrelin and leptin in bulimic clients have shown dysregulated levels that may contribute to symptoms seen in bulimia (Presseller et al., 2021).

Addiction is also associated with bulimia. Studies have shown biological similarities between people with bulimia and people with drug addiction; food and illicit drugs both have the same pleasurable effects on neurons in the brain (di Giacomo et al., 2022). The binge eating behaviors seen in bulimia follow a similar pattern to addictive behaviors seen in substance misuse. Substance use disorder may be seen with eating disorders with increased associations reported in individuals with bulimia (Gregorowski et al., 2013).

REAL RN STORIES

Nurse: Andrea P.
Clinical Setting: Psychiatric unit
Geographic Location: Saskatchewan, Canada

Andrea is a psychiatric nurse in Canada who battled with bulimia nervosa for sixteen years. Andrea's bulimia began in ninth grade before a trip to Hawaii where she reports that she began starving herself to look better in her bikini. After the trip, her disordered eating persisted and was influenced by a friend who she found in a bathroom purging. She would wake up obsessing over food and would purge after her binges. As her bulimia worsened, she admitted to purging up to ten times a day and hiding her eating behaviors from her spouse. She was consumed with feelings of overwhelming guilt after her binges and reports feeling a loss of control over her eating. Her husband discovered that she had issues with eating after finding a hidden bag of vomit one day, and he encouraged her to get help. She recovered after three admissions to a center for eating disorders, but still has dental complications from her years of purging. She has veneers on four of her teeth from tooth decay and now calls herself a nonactive bulimic.

Social Factors

There are several social factors associated with bulimia. Temperamental factors like low self-esteem, social anxiety, and depressive symptoms can increase the risk for bulimia (APA, 2023b). Individuals with bulimia also tend to engage in their binge eating behaviors in isolation, which could lead to social withdrawal (Hadad & Knackstedt, 2014). The individual with bulimia may experience such strong emotion that they impulsively binge eat to find comfort. The loss of control that individuals with bulimia experience during binge eating and purging episodes demonstrates issues with impulse control (Howard et al., 2020).

Mental Health Comorbidities

Mental health disorders are common in individuals with bulimia. In adolescents, the most frequently seen comorbid mental health conditions were mood and anxiety disorders (Hail & Le Grange, 2018). Adolescents with bulimia also have the highest levels of suicide attempts (Hail & Le Grange, 2018) of all of the eating disorders. The *DSM-5* lists depressive disorders, bipolar disorders, borderline personality disorder, and anxiety disorders as mental health conditions that have the highest rates of comorbidity with bulimia; these conditions can either precede the bulimia, occur simultaneously, or can develop shortly after (APA, 2023b). Substances like stimulants may be used to control appetite, and alcohol use is also reported to be higher in individuals with bulimia (APA, 2023b). Individuals with bulimia may use laxatives to promote weight loss; in fact, some studies found laxative abuse in as many as 56 percent of people with eating disorders (Addiction Center, 2023).

Nursing Care Planning

Nurse care planning for individuals with bulimia should focus on restoring metabolic and electrolyte balance, treating any underlying mental health issues, and establishing ordered eating patterns. A sample care plan for a client with bulimia is provided Table 20.2.

CJMM Step	Notes
Assessment	Hyponatremia Hypokalemia Palpitations
Priority problem	Fluid volume deficit related to frequent self-induced vomiting
Outcomes	Clients' electrolytes will return to normal limits
Interventions	Daily labs Electrolyte replacements (oral and IV)
Rationale	To ensure that client is adequately hydrated and that client's electrolyte balance is restored To assist with healthy eating habits/choices
Evaluation	Client's sodium and potassium levels increased during admission

TABLE 20.2 Nursing Care Plan for Client with Bulimia

Bulimia Nervosa—Purging Type

Some individuals with bulimia use compensatory measures like purging to prevent weight gain after they binge. Though self-induced vomiting is the most common method used, purging can also include laxative and diuretic overuse (APA, 2023b). These individuals are more at risk for fluid and electrolyte imbalances due to dehydration that can be caused by recurrent purging.

Assessing dental health in clients with bulimia is important because repeated purging can cause complications. Dental erosions are common with chronic vomiting due to the acidity of vomit (Nitsch et al., 2021). Frequent purging can also cause trauma to the oral cavity from coming in contact with acidic vomit or from methods used to induce vomiting like inserting objects in the mouth. It is important for nurses to ask questions related to dental hygiene to assess oral health.

Bulimia Nervosa—Nonpurging Type

There are several nonpurging behaviors that are seen in bulimia to compensate for binge eating. Enemas, thyroid hormone, and excessive exercising are a few nonpurging behaviors that individuals with bulimia may use to control weight gain (APA, 2023b). Individuals who have diabetes mellitus may also manipulate insulin to control weight gain after binges. The client may typically reduce or withhold insulin in an attempt to decrease the metabolism of the excessive food consumed during a binge (APA, 2023b). This can lead to diabetes-related ketoacidosis, which can progress to diabetic coma, and even death from cerebral edema.

Life-Threatening Complications

Bulimia nervosa can lead to life-threatening complications that require immediate nursing intervention. The most common cause of morbidity and mortality seen with bulimia is a result of complications from electrolyte and metabolic disturbances (Nitsch et al., 2021). In addition, other common life-threatening complications of bulimia include:

- Suicide: Suicide risk is high in clients with bulimia, particularly adolescents.
- Esophageal rupture: Esophageal rupture can occur from forceful stomach contraction with repeated vomiting. If bleeding is severe, it can lead to death if not promptly treated.
- Cardiac arrhythmia: Hypokalemia from purging and stimulant abuse can cause prolongation of the QT interval,

increasing the risk for life-threatening arrhythmias.

Criteria for Hospitalization

Most individuals with bulimia are normal weight or overweight, making it difficult to detect compared with anorexia and ARFID (Nitsch et al., 2021). Though weight is often not an issue in clients with bulimia, they can have several medical complications. Bulimia has significantly increased mortality rates from these medical complications that can affect many body systems. The complications occur as a result of repeated purging and laxative abuse that cause electrolyte disturbances, metabolic abnormalities, and other physiological complications (Nitsch et al., 2021) (Table 20.3).

Body System	Symptom(s)
Integumentary	Calluses on dominant hand (also known as Russell sign)
HEENT	• Dental erosions • Trauma to the oral mucosa (pharynx, soft palate) • Subconjunctival hemorrhage • Recurrent epistaxis • Pharyngitis • Parotid gland hypertrophy (sialadenosis)
Gastrointestinal (GI)	Upper GI symptoms (seen more in those who purge) • Gastrointestinal reflux • Barrett's esophagus • Esophageal adenocarcinoma Lower GI symptoms (seen more in those who abuse stimulant laxatives) • Colonic inertia (the inability to pass stool from the colon) • Black stool • Rectal prolapse
Cardiac	• Arrhythmias • QT prolongation • Cardiomyopathy • Palpitations
Pulmonary	• Aspiration pneumonia • Pneumomediastinum (air in the space between the two lungs)
Metabolic/electrolyte	• Hypokalemia • Hypochloremia • Metabolic alkalosis • Metabolic acidosis • Hyponatremia
Endocrine	• Irregular menses

TABLE 20.3 Symptoms of Bulimia (Nitsch et al., 2021)

Interventions

There are multiple interventions used to manage bulimia. These interventions include stabilizing nutritional status,

interrupting maladaptive behaviors, assessing and managing complications, managing medication, and psychotherapy (Nitsch et al., 2021). These interventions involve a collaborative team approach from multiple disciplines in addition to nurses, depending on the needs of the client. For example, a dietitian will work closely with all clients with bulimia, but if the client is having a complication like hypokalemia, a cardiology clinician may manage their cardiac condition. Other examples of nursing interventions that can be used to manage bulimia include:

- monitoring meals and ensuring that purging behaviors are not performed one hour after meals
- providing small frequent meals
- teaching coping skills to help manage emotions related to bulimia
- identifying the clients' strengths to help increase their self-esteem

Psychotherapy

Cognitive behavioral therapy and interpersonal psychotherapy are two psychotherapeutic modalities that have demonstrated efficacy for bulimia (Jain & Yilanli, 2023). Cognitive behavioral therapy is used to help change maladaptive thinking patterns and behaviors that can help with disrupted eating patterns. Interpersonal therapy aims to improve interpersonal and social factors that may contribute to the behaviors seen with bulimia.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Competencies and Interventions for Bulimia

The six QSEN competencies developed for nursing programs are important to consider when working with individuals with bulimia.

QSEN Competency	Examples of Nursing Interventions
Client-centered care	Assess the client's vital signs and labs to evaluate for physiological complications. Educate the client on healthy eating behaviors.
Teamwork & collaboration	Collaborate with other disciplines involved in the client's plan of care, like dietitians and psychiatrists. Delegate appropriate tasks to other personnel. For example, a nurse's assistant can help check vitals.
Evidence-based practice (EBP)	Provide evidence-based resources to clients to educate them on bulimia. Attend continuing education nursing activities on bulimia to stay up to date on the latest evidence-based practices.
Quality improvement	Assess processes in place related to caring for clients with bulimia and help to create solutions to improve client care.
Safety	Assess clients with bulimia for suicidal thoughts using screening tools. Implement needed precautions for clients at high risk for suicide, like one-on-one supervision.
Informatics	Use clinical tools to help monitor the clients' vitals and document them in the electronic medical record.

Pharmacology

Pharmacological interventions have been well-studied with bulimia and have proven to be effective in managing symptoms of individuals with bulimia (Davis & Attia, 2017). The two most common classes of medications used are antidepressants and antiepileptic medications. Fluoxetine is the most commonly prescribed antidepressant and the only one approved by the FDA for bulimia nervosa (Davis & Attia, 2017). It has been found to significantly help

reduce binging and purging episodes. There are several other antidepressants that are also used for bulimia off-label, or they may be used to manage any comorbid depression or anxiety. It is important to note that bupropion, a common antidepressant used to manage depression, is specifically contraindicated in treating bulimia due to its seizure risks. Antidepressants also carry a warning related to increased suicide risk in adolescents, so it is important to monitor clients on antidepressants closely (Davis & Attia, 2017).

Antiepileptic medications are used in the treatment of bulimia due to their effect on binging and purging (Davis & Attia, 2017). Topiramate is a common antiepileptic medication that helps reduce binging and purging episodes. It must be used with caution with clients who have low body weight because it can also cause significant weight loss (Davis & Attia, 2017).

Client's Self-Help

Self-help can be effective in bulimia treatment. There is a known treatment gap in those diagnosed with bulimia and those being treated routinely for the disorder (Hartmann et al., 2022). Clients may prefer to access resources on their own to help manage their eating disorder. Other factors like stigma, shame, guilt, and poor motivation have also been found to be barriers to individuals with bulimia seeking care (Hartmann et al., 2022). Studies have shown that web-based self-help interventions can effectively help reduce symptoms seen in bulimia. These interventions often incorporate cognitive behavioral therapies in an online format.

Nursing Implications

Nurses will encounter clients with bulimia who require intervention. Assessing these clients for disordered eating habits and any purging behaviors is important. It is also imperative to screen for suicide. Physical assessment will include height, weight, and vital signs along with labs measuring metabolic and electrolyte abnormalities. These clients may have other nursing assessments that reveal ineffective coping or chronic low self-esteem that will require care planning to achieve treatment goals.

Therapeutic Relationship

Individuals with bulimia can have feelings of shame and guilt related to their disorder. They may have issues with self-esteem, depression, and impulse control that may cause them to be reluctant to seek care. It is important to show compassion for these clients and build a therapeutic relationship to facilitate their recovery.

Nurses' reactions to clients with bulimia will vary. Disordered eating and purging behaviors may seem very abnormal to nurses caring for them. Some clients may report purging several times a day or taking very large quantities of laxatives to prevent weight gain. It is important for nurses to show empathy and to be nonjudgmental in their interactions with these clients to help facilitate a therapeutic relationship.

Safe Environment

Like anorexia, clients with bulimia are also at high risk for suicide. It is essential to provide a safe environment for these clients and to screen for suicide risk. For clients at high risk, implement safety interventions to prevent self-harm and provide crisis information. Hospitalization can provide opportunities for group work and behavior modification therapies in a supportive environment.

LINK TO LEARNING

This video explains bulimia nervosa and anorexia nervosa (https://openstax.org/r/77anorexbulimia) and provides nursing management. The video also provides NCLEX tips to help facilitate learning.

20.5 Binge-Eating Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Differentiate between bulimia nervosa and binge eating disorder and discuss the driving factors and comorbidities that accompany binge eating disorder
- Plan nursing care and discuss nursing implications for clients in treatment for binge eating disorder

Repeated episodes of excessive eating in shorter amounts of time than most people would eat in that situation

accompanied by significant lack of control of eating is called **binge eating disorder (BED)** (APA, 2013). It is the most common eating disorder in the United States and affects approximately 1.25 percent of adult persons AFAB, 0.42 percent of adult persons AMAB, and 1.6 percent of all teens (National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK], 2021). Individuals who binge tend to eat even when they are full or not hungry and may also feel shame or guilt after eating. They exhibit **control issues** where they consume large amounts of food and have the inability to stop eating. Binge eating recently became categorized as an eating disorder in the *DSM-5* after it was formerly recognized as an eating disorder not otherwise specified (APA, 2013).

Comparison with Bulimia Nervosa and Driving Factors behind BED

Bulimia nervosa and binge eating disorder can present in similar fashions. In both disorders, there is a loss of control that can occur with food during binge eating episodes. There are also repeated episodes of eating large quantities of food in a short period of time.

Bulimia versus Binge Eating Disorder

The major difference between the two is that there are no repeated purging behaviors that occur in binge eating disorder. Some people with binge eating disorder may occasionally try strategies to prevent weight gain but not on a regular basis (NIDDK, 2021). These clients tend to be overweight from excess consumption of calories versus clients with bulimia who may be normal weight.

Psychological, Emotional, and Social Drivers of Behaviors

Psychological drivers can play an important role in the behaviors seen with binge eating disorders. Alterations in impulse control are thought to be central to BED, including dysfunctions related to emotion regulation and reward processing (Giel et al., 2022); stress is a common prompt for binge eating episodes.

Other drivers associated with BED include being teased about weight, issues with weight, and body dissatisfaction (Giel et al., 2022). For example, individuals from families that are highly critical of a child's weight and/or size are at increased risk for developing BED (NIDDK, 2021). Adverse childhood experiences have also been associated with BED.

PSYCHOSOCIAL CONSIDERATIONS

Social Factors Contributing to Binge Eating Disorder

There are several social factors that have been associated with BED. Though BED is prevalent in all socioeconomic groups, it affects certain populations more than others. People who have experienced events like violence, trauma, or poverty are at an increased risk for developing BED (Giel et al., 2022). Factors like race, ethnicity, and sexual orientation also affect risk for BED. Studies have shown higher prevalence in Black and Latinx populations along with sexual minorities (Giel et al., 2022). Stigma and stereotypes may play a role in the disparities seen with BED, so it is important to promote awareness and adequately screen clients for BED.

Risk for Medical Comorbidities

Clients with BED are at risk for medical comorbidities. The most common medical comorbidities seen with BED are obesity, hypertension, arthritis, high cholesterol, cardiac conditions, diabetes, smoking, sleep issues, and metabolic syndrome (Giel et al., 2022). The increase in these medical comorbidities also increases morbidity and mortality. Being obese increases the risk of health-related problems like type 2 diabetes, heart disease, and some cancers (NIDDK, 2021).

Nursing Care

Nurses may encounter clients with BED due to medical complications or attempts to lose weight. Studies have shown that about 50 percent of individuals with BED seek help for their condition and may have barriers related to stigma and shame (Giel et al., 2022). Another barrier to seeking care can include not being aware that they have an eating disorder, so awareness of BED is important. Nursing care for these clients should include an accurate assessment using validated screening tools like the SCOFF questionnaire. Other useful tools are the Eating Attitudes Test (EAT) and the Questionnaire on Eating and Weight patterns (QEWP-R). EAT is a twenty-six-question test used to screen for disordered eating and QEWP-R is a five-question tool used to screen for BED based on diagnostic criteria.

The physical exam should include vital signs and height and weight measurements. Since clients with binge eating disorder can have high BMIs, nurses may need access to scales with large weight capacities. These clients may also require blood sugar monitoring in addition to labs due to their risk of diabetes.

Treatment Interventions

Nursing interventions will focus on weight loss, treating comorbid conditions, avoiding medical complications, and increasing the client's self-esteem. It may be easier to manage eating behaviors and portions in a controlled environment like in the hospital setting and the client must be encouraged to transition toward self-care. Education and resources to provide discharge support are essential to ensure that clients can continue to make progress. This support may include arranging follow-up care and referrals in the community, providing appropriate contacts for routine care and for emergencies, reviewing medications, and reviewing healthy lifestyles.

Children and Adolescents

Children and adolescents may not be diagnosed with BED but may exhibit issues with control of eating (Giel et al., 2022). This makes diagnosing pediatric populations a challenge because they may not meet the full criteria due to limitations or restrictions regarding food access. Currently, there are no specific guidelines on managing BED in pediatric populations and studies related to treatment are lacking.

Psychotherapy and Behavioral Modifications

Psychotherapy is first-line treatment for BED and can include modalities like CBT, IPT, and DBT (Giel et al., 2022). CBT helps to restructure maladaptive cognitive processes that lead to overeating, such as low self-esteem. Self-help CBT programs that focus on regular eating behaviors, self-control, and problem-solving have also been effective in managing BED (Iqbal & Rehman, 2022). IPT can explore interpersonal function and issues with self-esteem while DBT can be used to help regulate emotions and improve distress responses (Giel et al., 2022).

Behavioral therapies that focus on diet therapy and physical activity have been proven to be effective in treating BED. Diet therapy is used to promote weight loss and includes calorie restrictions, meal planning, and controlling eating behaviors (Amianto et al., 2015). Physical activity is used with caution in clients with medical complications but can be a useful adjunct to diet therapy in stable clients. Physical activity can help promote weight loss and improve mood and overall health (Amianto et al., 2015).

Pharmacology

Lisdexamfetamine is the only FDA-approved medication for BED on the market in the United States. It has been shown to help decrease binge eating and decrease body weight by up to 6 percent (Giel et al., 2022). Lisdexamfetamine is a controlled medication that should be used with caution due to its potential for abuse.

Other medications that have been used to treat BED include SSRIs, antiepileptics medications, stimulants, and weight loss medications. SSRIs like fluoxetine have been shown to reduce bingeing; it is the most commonly prescribed SSRI due to its efficacy with bulimia (Amianto et al., 2015). Antiepileptics like topiramate decrease hunger and stimulants like atomoxetine also decrease bingeing and promote weight loss (Amianto et al., 2015). Phentermine is another stimulant used for weight loss but must be used with caution because of adverse cardiovascular effects that can occur. Medications used for weight loss like orlistat, in combination with a low-calorie diet, can be effective in helping with weight loss but are not helpful for reducing binge eating (Amianto et al., 2015).

Surgical Interventions

Severe obesity in individuals with BED can be treated with bariatric surgery. Severe obesity is defined as clients with a BMI of >40 or >35 with comorbid conditions (Amianto et al., 2015). Bariatric surgery is controversial for clients with BED because it is usually contraindicated in clients with an eating disorder diagnosis. Clinical data and research have shown that it can be effective in BED treatment when it is done in conjunction with psychological interventions and follow-up care (Amianto et al., 2015).

Collaborative Care

BED is a complex eating disorder that requires collaboration from multiple disciplines during care planning. Nurses will play a key role in assessing these clients and implementing interventions from the care plan, such as medication management and health education. Assistive personnel will be essential in completing tasks delegated from the nurse like taking vital signs, passing food trays, and weighing clients. Clients at high risk for suicide may be

monitored one-on-one by assistive personnel with frequent assessments by the nurse. Psychiatry and psychology professionals may help manage the disordered thought processes that occur with binge eating. Cardiology or endocrinology professionals may be part of the team if there are medical complications like diabetes or cardiac issues. Nutritionists may also help manage diet therapy and meal planning. A collaborative effort may result in more positive outcomes for the client.

The Therapeutic Relationship and Binge Eating Disorder

Clients with BED often feel a lot of shame and guilt about their condition making a therapeutic relationship an essential part of their care. In addition to providing compassionate, nonjudgmental care, it is important for nurses to be patient and flexible. Clients with BED may lack motivation or have physical limitations due to obesity that may make it difficult to complete tasks. Be flexible with therapeutic efforts and add treatment strategies one at a time to help with satisfaction and compliance (Amianto et al., 2015).

20.6 Pica

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the etiology of pica
- Identify conditions that are associated with pica
- Summarize the treatment options for pica
- Describe nursing considerations for clients with pica

The eating disorder in which an individual repeatedly and compulsively consumes nonfood items that lack nutritional value is called **pica** (Stiegler, 2005). Items defined as **nonfood** are those that lack nutritional value. Common nonfood items consumed by people with pica include paint chips, clay, charcoal, metal, hair, soap, paper, chalk, metal, or small stones (APA, 2023a). Some individuals with pica have cravings for ice. A **craving** is an intense desire for something.

It is important to note that pica does not include culturally or socially accepted practices. It also is important to note that small children commonly place nonfood items in their mouth and that this is not considered pica. For these reasons, pica is not diagnosed in the presence of accepted social or cultural practices or in children under the age of two.

Etiology of Pica

Though the cause of pica is unknown, there are a few suspected etiologies. Studies have shown associations between pica and factors such as stress, child abuse/neglect, and vitamin/mineral deficiencies (Al Nasser et al., 2023). Iron deficiency anemia is a common proposed etiology; it is thought that the deficiency may modify enzymes in the brain and cause cravings for items such as clay, laundry starch, and ice. In the alternative, eating these items may alter the client's experience of the deficiency (Advani et al., 2014). Evidence to support these etiologies varies, and more research is needed to explore the cause of pica.

Behavioral Factors Associated with Other Conditions

Behavioral factors have been associated with an increased risk of developing pica. Behavioral factors seen in individuals with autism and intellectual differences that can contribute to developing pica include sensory seeking behaviors, automatic reinforcement, and seeking attention from caregivers (Fields et al., 2021). Maladaptive eating behaviors are also commonly seen in clients with schizophrenia and are also associated with developing pica. Clients with schizophrenia may ingest nonfood items, including feces (Khosravi, 2021).

Acculturated Behaviors

There are relevant cultural factors associated with pica. In some cultures, consumption of nonfood items are socially accepted practices or **social norms**. For example, in parts of India, mud eating is culturally accepted and cravings for items like ash and dust are said to help predict the gender of an unborn child (Bhatia, 2014). Other examples are certain tribes in Peru who consume clay for health benefits and some cultures in Africa who eat soil during pregnancy and postpartum for health and spiritual benefits (Bhatia, 2014). The most common substances consumed by various cultures are soil and raw starches (Chung et al., 2019). These culturally accepted practices are not considered pica, so it is important to conduct a cultural assessment when evaluating clients who are suspected

to have this disorder.

Learned/Reinforced Behaviors

Learned behaviors can play a role in the development of pica. For example, if a child grows up in a home where everyone eats ice or nonfood items, they may continue this learned behavior. Pica may also be a learned or reinforced behavior done in response to a stressor and used as a way to self-soothe (Liu et al., 2021).

Conditions Associated with Pica

Consumption of nonfood items can have sequelae, such as dental damage, toxicity, infection, parasites, or gastrointestinal blockage. Thorough medical and nursing assessment should identify client needs and focus the care. Problematic conditions may arise before determining that pica is the cause.

Nutritional Deficiencies

Pica has been associated with nutritional deficiencies. Deficiencies in minerals such as iron, zinc, and calcium are thought to cause cravings for nonfood items (Chung et al., 2019). The problem with consumption of certain nonfood items is that they can worsen these nutritional deficiencies. For example, consumption of clay and starch can bind to iron in the gastrointestinal tract and worsen iron deficiency anemia (Advani et al., 2014).

Medical/Pregnancy

Pica can develop during pregnancy. Though the prevalence is unknown, it estimated in a metanalysis to occur in approximately 28 percent of persons during pregnancy and the postpartum period (Liu et al., 2021). Pica is a great concern during pregnancy due to the risk that it poses to the fetus. Consumption of nonfood items like clay or paint chips can be toxic to the developing fetus. It can also lead to complications such as lead poisoning, which has been associated with chronic neurological complications and motor function delays in children (Al Nasser et al., 2023).

Iron deficiency anemia is associated with pica and is also seen in pregnant persons. Other people at risk for iron deficiency anemia include premenopausal menstruating persons, and frequent blood donors (Liu et al., 2021). Because these populations have a higher occurrence of iron deficiency anemia, the incidence of pica is also seen more in these groups. Individuals with iron deficiency anemia often consume large amounts of ice, known as **pagophagia**. Pagophagia is the most common form of pica in the United States and can lead to complications like dental injuries (Liu et al., 2021). It is important to note that pica is only diagnosed in pregnancy if the consumption of the nonfood item poses harm or risk. If there are no medical risks associated with the consumption of the nonfood item, the client may not require clinical care for this behavior (APA, 2023b).

Mental Health

There are several mental health conditions frequently seen with pica. Pica is commonly seen in individuals with intellectual disabilities and mental health disorders, such as schizophrenia, obsessive-compulsive disorder (OCD), and trichotillomania (Al Nasser et al., 2023). It can also be seen in individuals with autism and disorders like excoriation disorder (APA, 2023b). Pica has also been associated with other eating disorders like ARFID. Individuals with ARFID may have sensory sensitivities that can play a role in the development of pica (APA, 2023b).

Treatment of Pica

There are no medications to treat pica. Restoration of deficient minerals and nutrients is considered the first-line treatment for pica if there are deficiencies (NEDA, 2023b). If replacing minerals and nutrients is not effective, other methods like behavioral interventions may be effective. Behavioral interventions have shown promise in clients with mental disabilities and include redirection of compulsive eating of nonfood items to other activities (Al Nasser et al., 2023). It is also important to prevent continued consumption by removing the nonfood items or restricting access.

Behavior Modification

Behavior modification used in treating pica utilizes a technique called **differential reinforcement**, which is a strategy that redirects an unwanted behavior to more favorable activities (Al Nasser et al., 2023). For example, if a child consistently consumes clay or playdough during activity time, they can be redirected to choose a healthy snack such as baby carrots. Studies conducted on individuals with autism have shown that differential reinforcement is an effective strategy and can include rewarding favorable behaviors (NEDA, 2023b).

Emergency Care

Consumption of nonfood items can cause several medical complications that require emergency care. Complications that can occur include heavy metal toxicity, choking, sepsis, and intestinal blockages or perforation (Fields et al., 2021). Clients who consume items like paint chips are at risk for poisoning from high levels of toxic metals like lead (APA, 2023a). Choking can occur from nonfood items becoming lodged in the throat and causing airway blockages. Sepsis can develop from exposure to toxins in the nonfood items consumed, and intestinal blockages can occur from the buildup of the nonfood items in the gastrointestinal tract; that can also lead to perforation. These medical complications can lead to fatalities if they do not receive prompt medical intervention (Fields et al., 2021).

Nursing Considerations

Nurses are key players in helping manage individuals with pica. These individuals may seek care due to medical complications from ingesting nonfood items or they may seek care for routine examinations such as well-child or prenatal visits. These clients require compassionate, person-centered care to address their health needs. Nurses can help identify vulnerable clients who are at risk, such as pregnant individuals or children who reside in older homes that may contain lead paint, and educate clients on prevention strategies (Al Nasser et al., 2023).

Teaching

Client and family education regarding pica should focus on prevention and behavior modification. Individuals with pica need to learn strategies to limit their exposure to the substance or substances that they crave. This can be facilitated by decreasing access or substituting the nonfood item with a similarly textured item that is more appropriate (Al Nasser et al., 2023). Parents and caregivers play an essential role in managing pica in children. Preventative strategies that have been proven effective include making other caregivers aware of the pica behaviors, keeping a close watch on children, removing access to nonfood items, engaging childproof locks, and finding alternative activities to divert the child's attention (Fields et al., 2021).

Family Support/Empowerment

Living with individuals with pica can be difficult for families. Because pica is commonly seen in children, parents, caregivers, and other family members are vital to include in the client's plan of care. Empowering families to take an active role in the plan of care can help promote positive outcomes in individuals with pica.

20.7 Rumination Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss etiologies and diagnostic criteria of rumination disorder
- Summarize treatment for rumination disorder
- Plan nursing care for clients with rumination disorder

In a gastrointestinal context, **rumination** is when ingested food is repeatedly regurgitated, rechewed, or spat out (APA, 2023a). Rumination is derived from the Latin word *ruminor,* which translates as to *chew over again* (Sasegbon et al., 2022). When food that has been ingested is ejected through the esophagus back into the mouth, this is known as **regurgitation**. It is important to distinguish regurgitation from vomiting. With vomiting, there is forceful expulsion of gastric contents from the mouth. With rumination, the action is effortless, and the food remains in the mouth unless it is spat out by choice (Kusnik & Vaqar, 2023).

The eating disorder in which food is repeatedly regurgitated and rechewed or spat out after being ingested is called **rumination syndrome**, or **merycism**. The rumination typically occurs within fifteen minutes of a meal and is repeated for up to two hours (Kusnik & Vaqar, 2023). It can lead to medical complications and impairments in occupational and/or social functioning, so it is important to assess rumination disorder in suspected individuals.

Rumination syndrome is described as having a primary maintenance pathway and secondary mechanisms that maintain the disorder. In the primary maintenance pathway, the regurgitations are a result of a conditioned response to oral stimuli (typically food) and cause habitual contraction of the abdominal wall (Taclob et al., 2022). For example, individuals may regurgitate after eating a certain food. Secondary mechanisms associated with rumination syndrome include gastrointestinal reflux and other gastrointestinal conditions like gastroparesis that can

cause regurgitation from acid reflux (Murray et al., 2019). There is also a form of rumination syndrome where belching occurs before regurgitation that is known as supragastric rumination.

Etiology and Diagnosis of Rumination

Rumination syndrome can mimic gastrointestinal disorders and is often misdiagnosed (Taclob et al., 2022). Clients can present with symptoms of heartburn or abdominal pain that is also seen with gastrointestinal disorders, and report "vomiting." (Kusnik & Vaqar, 2023). Obtaining a detailed history is essential to determining if the client has an eating disorder. For example, it will be helpful to know if the client is experiencing vomiting versus regurgitation where the action is effortless. *DSM-5* criteria also requires that the symptoms occur over one month and not be from a medical condition, so evaluation and testing may be needed to rule out gastrointestinal causes. Rumination syndrome can affect individuals of all ages with an estimated prevalence between 0.8 percent and 10.6 percent (Murray et al., 2019). There are also higher incidences of rumination disorder seen in individuals with intellectual disorders such as developmental delays (APA, 2023b). The recommended diagnostic tests used to evaluate possible rumination syndrome include the following:

- Gastric emptying studies: These studies measure the time it takes for food to move in the gastrointestinal tract and can help rule out conditions like reflux or gastroparesis.
- Electromyography (EMG): This test measures electrical signals in the abdominal muscles and can help determine a rumination diagnosis.
- High-resolution esophageal manometry (HRIM): This test measures gastric pressure and can be used to evaluate for rumination syndrome.
- Endoscopy: A scope is inserted into the gastrointestinal tract and can be used to visualize any possible mechanical obstructions.
- High-resolution impedance-pH manometry: The study measures pressure and pH and is used to confirm rumination syndrome and determine if it is primary or secondary. With primary rumination, there is reflux followed by abdominal pressure increase, whereas the opposite is seen in secondary rumination (Kusnik & Vaqar, 2023).

There is limited information regarding the development of rumination disorder (Schweizer et al., 2018). Temperament and parenting factors have been associated with rumination syndrome. Individuals with temperaments that include high negative emotions such as fear, anger, and sadness are at higher risk for developing rumination disorder; a persistent focus on negative emotions is seen with rumination (Schweizer et al., 2018). Parenting styles also may have an effect on the development of rumination disorder. The highest levels of rumination disorder have been found in clients with overcontrolling parents and those who have negative parenting behaviors like hostility (Schweizer et al., 2018). Other developmental factors, such as having developmental delays seen with intellectual disorders, have also been associated with rumination disorder. The act of regurgitating is thought to be self-soothing or self-stimulating for infants along with individuals with intellectual disabilities, and that may factor into the development of rumination syndrome (APA, 2023b).

Treatment

Rumination syndrome is a treatable condition and is considered an acquired habit that can be reversed (Kusnik & Vaqar, 2023). The most effective treatments for rumination syndrome are behavioral therapies that include diaphragmatic breathing and biofeedback (Sasegbon et al., 2022). Diaphragmatic breathing is a technique that involves having the client breathe by expanding and contracting their abdomen versus chest breathing (Sasegbon et al., 2022). This technique interferes with abdominal contractions that may lead to regurgitation, especially after a meal (Sasegbon et al., 2022). Biofeedback is an advanced behavioral therapy that may be used to improve diaphragmatic breathing. It involves using electromyography to guide diaphragmatic breathing by helping to decrease chest breathing and increase abdominal breathing (Murray et al., 2019). Other behavioral therapies that have shown promise include general relaxation and distractions like gum chewing. Cognitive behavioral therapy for rumination disorder may also be effective (Kusnik & Vaqar, 2023).

Medications are not typically used to manage rumination disorders unless they are treating underlying conditions. Behavioral therapies are considered first-line, but baclofen is a medication that has been used for clients who do not respond to behavioral interventions (Murray et al., 2019). Baclofen is an antispasmodic medication that has been found to reduce the frequency of regurgitation in clients with rumination syndrome (Murray et al., 2019). Its

mechanism of action involves stopping the relaxation of the lower esophageal sphincter by increasing the pressure in that area. The counteractivity produced by baclofen has been effective in decreasing episodes of regurgitation (Kusnik & Vaqar, 2023).

Family Therapy

Families play an essential role in therapy for individuals with rumination disorders. It is important to provide client-centered care that includes the client's family in their plan of care. Families are typically a part of mealtime and can help implement behavioral techniques like diaphragmatic breathing after meals. They can also help individuals with rumination disorder with relaxation skills or can provide distractions that can help discourage regurgitation.

Complications

Rumination syndrome can lead to medical complications that require intervention. There may be a reluctance to eat due to regurgitation that can increase risk for malnutrition, electrolyte imbalances, and even refeeding syndrome when restoring nutritional balance (Sasegbon et al., 2022). Other medical complications seen in individuals with rumination syndrome include:

- dental erosions (from repeated regurgitation)
- failure to thrive (from nutritional deficiencies)
- halitosis (from repeated regurgitation and dental erosion)
- increased risk for choking and aspiration (from repeated regurgitation)

Severe electrolyte imbalances and refeeding syndrome are serious complications that can be fatal if not treated promptly. Choking and aspiration can also be lethal complications that require immediate medical intervention. There are also impairments in social functioning that are seen with rumination syndrome, such as avoiding eating in social settings or avoiding work (Murray et al., 2019).

Nursing Considerations

Nurses have vital roles in managing clients with rumination disorder. They can help manage medical complications like dehydration by administering fluids and electrolyte replacements. They can provide education on rumination disorder and help clients and their families understand the condition. They can also implement behavioral therapies and collaborate with other professionals involved in the plan of care, such as medical providers and behavioral therapists.

Education on rumination syndrome should occur with the client and family. They should be educated on symptoms to look for related to medical complications and when to seek prompt care. Symptoms like notable weight loss and signs of dehydration could indicate severe nutritional or electrolyte deficiencies that require treatment. Because dental erosions are a common complication seen with rumination disorder, encourage oral hygiene.

Clients should also be educated on behavioral techniques used to manage rumination syndrome, like diaphragmatic breathing. Abdominal breathing is different from chest breathing, so it will be helpful to demonstrate this technique for clients and families when providing education. Recommend that clients start practicing diaphragmatic breathing for five to ten minutes while lying flat with their knees bent until they become comfortable with the technique. Once they are comfortable, they can perform this technique while sitting to suppress the urge to regurgitate (Sasegbon et al., 2022). Education can include providing links to John Hopkins and Mayo Clinic, which offer resources regarding eating disorders, including rumination disorder.

LINK TO LEARNING

This video demonstrates how to educate clients on diaphragmatic breathing (https://openstax.org/r/77breathing) for rumination syndrome.

Summary

20.1 Psychological, Social, and Physiological Factors

Eating disorders are a growing concern in nursing that can affect individuals of all ages and backgrounds. Anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, pica, and rumination are all eating disorders influenced by many psychological, behavioral, genetic, social, and environmental factors. Clients with eating disorders can have severe complications, and nurses are essential members of the health-care team when managing these clients. A collaborative approach that will include several disciplines in the plan of care and medication management is required in assessing and treating eating disorders.

20.2 Anorexia Nervosa

Anorexia nervosa is an eating disorder characterized by extreme restriction of food intake below the daily requirements, causing very low body weight that can be fatal. Anorexia is divided into two categories—restricting type and binge eating/purging type—and can involve cognitive distortions like thought-shape fusion. Clients with anorexia nervosa often have other comorbid mental health conditions, such as anxiety and depression. Beneficial interventions include medications, mentoring, self-help, and therapy. Clients with anorexia nervosa are at high risk for suicide, so nurse care planning should include suicide assessment, providing a safe environment, and maintenance of the therapeutic relationship.

20.3 Avoidant/Restrictive Food Intake Disorder

ARFID is an eating disorder characterized as a disturbance with eating or feeding resulting in an individual continuously not meeting their nutritional or energy needs (SAMHSA, 2016). It can be caused by sensory sensitivity, low appetite/interest in foods, or avoidance due to trauma, and it can lead to a severe reduction in nutrients. ARFID differs from anorexia because it is often seen in infancy and early childhood and does not involve issues with body image. Other mental disorders, such as autism and anxiety, can be psychological drivers for ARFID along with a history of trauma related to eating. Treatment of ARFID requires a collaborative approach that focuses on restoring nutritional balance, stabilizing weight, and modifying disrupted eating behaviors. Family-based care is essential to treatment, along with therapies that focus on behavior modification, cognitive thought processes, and nutritional skills building.

20.4 Bulimia Nervosa

Bulimia nervosa is an eating disorder where there are recurrent episodes of binge eating that are followed by behaviors to prevent weight gain like extreme exercise, fasting, or purging. It affects females more than males and there are several biological, psychological, environmental, and temperamental factors associated with it. Bulima is categorized as purging and nonpurging type and can cause significant medical complications that can require hospitalization. Severe life-threatening complications can also occur with bulimia, such as suicide, esophageal rupture, and cardiac arrhythmias. Nurse care planning includes interventions to stabilize nutritional status, interrupt maladaptive behaviors, and manage complications. Treatment includes behavioral therapy, medications, and client self-help. It is also important to provide a safe environment for clients with bulimia due to their increased suicide risk.

20.5 Binge-Eating Disorder

Binge eating disorder (BED) is the most common eating disorder, is characterized by repeated episodes of excessive eating in short amounts of time, and is accompanied by the inability to control eating. Loss of control over eating can cause feelings of shame or guilt. BED differs from bulimia in that there are no repeated purging behaviors that occur in BED and clients with BED tend to be overweight. There are several medical complications associated with BED that may require nursing care. Treatment of BED requires a collaborative approach that includes medications, psychotherapy, behavioral therapies, and surgical interventions. The goals of treating BED include weight loss and changing disordered eating patterns, which a therapeutic relationship with the client can help facilitate.

20.6 Pica

Pica is an eating disorder where people consume nonfood items repeatedly. Medical complications can occur with pica that require immediate medical intervention. Consumption of nonfood items may not be considered pica if it is

a culturally accepted practice or occurs in children under the age of two. The cause of pica is unknown, but there are several suspected etiologies and behavioral factors that are associated with pica, such as iron deficiency anemia. Pica can occur in pregnancy and, if severe, can cause harm to the mother and unborn child. Nutritional deficiencies and mental health comorbidities are also common in individuals with pica. Treatment includes restoring deficient minerals and nutrients, behavioral interventions, and prevention strategies. Nurses play an essential role in managing pica and can empower families to be active in the client's plan of care.

20.7 Rumination Disorder

Rumination syndrome is an eating disorder where food is repeatedly regurgitated and rechewed or spat out after being ingested. It affects all ages, but the age of onset for infants is typically between three and twelve months. It can mimic gastrointestinal conditions, so it is important to rule out gastrointestinal causes when assessing for rumination syndrome. Medical complications can occur with rumination disorders, such as dental erosions, choking, and nutritional deficiencies. The most effective treatments for rumination syndrome are behavioral therapies such as diaphragmatic breathing. Other treatment options include medication, cognitive behavioral therapy, and family therapy. Client education, family support, and empowerment are essential to treating individuals with rumination disorder.

Key Terms

anorexia nervosa self-induced restriction of food due to fear of weight gain that results in weight being below the normal parameters for age and height
avoidant/restrictive food intake disorder (ARFID) disturbance with eating or feeding where nutritional or energy needs are continuously not met
binge eating disorder repeated episodes of excessive eating in shorter amounts of time than most people would eat in that situation, accompanied by significant lack of control over eating
binge eating/purging type anorexia kind of anorexia where binge eating and/or purging is used to achieve weight loss
binge-purge cycle cycle of out-of-control consumption of large amounts of food in a short period of time followed by methods to prevent weight gain
body mass index (BMI) value that is calculated from an individual's height and weight
bulimia nervosa recurrent episodes of binge eating that are followed by behaviors to prevent weight gain like purging
cognitive distortion irrational or exaggerated thinking patterns
control issues where clients with binge eating disorder consume large amounts of food and have the inability to stop eating
craving intense desire for something
differential reinforcement strategy used to redirect an unwanted behavior to more favorable activities
eating disorder illness where there is an abnormal disturbance in attitudes and behaviors related to food
family-based care treatment approach that involves partnering with the clients' families in care planning and decision making
heritability how much genes influence differences in traits
ideal body weight height and weight with the lowest risk for mortality
lanugo soft, fine hair that typically covers the face and back of newborns
merycism another term used for rumination syndrome, an eating disorder where food is repeatedly regurgitated and rechewed or spat out after being ingested
nonfood items that lack nutritional value
nutritional deficiency reduction in the essential nutrients that are needed to maintain adequate bodily functions
pagophagia consuming large amounts of ice
pica eating disorder where an individual repeatedly consumes nonfood items that lack nutritional benefits
refeeding the gradual starting of oral intake for a client with anorexia nervosa
refeeding syndrome rapid changes in fluid and electrolytes causing complications like cardiac arrhythmias, delirium, coma, and even death
regurgitation when food that has been ingested is effortlessly brought back into the mouth
restricting type anorexia where weight loss is achieved by dieting, fasting, or extreme exercise

rumination when gastrointestinal related, is when ingested food is repeatedly regurgitated and rechewed or spat out

rumination syndrome an eating disorder where food is repeatedly regurgitated and rechewed or spat out after being ingested

social norms socially accepted practices

thought-shape fusion type of distortion seen with eating disorders like anorexia where there are altered beliefs about food, weight, and shape

Assessments

Review Questions

1. The nurse is assessing psychological factors in a client who presents with an eating disorder. What factor is considered a risk factor associated with eating disorders?
    a. poor body image
    b. happy childhood
    c. adoption
    d. being an only child

2. During history taking, it is revealed that a client has disordered eating behaviors. What would be considered a ritual or habit seen with eating disorders?
    a. enjoying a meal with family
    b. grocery shopping
    c. cutting food into small pieces
    d. exercising for 30 minutes once a week

3. The nurse is assessing risk factors in a client who presents with anorexia nervosa. What factor is considered a risk factor associated with anorexia?
    a. perfectionism personality
    b. being assigned male at birth
    c. having an adopted relative with anorexia
    d. having severe obesity

4. A client who you are caring for with anorexia has been prescribed medication. What medication can be used to manage potential comorbidities of this client?
    a. phentermine
    b. orlistat
    c. olanzapine
    d. Wegovy

5. How does ARFID differ from anorexia?
    a. It does not involve issues with body image.
    b. It can cause severe nutritional deficiencies.
    c. It is characterized by very low weight.
    d. It can involve restriction of foods.

6. What statement best describes what nurses should expect to hear from a client with bulimia when obtaining a history regarding a binge-purge cycle?
    a. A large amount of food is consumed in a longer than normal time frame.
    b. Severe calorie restriction occurs followed by increased laxative use.
    c. Self-induced vomiting occurs after a small low-calorie meal is consumed.
    d. Out-of-control eating occurs followed by self-induced vomiting.

7. What is the only FDA-approved medication for bulimia treatment?

a. fluoxetine
b. topiramate
c. olanzapine
d. bupropion

8. What is the only medication that is FDA approved to treat binge eating disorder?
a. fluoxetine
b. orlistat
c. lisdexamfetamine
d. phentermine

9. How does BED compare with bulimia?
a. There is a loss of control that can occur with food during binge eating episodes in bulimia that are not seen BED.
b. There are also repeated episodes of eating large quantities of food in a short period of time seen in BED that are not seen in bulimia.
c. Clients with bulimia and BED are severely obese.
d. There are no repeated purging behaviors in BED that are seen in bulimia.

10. What eating disorder has been associated with pica due to sensory sensitivity?
a. anorexia nervosa
b. bulimia nervosa
c. ARFID
d. BED

11. What is a recommended treatment intervention for pica?
a. a behavioral therapist educating a parent on redirection strategies
b. a dietitian adding nonfood items to a client's menu plans to encourage eating
c. a nurse allowing a client with pica and iron deficiency anemia to keep starch at the bedside
d. a parent allowing access to nonfood items to prevent tantrums

12. What is considered one of the most effective treatments for rumination disorder?
a. baclofen
b. Reglan
c. diaphragmatic breathing
d. gum chewing

13. What diagnostic test can be used to measure the time it takes for food to move in the gastrointestinal tract and can help determine the cause of symptoms experienced by clients with suspected rumination disorder?
a. gastric emptying studies
b. electromyography (EMG)
c. high-resolution esophageal manometry (HRIM)
d. high-resolution impedance-pH manometry

14. What statement made by the family of a young child with rumination syndrome will make the nurse recognize the need for further teaching?
a. "If Dee-Dee starts losing weight, we will notify the doctor's office."
b. "Dee-Dee fusses when we make her brush her teeth, so we don't push it."
c. "We understand it could be dangerous for Dee-Dee to get dehydrated."
d. "We are all participating in the family therapy sessions."

Check Your Understanding Questions

1. Describe how heritability can influence the development of eating disorders.

2. Describe how nurses can provide milieu management for clients with anorexia nervosa.
3. What are examples of nursing care that can be included when planning care for individuals with ARFID?
4. Clients with bulimia are at risk for many life-threatening complications. Describe a life-threatening complication that can occur as a result of purging behaviors.

Reflection Questions

1. How can nurses provide holistic care to clients with eating disorders?
2. Describe how a nurse can provide a safe environment when caring for a client with anorexia.
3. As a nurse, how can you establish a therapeutic relationship with a client diagnosed with anorexia nervosa, considering the challenges related to trust and control?
4. A sixteen-year-old client with bulimia reports bingeing up to ten times a day followed by self-induced vomiting. She was admitted with severe dehydration and a possible esophageal tear from purging. How can a nurse promote a therapeutic relationship in caring for this client?
5. PJ is a thirty-year-old from Kenya. She recently immigrated to the United States and discovered she is pregnant. During her prenatal visit, she informs the nurse that she desires to engage in a cultural practice to help her pregnancy that involves eating clay. How can the nurse provide person-centered care when providing education for this client?

What Should the Nurse Do?

Mariela is a 19-year-old college student who has recently lost a significant amount of weight and expresses dissatisfaction with her body image. She reports engaging in restrictive eating behaviors, excessive exercise, and frequent self-criticism related to her appearance. Mariela appears anxious and avoids making eye contact during the assessment.

1. What psychological factors might contribute to Mariela's development of an eating disorder, based on the information provided?
2. How do social factors, such as societal standards of beauty and peer influences, potentially influence Mariela's perception of body image and eating behaviors?
3. Considering physiological, hereditary, and environmental factors, what could be contributing to Mariela's presentation of an eating disorder, and how would you rank these hypotheses in terms of likelihood?
4. What nursing interventions would be appropriate for addressing Mariela's identified problems related to her eating disorder symptoms?

KB is a sixteen-year-old who presents to the clinic with her mother with reports of no menses for four months. She has no past medical history and takes no medications. Her mother mentioned having the same issue at her age when she was modeling and states that her issue was caused by her extreme dieting habits. Her mother also states that she feels that KB is underweight and that she has lost twenty pounds since she had her last visit eight months ago. KB reports that she often skips meals and reports that she is on an extreme diet plan to help her look more like her favorite YouTube model who is admired for her tiny waistline. During the exam, KB has a BMI of 17.5, a heart rate of 55 beats/min, and a blood pressure of 90/50. Based on the information you have, answer the following questions:

5. What eating disorder do you suspect KB may have and why?
6. How does her mother's history affect KB's risk?
7. What would be a priority nursing intervention for KB?

Drake, a 16-year-old, has been admitted to the pediatric unit of a hospital for evaluation and treatment of disordered eating behaviors. Drake presents with significant weight loss, extreme food avoidance, and nutritional deficiencies. Upon assessment, it becomes evident that Drake's eating patterns are driven by a fear of adverse consequences associated with eating, rather than a concern about body weight or shape. The client exhibits distress or impairment in social, occupational, or other important areas of functioning due to food intake restrictions.

8. Based on Drake's presentation, what features differentiate their condition from anorexia nervosa?
9. What nursing interventions could be included in Drake's care plan to address their avoidant/restrictive food

intake disorder (ARFID)?

Jamal, a 10-year-old male, has been brought to the pediatric clinic by his parents due to concerns about his eating habits. Jamal's parents report that he frequently consumes non-nutritive, nonfood items such as paper, clay, and dirt. Despite their attempts to intervene, Jamal continues to engage in this behavior, and they are worried about potential health risks. Upon assessment, it becomes evident that Jamal's consumption of nonfood items is not a culturally sanctioned practice and is not better explained by another psychiatric disorder.

10. What factors might contribute to the development of pica in Jamal's case?
11. What conditions or comorbidities should the nurse assess for in Jamal's case, given his presentation with pica?
12. What treatment options would be appropriate for addressing Jamal's pica, and how would you rank these options based on his individual needs and circumstances?
13. What nursing considerations should be prioritized when caring for Jamal and supporting him in managing his pica?

Competency-Based Assessments

1. Perform research from reputable sources on nursing assessment of a client with a potential eating disorder. What behavioral cues might indicate a potential eating disorder, and how would you prioritize these cues?
2. What measurable outcomes could indicate the effectiveness of nursing interventions in the treatment of an eating disorder?
3. Create a plan of care for a teenage client with anorexia nervosa. What interdisciplinary strategies could you implement, and how might they contribute to a comprehensive care plan?
4. As a nurse, how can you establish a therapeutic relationship with a client diagnosed with anorexia nervosa, considering the challenges related to trust and control?
5. Analyze the psychological and behavioral aspects that distinguish anorexia nervosa from ARFID. How might these differences influence nursing care?
6. As a clinical nurse, how would you plan care for a client with avoidant/restrictive food intake disorder (ARFID) and what hypotheses might guide the prioritization of interventions, considering the unique challenges of this disorder?
7. As a nursing student, you are working with a college student you suspect may have an eating disorder. Identify potential risk factors for bulimia nervosa in the student's history. How might recognizing these cues contribute to early intervention?
8. How can a nurse collaborate with a multidisciplinary team to develop a comprehensive care plan for a client with bulimia nervosa?
9. As a clinical nurse, how can you involve family members or support systems in the care of a client with binge eating disorder? What potential benefits can this collaboration offer?
10. In the context of binge eating disorder treatment, what actions can a nurse take to address potential client barriers to adherence and engagement in therapy?
11. As a clinical nurse, why is it important to be aware of associated conditions when caring for a client with pica?
12. As a clinical nurse, how can you evaluate the outcomes of treatment for a client with pica? What indicators suggest improvement or the need for adjustments in the care plan?

References

Addiction Center. (2023). *Laxative abuse*. https://www.addictioncenter.com/drugs/laxative-abuse/

Advani, S., Kochhar, G., Chachra, S., & Dhawan, P. (2014). Eating everything except food (PICA): A rare case report and review. *Journal of International Society of Preventive & Community Dentistry*, *4*(1), 1–4. https://doi.org/10.4103/2231-0762.12785

Al Nasser, Y., Muco, E., & Alsaad, A. J. (2023). Pica. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK532242/

American Medical Association. (2023). AMA adopts new policy clarifying role of BMI as a measure in medicine. https://www.ama-assn.org/press-center/press-releases/ama-adopts-new-policy-clarifying-role-bmi-measure-medicine

American Psychiatric Association. (2013). *Feeding and eating disorders*. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Eating-Disorders.pdf

American Psychiatric Association. (2023a). *What are eating disorders?* https://www.psychiatry.org/clients-families/eating-disorders/what-are-eating-disorders

American Psychiatric Association. (2023b). *Diagnostic and statistical manual of mental disorders, fifth edition, text revision* (5th ed.). American Psychiatric Association.

American Psychiatric Association. (2023c). *Eating disorders*. https://dictionary.apa.org/eating-disorder

Amianto, F., Ottone, L., Abbate Daga, G., & Fassino, S. (2015). Binge-eating disorder diagnosis and treatment: A recap in front of DSM-5. *BMC psychiatry*, *15*, 70. https://doi.org/10.1186/s12888-015-0445-6

Andreotti, E. T., Ipuchima, J. R., Cazella, S. C., Beria, P., Bortoncello, C. F., Silveira, R. C., & Ferrão, Y. A. (2020). Instruments to assess suicide risk: A systematic review. *Trends in Psychiatry and Psychotherapy*, *42*(3), 276–281. https://doi.org/10.1590/2237-6089-2019-0092

Aouad, P., Hay, P., Foroughi, N., Cosh, S. M., & Mannan, H. (2021). Associations between defence-style, eating disorder symptoms, and quality of life in community sample of women: A longitudinal exploratory study. *Frontiers in Psychology*, *12*, 671652. https://doi.org/10.3389/fpsyg.2021.671652

Aparicio-Martinez, P., Perea-Moreno, A. J., Martinez-Jimenez, M. P., Redel-Macías, M. D., Pagliari, C., & Vaquero-Abellan, M. (2019). Social media, thin-ideal, body dissatisfaction and disordered eating attitudes: An exploratory analysis. *International Journal of Environmental Research and Public Health*, *16*(21), 4177. https://doi.org/10.3390/ijerph16214177

Belsiyal, C. X., Rentala, S., & Das, A. (2022). Use of therapeutic milieu interventions in a psychiatric setting: A systematic review. *Journal of Education and Health Promotion, 11*, 234. https://doi.org/10.4103/jehp.jehp_1501_21

Bhatia, J. K. (2014). Pica is a culture bound syndrome. *Delhi Psychiatry Journal. 17*(1), 144–147. https://static1.squarespace.com/static/575f16758259b52cea318166/t/5b61fe68575d1fdc0a3987c5/1533148812826/Pica+article.pdf

Białek-Dratwa, A., Szymańska, D., Grajek, M., Krupa-Kotara, K., Szczepańska, E., & Kowalski, O. (2022). ARFID-strategies for dietary management in children. *Nutrients*, *14*(9), 1739. https://doi.org/10.3390/nu14091739

Brelet, L., Flaudias, V., Désert, M., Guillaume, S., Llorca, P. M., & Boirie, Y. (2021). Stigmatization toward people with anorexia nervosa, bulimia nervosa, and binge eating disorder: A scoping review. *Nutrients*, *13*(8), 2834. https://doi.org/10.3390/nu13082834

Brigham, K. S., Manzo, L. D., Eddy, K. T., & Thomas, J. J. (2018). Evaluation and treatment of avoidant/restrictive food intake disorder (ARFID) in adolescents. *Current Pediatrics Reports*, *6*(2), 107–113. https://doi.org/10.1007/s40124-018-0162-y

Calugi, S., Chignola, E., & Dalle Grave, R. (2019). A longitudinal study of eating rituals in clients with anorexia nervosa. *Frontiers in Psychology*, *10*, 15. https://doi.org/10.3389/fpsyg.2019.00015

Cardi, V., Albano, G., Salerno, L., Lo Coco, G., Ambwani, S., Schmidt, U., Macdonald, P., & Treasure, J. (2020). The feasibility of using guided self-help in anorexia nervosa: An analysis of drop-out from the study protocol and intervention adherence. *Frontiers in Psychology*, *11*, 707. https://doi.org/10.3389/fpsyg.2020.00707

Chichester, S., Holmes, T. M., & Hubbard, J. (2021). Ideal body weight: A commentary. *Clinical Nutrition ESPEN*, *46*, 246–250. https://doi.org/10.1016/j.clnesp.2021.09.746

Chung, E. O., Mattah, B., Hickey, M. D., Salmen, C. R., Milne, E. M., Bukusi, E. A., Brashares, J. S., Young, S. L., Fernald, L., & Fiorella, K. J. (2019). Characteristics of pica behavior among mothers around Lake Victoria, Kenya: A cross-sectional study. *International Journal of Environmental Research and Public Health. 16*(14), 2510. https://doi.org/10.3390/ijerph16142510

Corral-Liria, I., Alonso-Maza, M., González-Luis, J., Fernández-Pascual, S., Becerro-de-Bengoa-Vallejo, R., & Losa-Iglesias, M. (2022). Holistic nursing care for people diagnosed with an eating disorder: A qualitative study based on clients and nursing professionals' experience. *Perspectives in Psychiatric Care*, *58*(2), 840–849. https://doi.org/10.1111/ppc.12858

Costandache, G. I., Munteanu, O., Salaru, A., Oroian, B., & Cozmin, M. (2023). An overview of the treatment of eating disorders in adults and adolescents: Pharmacology and psychotherapy. *Postepy Psychiatrii Neurologii, 32*(1), 40–48.

Davis, H., & Attia, E. (2017). Pharmacotherapy of eating disorders. *Current Opinion in Psychiatry*, *30*(6), 452–457. https://doi.org/10.1097/YCO.0000000000000358

Davis, L. E., & Attia, E. (2019). Recent advances in therapies for eating disorders. *F1000Research*, *8*, F1000 Faculty Rev-1693. https://doi.org/10.12688/f1000research.19847.1

Davis, L., Walsh, B. T., Schebendach, J., Glasofer, D. R., & Steinglass, J. E. (2020). Habits are stronger with longer duration of illness and greater severity in anorexia nervosa. *The International Journal of Eating Disorders*, *53*(5), 413–419. https://doi.org/10.1002/eat.23265

De Young, K. P., Lavender, J. M., Wonderlich, S. A., Crosby, R. D., Engel, S. G., Mitchell, J. E., Crow, S., Peterson, C. B., & Le Grange, D. (2013). Moderators of post-binge eating negative emotion in eating disorders. *Journal of Psychiatric Research*, *47*(3), 323–328. https://doi.org/10.1016/j.jpsychires.2012.11.012

di Giacomo, E., Aliberti, F., Pescatore, F., Santorelli, M., Pessina, R., Placenti, V., Colmegna, F., & Clerici, M. (2022). Disentangling binge eating disorder and food addiction: A systematic review and meta-analysis. *Eating and Weight Disorders : EWD*, *27*(6), 1963–1970. https://doi.org/10.1007/s40519-021-01354-7

Ellis, J. M., Essayli, J. H., Zickgraf, H. F., Rossi, J., Hlavka, R., Carels, R. A., & Whited, M. C. (2020). Comparing stigmatizing attitudes toward anorexia nervosa, binge-eating disorder, avoidant-restrictive food intake disorder, and subthreshold eating behaviors in college students. *Eating Behaviors*, *39*, 101443.

Fields, V. L., Soke, G. N., Reynolds, A., Tian, L. H., Wiggins, L., Maenner, M., DiGuiseppi, C., Kral, T. V. E., Hightshoe, K., & Schieve, L. A. (2021). Pica, autism, and other disabilities. *Pediatrics*, *147*(2), e20200462. https://doi.org/10.1542/peds.2020-0462

Giel, K. E., Bulik, C. M., Fernandez-Aranda, F., Hay, P., Keski-Rahkonen, A., Schag, K., Schmidt, U., & Zipfel, S. (2022). Binge eating disorder. *Nature Reviews. Disease Primers*, *8*(1), 16. https://doi.org/10.1038/s41572-022-00344-y

Gorrell, S., & Murray, S. B. (2019). Eating disorders in males. *Child and Adolescent Psychiatric Clinics of North America*, *28*(4), 641–651. https://doi.org/10.1016/j.chc.2019.05.012

Gregorowski, C., Seedat, S., & Jordaan, G. P. (2013). A clinical approach to the assessment and management of co-morbid eating disorders and substance use disorders. *BMC Psychiatry*, *13*, 289. https://doi.org/10.1186/1471-244X-13-289.

Hadad, N. A., & Knackstedt, L. A. (2014). Addicted to palatable foods: Comparing the neurobiology of bulimia nervosa to that of drug addiction. *Psychopharmacology*, *231*(9), 1897–1912. https://doi.org/10.1007/s00213-014-3461-1

Hail, L., & Le Grange, D. (2018). Bulimia nervosa in adolescents: Prevalence and treatment challenges. *Adolescent Health, Medicine and Therapeutics*, *9*, 11–16. https://doi.org/10.2147/AHMT.S135326

Hartley, S., Redmond, T., Berry, K. (2022). Therapeutic relationships within child and adolescent mental health inpatient services: A qualitative exploration of the experiences of young people, family members and nursing staff. *PLoSOne, 17*(1), e0262070. https://doi.org/10.1371/journal.pone.0262070

Hartmann, S., Pruessner, L., Rubel, J. A., Lalk, C., Barnow, S., & Timm, C. (2022). Applying a web-based self-help intervention for bulimia nervosa in routine care: Study protocol for a randomized controlled trial. *Internet Interventions*, *28*, 100512. https://doi.org/10.1016/j.invent.2022.100512

Himmerich, H., Kan, C., Au, K., & Treasure, J. (2021). Pharmacological treatment of eating disorders, comorbid mental health problems, malnutrition and physical health consequences. *Pharmacology & Therapeutics*, *217*, 107667. https://doi.org/10.1016/j.pharmthera.2020.107667

Holland, L. A., Bodell, L. P., & Keel, P. K. (2013). Psychological factors predict eating disorder onset and maintenance at 10-year follow-up. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, *21*(5), 405–410. https://doi.org/10.1002/erv.2241

Hookmani, A. A., Lalani, N., Sultan, N., Zubairi, A., Hussain, A., Hasan, B. S., & Rasheed, M. A. (2021). Development of an on-job mentorship programme to improve nursing experience for enhanced patient experience of compassionate care. *BMC Nursing*, *20*(1), 175. https://doi.org/10.1186/s12912-021-00682-4

Howard, M., Gregertsen, E. C., Hindocha, C., & Serpell, L. (2020). Impulsivity and compulsivity in anorexia and bulimia nervosa: A systematic review. *Psychiatry Research*, *293*, 113354. https://doi.org/10.1016/j.psychres.2020.113354

Iqbal, A., & Rehman, A. (2022). Binge eating disorder. [Updated 2022 Oct 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK551700/

Izydorczyk, B., & Sitnik-Warchulska, K. (2018). Sociocultural appearance standards and risk factors for eating disorders in adolescents and women of various ages. *Frontiers in Psychology*, *9*, 429. https://doi.org/10.3389/fpsyg.2018.00429

Jain, A., & Yilanli, M. (2023). Bulimia nervosa. [Updated 2023 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK562178/

Keel, P. K., Forney, K. J., Brown, T. A., & Heatherton, T. F. (2013). Influence of college peers on disordered eating in women and men at 10-year follow-up. *Journal of Abnormal Psychology*, *122*(1), 105–110. https://doi.org/10.1037/a0030081

Khosravi, M. (2021). Pica behaviors in schizophrenia: a call for further research. *Journal of Eating Disorders*, *9*(1), 117. https://doi.org/10.1186/s40337-021-00472-y

Kit Tan, J. S., Sing Tan, L. E., Davis, C., & Chew, E. S. E. (2022, June). Eating disorders in children and adolescents. *Singapore Medical Journal, 63*(6), 294–298. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9329554/

Kovács-Tóth, B., Oláh, B., Kuritárné Szabó, I., & Fekete, Z. (2023). Psychometric properties of the adverse childhood experiences questionnaire 10 item version (ACE-10) among Hungarian adolescents. *Frontiers in Psychology*, *14*, 1161620. https://doi.org/10.3389/fpsyg.2023.1161620

Kovács-Tóth, B., Oláh, B., Kuritárné Szabó, I., & Túry, F. (2022). Adverse childhood experiences increase the risk for eating disorders among adolescents. *Frontiers in Psychology, 13*. https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2022.1063693

Kusnik, A., & Vaqar, S. Rumination disorder. [Updated 2023 May 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK576404/

Kutz, A. M., Marsh, A. G., Gunderson, C. G., Maguen, S., & Masheb, R. M. (2020). Eating disorder screening: A systematic review and meta-analysis of diagnostic test characteristics of the SCOFF. *Journal of General Internal Medicine*, *35*(3), 885–893. https://doi.org/10.1007/s11606-019-05478-6.

Lev Ari, H. S., Gur, E., Lotan-Wohl, M. Bernstein, Z. L., & Tuval-Mashiach. (2024). Facilitators and obstacles to therapeutic alliance among patients with anorexia nervosa: A qualitative dyadic research. *Counseling and Psychotherapy Research, 24*, 136–153. https://doi.org/10.1002/capr.12617

Liu, H., Burns, R. T., Spencer, B. R., Page, G. P., Mast, A. E., & NHLBI Recipient Epidemiology Donor Evaluation Study (REDS)-III (2021). Demographic, clinical, and biochemical predictors of pica in a large cohort of blood donors.

Transfusion, *61*(7), 2090–2098. https://doi.org/10.1111/trf.16409

Mehler, P. S., & Brown, C. (2015). Anorexia nervosa - medical complications. *Journal of Eating Disorders*, *3*, 11. https://doi.org/10.1186/s40337-015-0040-8

Mereu, A., Fantoni, T., Caini, S., Monzali, F., Roselli, E., Taddei, S., Lucarelli, S., & Pisano, T. (2022). Suicidality in adolescents with onset of anorexia nervosa. *Eating and Weight Disorders: EWD*, *27*(7), 2447–2457. https://doi.org/10.1007/s40519-022-01384-9

Mora, F., Alvarez-Mon, M. A., Fernandez-Rojo, S., Ortega, M. A., Felix-Alcantara, M. P., Morales-Gil, I., Rodriguez-Quiroga, A., Alvarez-Mon, M., & Quintero, J. (2022). Social factors in adolescence and risk of development of eating disorders. *Nutrients*, *14*(7), 1481. https://doi.org/10.3390/nu14071481

Murray, H. B., Juarascio, A. S., Di Lorenzo, C., Drossman, D. A., & Thomas, J. J. (2019). Diagnosis and treatment of rumination syndrome: A critical review. *The American Journal of Gastroenterology*, *114*(4), 562–578. https://doi.org/10.14309/ajg.0000000000000060

National Eating Disorders Association. (2023a). Risk factors. https://www.nationaleatingdisorders.org/risk-factors

National Eating Disorders Association. (2023b). Pica. https://www.nationaleatingdisorders.org/pica

National Institute of Diabetes and Digestive and Kidney Diseases. (2021). Binge eating disorders. Retrieved August 22, 2023, from https://www.niddk.nih.gov/health-information/weight-management/binge-eating-disorder/definition-facts

National Institute of Mental Health. (2023, January). Eating disorders. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/eating-disorders.

Nitsch, A., Dlugosz, H., Gibson, D., & Mehler, P. S. (2021). Medical complications of bulimia nervosa. *Cleveland Clinic Journal of Medicine*, *88*(6), 333–343. https://doi.org/10.3949/ccjm.88a.20168

Oregon Health & Science University Center for Women's Health. (2023). Why are eating disorders on the rise? https://www.ohsu.edu/womens-health/why-are-eating-disorders-rise

Paolacci, S., Kiani, A. K., Manara, E., Beccari, T., Ceccarini, M. R., Stuppia, L., Chiurazzi, P., Dalla Ragione, L., & Bertelli, M. (2020, July). Genetic contributions to the etiology of anorexia nervosa: New perspectives in molecular diagnosis and treatment. *Mol Genet Genomic Med. 8*(7), 1244. https://doi.org/10.1002/mgg3.1244 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7336737/

Peckmezian, T., & Paxton, S. J. (2020). A systematic review of outcomes following residential treatment for eating disorders. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, *28*(3), 246–259. https://doi.org/10.1002/erv.2733

Pennell, A., Webb, C., Agar, P., Federici, A., & Couturier, J. (2019). Implementation of dialectical behavior therapy in a day hospital setting for adolescents with eating disorders. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie Canadienne de Psychiatrie de l'enfant et de l'adolescent*, *28*(1), 21–29.

Perez, M., Van Diest, A. K., & Cutts, S. (2014). Preliminary examination of a mentor-based program for eating disorders. *Journal of Eating Disorders*, *2*(1), 24. https://doi.org/10.1186/s40337-014-0024-0

Presseller, E. K., Clark, K. E., Fojtu, C., & Juarascio, A. S. (2021). An empirical examination of appetite hormones and cognitive and behavioral bulimic symptomatology. *Eating and Weight Disorders: EWD*, *26*(4), 1129–1137. https://doi.org/10.1007/s40519-020-01009-z

Ramsewak, S., Moty, N., Putteeraj, M., Somanah, J., & Nirmala, L. P. (2022). Parenting style and its effect on eating disorders and substance abuse across the young population. *Discover Psychology*, *2*(1), 9. https://doi.org/10.1007/s44202-022-00025-7

Reilly, E., Orloff, N. C., Luo, T., Berner, L., Brown, T. A., Claudat, K., Kaye, W. H., & Anderson, L. K. (2020). Dialectical behavioral therapy for the treatment of adolescent eating disorders: A review of existing work and proposed future directions, *Eating Disorders, 28*(2), 122–141. https://doi.org/10.1002/mgg3.124410.1080/

10640266.2020.1743098

Rikani, A. A., Choudhry, Z., Choudhry, A. M., Ikram, H., Asghar, M. W., Kajal, D., Waheed, A., & Mobassarah, N. J. (2013). A critique of the literature on etiology of eating disorders. *Annals of Neurosciences*, *20*(4), 157–161. https://doi.org/10.5214/ans.0972.7531.200409

Riva, G. (2016). Neurobiology of anorexia nervosa: Serotonin dysfunctions link self-starvation with body image disturbances through an impaired body memory. *Frontiers in Human Neuroscience, 24*. https://www.frontiersin.org/articles/10.3389/fnhum.2016.00600/full

Rnic, K., Dozois, D. J., & Martin, R. A. (2016). Cognitive distortions, humor styles, and depression. *Europe's Journal of Psychology*, *12*(3), 348–362. https://doi.org/10.5964/ejop.v12i3.1118

Rohrbach, P. J., Dingemans, A. E., Spinhoven, P., Van Ginkel, J. R., Fokkema, M., Wilderjans, T. F., Bauer, S., & Van Furth, E. F. (2022). Effectiveness of an online self-help program, expert-patient support, and their combination for eating disorders: Results from a randomized controlled trial. *The International Journal of Eating Disorders*, *55*(10), 1361–1373. https://doi.org/10.1002/eat.23785

Sanzone, M. M. (2011). Collaborative treatment of eating disorders. In: Kapalka, G. (eds) *Pediatricians and pharmacologically trained psychologists*. Springer. https://doi.org/10.1007/978-1-4419-7780-9_10.

Sasegbon, A., Hasan, S. S., Disney, B. R., & Vasant, D. H. (2022). Rumination syndrome: Pathophysiology, diagnosis and practical management. *Frontline Gastroenterology*, *13*(5), 440–446. https://doi.org/10.1136/flgastro-2021-101856

Schaefer, L. M., Anderson, L. M., Simone, M., O'Connor, S. M., Zickgraf, H., Anderson, D. A., Rodgers, R. F., & Thompson, J. K. (2019). Gender-based differential item functioning in measures of eating pathology. *The International Journal of Eating Disorders*, *52*(9), 1047–1051. https://doi.org/10.1002/eat.23126

Schweizer, T. H., Olino, T. M., Dyson, M. W., Laptook, R. S., & Klein, D. N. (2018). Developmental origins of rumination in middle childhood: The roles of early temperament and positive parenting. *Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *47*(sup1), S409–S420. https://doi.org/10.1080/15374416.2017.1359787

Sim, L. A., McAlpine, D. E., Grothe, K. B., Himes, S. M., Cockerill, R. G., & Clark, M. M. (2010). Identification and treatment of eating disorders in the primary care setting. *Mayo Clinic Proceedings*, *85*(8), 746–751. https://doi.org/10.4065/mcp.2010.0070.

Sjögren, M., Lichtenstein, M. B., & Støving, R. K. (2023). Trauma experiences are common in anorexia nervosa and related to eating disorder pathology but do not influence weight-gain during the start of treatment. *Journal of Personalized Medicine*, *13*(5), 709. https://doi.org/10.3390/jpm13050709

Steiger, H., & Booij, L. (2020). Eating disorders, heredity and environmental activation: Getting epigenetic concepts into practice. *Journal of Clinical Medicine*, *9*(5), 1332. https://doi.org/10.3390/jcm9051332

Stiegler, L. (2005). Understanding pica behavior. *Focus on Autism and Other Developmental Disabilities*, *20*, 27–38. https://doi.org/10.1177/10883576050200010301.

Substance Abuse and Mental Health Services Administration. (2016). *DSM-5 changes: Implications for child serious emotional disturbance*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK519712/table/ch3.t18/

Taclob, J. A., Kalas, M. A., Esteban, M. J., Didia, C., & McCallum, R. (2022). Virtual reality and mindfulness approaches in the treatment of rumination syndrome. *ACG Case Reports Journal*, *9*(10), e00871. https://doi.org/10.14309/crj.0000000000000871

Thomas, J. J., Lawson, E. A., Micali, N., Misra, M., Deckersbach, T., & Eddy, K. T. (2017). Avoidant/restrictive food intake disorder: A three-dimensional model of neurobiology with implications for etiology and treatment. *Current Psychiatry Reports*, *19*(8), 54. https://doi.org/10.1007/s11920-017-0795-

Thomas, J. J., Wons, O. B., & Eddy, K. T. (2018). Cognitive-behavioral treatment of avoidant/restrictive food intake disorder. *Current Opinion in Psychiatry*, *31*(6), 425–430. https://doi.org/10.1097/YCO.0000000000000454

Thornton, L. M., Mazzeo, S. E., & Bulik, C. M. (2011). The heritability of eating disorders: Methods and current findings. *Current Topics in Behavioral Neurosciences*, *6*, 141–156. https://doi.org/10.1007/7854_2010_91

Treasure, J., Hübel, C., & Himmerich, H. (2022). The evolving epidemiology and differential etiopathogenesis of eating disorders: Implications for prevention and treatment. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *21*(1), 147–148. https://doi.org/10.1002/wps.20935

U.S. Department of Agriculture. (2023). Myplate. https://www.myplate.gov/eat-healthy/what-is-myplate

Verplanken, B., & Orbell, S. (2003). *Self-report habit index (SRHI)* [Database record]. APA PsycTests. https://doi.org/10.1037/t03772-000

Wyssen, A., Debbeler, L. J., Meyer, A. H., Coelho, J. S., Humbel, N., Schuck, K., Lennertz, J., Messerli-Bürgy, N., Biedert, E., Trier, S. N., Isenschmid, B., Milos, G., Whinyates, K., Schneider, S., & Munsch, S. (2017). Cognitive distortions associated with imagination of the thin ideal: Validation of the thought-shape fusion body questionnaire (TSF-B). *Frontiers in Psychology*, *8*, 2194. https://doi.org/10.3389/fpsyg.2017.02194

Yoon, C. Y., Mason, S. M., Loth, K., & Jacobs, D. R., Jr. (2022). Adverse childhood experiences and disordered eating among middle-aged adults: Findings from the coronary artery risk development in young adults study. *Preventive Medicine*, *162*, 107124. https://doi.org/10.1016/j.ypmed.2022.107124

Zanella, E., & Lee, E. (2022). Integrative review on psychological and social risk and prevention factors of eating disorders including anorexia nervosa and bulimia nervosa: Seven major theories. *Heliyon*, *8*(11), e11422. https://doi.org/10.1016/j.heliyon.2022.e11422

Zugai, J., Stein-Parbury, J., & Roche, M. (2013). Effective nursing care of adolescents with anorexia nervosa: A consumer perspective. *Journal of Clinical Nursing*, *22*(13–14), 2020–2029. https://doi.org/10.1111/jocn.12182

CHAPTER 21
Somatic Symptom Disorders

FIGURE 21.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Somatic symptom and related disorders are fascinating areas of study in the field of psychiatric-mental health nursing, illustrating the complexities of the relationship between mind and body. These disorders encompass a range of conditions where physical symptoms manifest without a clear medical explanation, leading to distress and impairment in daily functioning. By delving into the world of somatic symptom and related disorders, nursing students can gain valuable insights into the delicate interplay between physical health and psychological well-being. These conditions challenge understanding of the mind-body connection. It is the nurse's responsibility to provide holistic care that encompasses both the physical and psychological dimensions of health. This way, nurses can develop the knowledge and skills necessary to approach clients with empathy, respect, and a comprehensive understanding of their unique struggles.

21.1 Psychological and Behavioral Factors in Somatic Symptom Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the *DSM-5-TR* diagnosis relative to somatic symptom disorders and their presentation
- Identify psychosocial and behavioral risk factors for somatic symptom disorders
- Give examples of client symptoms associated with somatic symptom disorders
- Describe stress responses reported by clients due to somatic symptom disorders
- Plan nursing and collaborative care for clients seeking treatment for somatic symptom disorders

Somatic symptom disorder (SSD), formerly known as somatization disorder, is a condition where individuals experience distressing physical symptoms that cannot be explained fully by an underlying medical condition. Somatic symptom disorder presents a unique challenge for health-care professionals because it involves the manifestation of physical symptoms without a clear underlying medical cause.

The nursing role goes beyond addressing physical ailments; it extends to acknowledging and addressing the psychological and emotional dimensions of health. Learning about the relationship between mind and body to understand these complexities is essential for providing compassionate care and supporting individuals with these disorders.

DSM-5 Medical Diagnosis

When a client is focused on physical symptoms to the point of significant distress and disruption of normal functioning, they are considered to have **somatic symptom disorder (SSD)** (American Psychiatric Association [APA], 2022). The term **somatic** means relating to or affecting the body. The physical symptoms experienced by the client may or may not be attributable to an actual physical problem. The defining feature of this diagnosis is the abnormal preoccupation with physical symptoms to the point that it causes distress and interferes with everyday life.

According to the *DSM-5-TR* (APA, 2022), there are three criteria to meet in order for an individual to be diagnosed with somatic symptom disorder:

- one or more somatic symptoms that cause significant distress and interference with daily life
- excessive thoughts about one's symptoms, high-level anxiety about health or symptoms, or disproportionate time and energy spent on symptoms and illness
- presence of symptoms for more than six months

It is estimated that 5 to 7 percent of the population meets criteria for SSD (D'Souza & Hooten, 2023), and it can occur in childhood, adolescence, or adulthood. Women are ten times as likely as men to be diagnosed with SSD. The prevalence of SSD is higher in individuals with functional disorders, including fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome.

LINK TO LEARNING

This case study of a thirty-one-year-old female client (https://openstax.org/r/77SSD) who was ultimately diagnosed with SSD after presenting with multiple complaints illustrates how SSD clients are usually diagnosed after presenting to primary care or emergency care departments, not psychiatric care settings.

People with SSD may be excessively negative about illness and their health and think the worst, even if there is no medical evidence, or there is medical evidence to the contrary. They may avoid physical activity. High levels of **services utilization**, or use of health-care services, may be part of the client's history. This may include trips to multiple providers for the same symptoms. Some clients believe that their medical diagnoses and treatments have been and continue to be inadequate. They may demonstrate increased sensitivity to adverse effects of medication but seemingly show resistance to treatment.

Clients with somatic symptom disorder may have a single complaint, but most often have multiple symptoms contributing to their distress. The top client complaint is pain, but clients may complain of any variety of symptoms, including fatigue, heart palpitations, and more. Somatic symptom disorder frequently occurs alongside other

confirmed medical diagnoses. For example, a person may undergo an uncomplicated hip replacement operation that does not result in any disability from the procedure itself, but become disabled by somatic symptom disorder afterward. Still, many individuals with SSD do not have a confirmed medical diagnosis, yet the physical complaints expressed and experienced by the individual are genuine, regardless of whether there is a medical explanation for it.

Psychosocial and Behavioral Risk Factors

Risk factors for SSD are varied and differ among life stages and cultures. These factors include psychosocial as well as behavioral elements.

Psychosocial Risk Factors

Experiencing adverse events during childhood, such as abuse, neglect, or other traumatic experiences, has been linked to an increased risk of developing somatic symptom disorder (SSD) later in life (D'Souza & Hooten, 2023). Early life stressors can have long-lasting effects on psychological well-being and may contribute to the development of somatic symptoms as a way of coping or expressing distress.

Anxiety and depression are commonly associated with SSD, as is a history of substance misuse. Additionally, certain personality traits may increase the risk of SSD. People with avoidant, paranoid, self-defeating, or obsessive thinking may be more prone to experiencing and focusing on somatic symptoms. Individuals who experience chronic stress, trauma, or have difficulty coping with emotional problems may be more susceptible to developing SSD. Dysfunctional family dynamics, including high levels of conflict, overprotection, or excessive attention to physical symptoms, can contribute to the development of SSD.

Certain cognitive factors and illness beliefs also can contribute to the development and maintenance of SSD. These may include catastrophizing (interpreting mild symptoms as indicative of severe illness), perceiving bodily sensations more intensely, and a tendency to focus on and misinterpret normal bodily sensations as abnormal or indicative of a serious medical condition. These illness beliefs can be formed by social and cultural factors that have influenced the client. Societal beliefs about the legitimacy of physical symptoms and cultural norms related to expressing distress, or the influence of cultural or religious beliefs on illness interpretations can all contribute to the development of SSD.

CULTURAL CONTEXT

Cultural Considerations and Somatic Symptom Disorder

Numerous studies have shown that unexpressed emotions play a notable role in somatic symptom disorder (SSD). The country of Iran has been identified as having a particularly high rate of SSD. The authors of one study found three main obstacles to the expression of emotion in Iran: genderizing of emotion (i.e., defining the expression of emotion as excessively feminine and perceived as fragile), a prohibition on expressing emotions about parents and authority figures, and problems expressing positive emotion.

The authors of the study concluded that because of these cultural barriers, SSD clients in Iran have difficulties directly expressing their emotions. Cultural considerations such as these must always be taken into account when evaluating a client with suspected or diagnosed SSD.

(Vaziri et al., 2019)

Behavioral Risk Factors

Importantly, behavioral factors can both contribute to the development of SSD and influence its persistence. Observing and learning from others' illness behaviors can contribute to the development or reinforcement of SSD. Per Leventhal (2001), illness is experienced as a threat and a need for protection, prompting the person to seek medical care. Family members who model illness behavior, or place excessive focus on physical complaints, may inadvertently reinforce somatic symptoms in individuals. For example, if a person frequently witnesses a family member displaying exaggerated illness behaviors or utilizing excessive health care, they may learn and imitate those behaviors.

People with SSD may frequently seek reassurance from health-care professionals, family members, or friends

regarding their symptoms or concerns. This behavior stems from the need for validation and confirmation that their symptoms are not indicative of a severe medical condition. Seeking reassurance repeatedly can reinforce the focus on symptoms and contribute to the maintenance of SSD. Individuals with SSD may experience **secondary gain**—the inadvertent advantages one receives from an illness—from adopting a sick role, such as receiving attention, sympathy, or support from others, or avoiding responsibilities or stressful situations. These reinforcements can encourage continuation of somatic symptoms.

Behaviors and Symptoms of Clients with SSD

Individuals with somatic symptom disorder (SSD) may adopt maladaptive coping strategies, such as excessive rumination about their symptoms, catastrophizing (interpreting symptoms as indicating a serious illness), or engaging in behaviors that temporarily relieve distress but reinforce the illness belief. One example of this type of behavior would be constantly checking the body for signs of illness.

Preoccupation with Health

Clients with SSD often display a heightened and persistent preoccupation with their health. They may spend excessive time researching medical information, participating in online health forums, or seeking reassurance from health-care professionals to validate their concerns. They also engage in excessive health-care-seeking behavior. They may visit multiple doctors or specialists in search of a diagnosis or treatment for their symptoms, even when medical tests and evaluations show no clear evidence of an underlying medical condition.

Clients with somatic symptom disorder often spend a significant amount of time and energy focused on their symptoms. This can involve constantly monitoring their bodies for any changes, analyzing symptoms, and engaging in excessive self-examination or self-checking behaviors. They may also exhibit exaggerated or dramatic expressions of their physical symptoms. This can involve amplifying the severity or impact of their symptoms during medical consultations or interactions with others, seeking validation or attention.

Avoidance Behaviors

Individuals with SSD may engage in avoidance behaviors that may affect their daily functioning and overall quality of life. They may refrain from physical activity or certain situations that they believe may exacerbate their symptoms. This avoidance can lead to a reduction in daily functioning, social withdrawal, and isolation. The symptoms of SSD can significantly impair an individual's ability to carry out their daily activities and fulfill their responsibilities.

Resist Psychological Explanations

Clients with somatic symptom disorder may resist psychological explanations for their symptoms. They may reject or dismiss the idea that their symptoms have psychological or emotional roots and instead continue to seek physical explanations.

Expression of Pain

Pain is the most cited single complaint among clients with SSD. Some of the specific symptoms reported include muscle and joint pain, back pain, headaches, noncardiac chest pain, heartburn, and irritable bowel. A variety of factors may contribute to SSD-related pain. These include possible genetic and biological vulnerability, such as increased sensitivity to pain.

Expression of Fear

People with SSD may have a heightened emotional response to their physical symptoms, experiencing extreme anxiety, fear, or distress even when the symptoms are mild or temporary. Their reaction may seem excessive or out of proportion to the actual medical severity of the symptoms.

Stress Responses Reported by Clients

Individuals with SSD experience persistent physical and emotional symptoms that are distressing and disruptive to their daily lives. These symptoms may cause pain, discomfort, fatigue, or other physical sensations, resulting in functional impairment and limitations in different aspects of client life. These clients are also likely to experience anxiety, depression, frustration, or fear related to their symptoms. They may worry about the cause of their symptoms, the impact on their health, and the potential for serious underlying conditions. The symptoms may interfere with work or school attendance, social interactions, personal relationships, and recreational activities. The cycle of medical appointments, tests, and treatments brought on by frequent health-care utilization can be

emotionally and financially draining. The level of impairment to the client's daily life can vary from mild to severe, depending on the severity and frequency of the symptoms.

SSD can strain personal relationships. Loved ones may become frustrated or concerned about the persistent focus on physical symptoms, leading to tension. SSD, like many other somatic disorders, can be stigmatized, leading to further challenges for individuals affected by it. There is often a lack of awareness or understanding among the general public, friends and family, and even health-care professionals, which may result in skepticism, dismissal, or blame placed on the individual experiencing the symptoms, and can lead to feelings of isolation and invalidation.

Nursing Care for Clients with SSD

The first step in effective nursing care of a client with SSD is building trust and rapport with the client. Nurses should create a safe and nonjudgmental environment where clients feel comfortable discussing their symptoms and concerns. Demonstrate empathy and active listening skills when interacting with clients. Nurses should validate the client's experiences, concerns, and emotions. It is important for the nurse to remember that clients with SSD are experiencing distress and this distress might not receive validation by medical tests (i.e., stomach upset with no explanation or insight gained from diagnostic testing). Nursing validation by acknowledging the client's distress can help build trust and improve the therapeutic relationship.

Nurses are encouraged to remain aware of professional boundaries and seek clinical guidance in care of clients with SSD. Some clients may have developed dependent behaviors that may be inadvertently reinforced by the nurse. Clients are likely to benefit more from empowerment toward self-care. For example, nurses may tend to spend more time with clients who readily express needs that the nurse can fulfill, strengthening the helping relationship. Nurses should remain aware that the helping relationship also exists when the nurse encourages the client toward self-care and gives honest praise for their efforts.

The nurse should provide the client with accurate information and education about SSD to help them understand the nature of their condition. Explain that SSD is a real illness, and symptoms are not intentionally produced or under the client's conscious control. Offer resources, such as educational materials or support groups, to assist them in learning more about their condition.

One of the more effective strategies for clients dealing with SSD is to "focus on the here and now." By encouraging clients to focus on the present moment, nurses can assist clients in finding relief from their distress and promote a sense of calm and control. Focusing on the here and now emphasizes the present moment and encourages clients to redirect their attention away from distressing or anxious thoughts to the present experience. For example, a nurse may engage a client in grounding exercises, such as deep breathing, guided imagery, or sensory stimulation, to help them anchor themselves in the present and alleviate anxiety or pain.

Work together with the client to establish realistic and attainable goals. Involve the client in their care plan to promote a sense of ownership and engagement. Realize that insight into the condition of SSD may develop slowly or not at all; the ultimate goal should be to restore the client to their optimal level of functioning.

Nursing Assessment

Medical screening tools include client self-report rating scales, which can be combined with the interview to determine symptom burden in order to make a medical diagnosis. When performing a nursing assessment on a client with potential SSD, the nurse must gather a thorough physical and psychiatric history, paying particular attention to the client's symptoms, their onset, duration, and any potential triggers. It is important to approach the process with sensitivity and empathy. Ask the client about their perception of their symptoms, their impact on daily functioning, and any previous medical evaluations or treatments they have undergone. Observe any inconsistencies or incongruence between the reported symptoms and medical findings. Be attentive to the client's emotional responses and their understanding of the mind-body connection.

Assess the client's mental health status, including any history of anxiety, depression, trauma, or other psychiatric disorders. Evaluate their emotional well-being, coping mechanisms, and stress levels. Look for any underlying psychosocial stressors that may contribute to the manifestation or exacerbation of somatic symptoms. Assess their ability to carry out activities of daily living, work, and engage in social interactions. Evaluate the impact of SSD on the client's daily functioning, relationships, and overall quality of life; this will help determine their treatment plan.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Safety for the Client with Somatic Symptom Disorder

The nurse will:

- discuss effective strategies for maintaining and ensuring safe environment, and provide client and family education
- describe factors that can create the therapeutic relationship, such as focusing on the "here and now" and teaching grounding exercises and goal setting
- demonstrate effective therapeutic communication during time with the client by building trust and rapport, and showing empathy and active listening
- communicate observations and concerns to other members of the health-care team by seeking clinical guidance as needed for professional boundaries issues
- value monitoring own performance for optimal therapeutic effect in client empowerment by providing nursing validation of client's concerns
- appreciate client's personal limits regarding ability to manage self-care due to heightened emotional responses to stressors; goal is restoration to optimal level of functioning; insight and coping develop per individual

(Quality and Safety Education for Nurses, 2022)

Approaches to Treating Somatic Disorders

The management of SSD can be complex. Individuals may face challenges in receiving an accurate diagnosis, finding appropriate health-care providers who understand the condition, and accessing effective treatments. The involvement of various health-care professionals, such as primary care physicians, psychiatrists and advance practice providers, psychologists, and other specialists, is necessary to provide comprehensive care. The client should be treated as a partner on the health-care team, and the team should employ a client-centered care approach. As discussed by Agarwal et al. (2020), there are several ways in which the nurse can advocate for the client and assist in finding and evaluating appropriate treatments. The nurse should encourage the client to participate in CBT, an evidence-based psychotherapy that focuses on identifying and modifying the maladaptive thoughts, emotions, and behaviors associated with SSD. Reinforce the benefits of therapy and provide referrals to mental health professionals as needed. Nurses can help the client develop strategies to manage their physical symptoms effectively. Encourage healthy coping mechanisms, such as relaxation techniques, deep breathing exercises, mindfulness, or guided imagery. Collaborating with the health-care team to ensure appropriate pharmacological interventions if indicated (medication management) is a critical nursing function. This may include the use of medications, such as SSRIs to manage associated anxiety or depression that often coexist with SSD. Nurses should also schedule regular appointments to monitor the client's progress, reassess symptoms, and adjust the treatment plan if necessary. Regular check-ins provide an opportunity to reinforce therapeutic interventions and provide ongoing support.

21.2 Functional Neurological Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the *DSM-5-TR* diagnosis relative to functional neurological disorder
- Identify risk factors for functional neurological disorder
- Give examples of client behaviors associated with functional neurological disorder
- Describe stress responses reported by clients due to functional neurological disorder
- Plan nursing and collaborative care for clients in treatment for functional neurological disorder

When clients present with puzzling neurological symptoms that defy traditional medical explanations, intricate connections between the mind and body may be the cause. Nurses encounter individuals experiencing a wide range of symptoms, from unexplained paralysis and tremors to sensory abnormalities and gait disturbances. The hidden connection may be that these symptoms often emerge in response to psychological stress or trauma. The intricacies

of functional neurological disorder call for exploration of the complex relationship between emotions, the brain, and physical health.

Medical Diagnosis

Also known as conversion disorder, **functional neurological disorder (FND)** is a condition where a person experiences neurological symptoms in the form of one or more altered motor or sensory symptoms that cannot be attributed to a specific medical or neurological condition (APA, 2022). In formulating a medical diagnosis of FND, there may or may not be compatibility of the symptoms with a known neurological diagnosis, but clinical findings (lab work, EEG, imaging) are incompatible. Medical evaluations and diagnostic tests may not reveal any underlying medical or neurological cause for the symptoms, and the symptoms experienced by the person may or may not follow typical patterns of known neurological disorders. It is thought that FND symptoms may occur because of a psychological conflict. It is important to note that clients are not intentionally producing symptoms; rather, the production of symptoms is involuntary and unconscious.

It is also important to note that FND can be present in clients with physical illness. Clients with epileptic seizures may also have nonepileptic seizures. And clients with significant and life-threatening physical illnesses may also present with dissociative symptoms and FND symptoms.

LINK TO LEARNING

Though research is ongoing regarding effective therapies, this article tells of a twenty-six-year-old male client who experienced severe neurological symptoms after an assault (https://openstax.org/r/77neurosympt) and how he was ultimately diagnosed with functional neurological disorder.

Risk Factors

Neurologic illness, such as epilepsy, stroke, or migraine, can increase the risk of symptoms of FND (Peeling & Muzio, 2023). Symptoms usually begin suddenly after a stressful experience. Other risk factors for FND include medical illness, dissociative disorder, and personality disorders.

Psychosocial Risk Factors

Psychosocial risk factors can contribute to the development and manifestation of FND. While the exact causes of FND are not fully understood, several psychosocial factors have been associated with an increased risk.

Individuals with a history of traumatic experiences, such as physical or sexual abuse, accidents, or witnessing violence, and those with post-traumatic stress disorder (PTSD) are more likely to develop FND because these conditions can overwhelm an individual's coping mechanisms. High levels of emotional distress, such as anxiety, depression, or unresolved conflicts, increase the vulnerability to FND. Individuals who have difficulty expressing or managing their emotions may unconsciously convert their emotional distress into physical symptoms as a way of coping or communicating their distress. Stressful life events, such as financial difficulties, relationship problems, or major life transitions, can contribute to the development of FND. The experience of acute or chronic stress and the inability to cope effectively with stressors can manifest as physical symptoms.

Certain personality traits or characteristics may increase the risk of FND. Individuals with a high level of neuroticism, perfectionism, or a tendency to internalize stress may be more prone to developing other symptoms affecting thoughts, physical movement, or sensory function. Poor coping strategies, such as avoidance or suppression of emotions, can contribute to the development of FND. Inadequate coping mechanisms may lead to the conversion of emotional distress into physical symptoms as a way of managing internal conflicts or stressors.

One's environment can play a large role in the risk of development of FND in the form of cultural and family systems. Dysfunctional family relationships, high levels of family conflict, or a history of childhood adversity can increase the risk, as can the presence of family members who inadvertently reinforce or encourage the symptoms. Additionally, cultural beliefs about illness, social expectations, and stigma associated with mental health can influence the expression of FND symptoms and can influence how a client perceives, interprets, and addresses symptoms within a particular cultural context (Canna & Seligman, 2020).

Behavioral Risk Factors

Behavioral risk factors for FND can both trigger the onset of the disorder and reinforce the cycle of its continuation. Seeking and receiving reassurance from others, especially regarding physical symptoms, may reinforce the belief that physical symptoms are the only way to gain attention or support, contributing to the maintenance or exacerbation of FND symptoms.

As with SSD, secondary gains associated with assuming the "sick role" can perpetuate FND symptoms. This may include receiving increased attention, sympathy, or support when experiencing physical symptoms, which may be more acceptable than emotional distress. If individuals receive attention or support primarily when they exhibit physical symptoms, they may be more likely to continue expressing those symptoms. This support can unintentionally strengthen the association between emotional distress and physical symptoms.

Maladaptive behaviors and poor coping mechanisms can increase the likelihood of FND symptoms. If individuals lack effective strategies for emotion regulation, they may unconsciously convert psychological distress into physical symptoms as a coping mechanism. This can present in multiple ways, from a client consciously engaging in maladaptive behaviors to a client experiencing trauma and not having the coping skills to respond to the trauma.

It is important to approach the understanding of behavioral risk factors cautiously, as the relationship between behavior and FND is complex, and not all individuals with FND exhibit the same behavioral patterns.

Behaviors and Symptoms Associated with FND

The symptoms associated with FND can be quite complex because they manifest as neurological symptoms that take the form of either altered motor symptoms or sensory symptoms. See the following lists for examples of the most common symptoms (NHS Inform, 2024).

Altered motor symptoms:

- Weakness or paralysis: Partial or complete loss of muscle strength or control in specific body parts, such as an arm or leg
- Abnormal movements: Involuntary movements, such as tremors, jerking, or dystonia (sustained muscle contractions causing abnormal postures)
- Abnormal gait: Difficulty walking or an unusual manner of walking
- Speech difficulties: Trouble speaking or slurred speech
- Swallowing difficulties: Difficulty swallowing or a sensation of a lump in the throat, called **globus**
- Nonepileptic seizures: Also known as **pseudoseizures**, which are seizure-like episodes without the characteristic electrical abnormalities observed in epilepsy on an electroencephalogram (EEG)

Sensory symptoms:

- Numbness or loss of sensation: Decreased or absent sensation in a specific body area
- Vision problems: Blurred vision, tunnel vision, or double vision
- Hearing loss or deafness: Partial or complete loss of hearing without any detectable organic cause
- Loss of touch or pain sensation: Reduced or absent ability to feel touch or pain

Other common behavioral symptoms include:

- a debilitating symptom that begins suddenly
- a history of a psychological problem that gets better after the symptom appears
- a lack of concern that usually occurs with a severe symptom

Stress Responses Reported by Clients

FND carries a wide range of neurological symptoms that can be distressing and debilitating, leading to limitations in mobility, self-care, and overall physical functioning. They may also interfere with activities of daily living and work or school attendance. For this and other reasons, living with FND can be emotionally challenging. Individuals may experience anxiety, depression, frustration, or a sense of loss due to the effect of symptoms on their daily lives.

The uncertainty surrounding the symptoms and the difficulty obtaining a clear medical explanation can contribute to heightened anxiety and distress. Clients can also experience distress when getting results from medical tests,

especially if the medical tests do not validate their physical symptoms. FND can lead to a sense of self-doubt and identity issues for clients. They may question the legitimacy of their symptoms, feel invalidated by others, or struggle with the dichotomy between physical symptoms and the absence of an identifiable medical cause. This can have a profound impact on self-esteem, self-image, and overall identity. Also, the stigma associated with functional disorders can further exacerbate emotional distress.

FND can strain personal relationships because loved ones may struggle to understand or accept the nature of the symptoms. The unpredictable nature of symptoms can lead to frustration, confusion, or feelings of helplessness among family members and friends. This may result in social isolation, as individuals with FND may withdraw from social activities due to embarrassment, fear of judgment, or limitations imposed by their symptoms.

FND symptoms can interfere with work or educational activities, leading to absenteeism, reduced productivity, or the need for accommodations. The impact on occupational functioning can result in financial difficulties, loss of employment opportunities, and diminished career prospects. Similarly, students with FND may face challenges in attending classes, completing assignments, and maintaining academic progress.

Individuals with FND often seek medical care from multiple health-care providers in an attempt to find an explanation or treatment for their symptoms. This can result in a long, expensive, and frustrating diagnostic journey, with frequent medical appointments, tests, and treatments. The fragmented nature of health care and the lack of awareness about FND among some health-care professionals can lead to stressful delays from appropriate diagnosis and treatment.

Nursing Care for Functional Neurological Disorder

FND is a medical condition classified by the *DSM-5*. As with other somatic symptom–related disorders, nursing care for FND begins with a caring and nonjudgmental approach to establish trust and rapport. The nurse should provide the client with accurate information about FND to help them understand the nature of their condition. Explain that FND is a real illness, that the client is not intentionally producing symptoms, and that they are not under the client's conscious control. Providing emotional support and reassurance to the individual is important because FND can be a chronic and debilitating condition.

Nurses should advocate for clients' needs and assist them in accessing appropriate resources and support groups. Work together with the individual to set realistic goals for their care. Involve them in decision-making processes and encourage their active participation in their treatment plan for best outcomes. Nurses can also help ensure continuity of care by maintaining regular communication with the individual and the health-care team. Monitor their progress, adjust the care plan as needed, and provide ongoing support throughout their journey.

REAL RN STORIES

Nurse: Jamila, RN
Years in Practice: Five
Clinical Setting: Charge nurse on a neurology floor at a large tertiary care hospital
Geographic Location: Major metropolitan area

Our neurology floor is large, and we care for a diverse population. We have a special epilepsy monitoring unit, which consists of eight client rooms with special equipment used for monitoring clients for seizures. These clients are planned admissions. They come in and stay for several days, attached to a continuous EEG that is monitored by clinicians who can interpret the client's brain activity. Clients are also monitored visually by camera around the clock for their own safety. If they are on any seizure medications, they are usually discontinued in advance of their stay, and we do not give them any while they're in the hospital unless there is an emergency and the clinician orders something.

Clients with confirmed epilepsy are sometimes admitted and their EEG studied in order to adjust their seizure medications to provide better control over their illness. Many of the clients in our epilepsy monitoring unit are admitted, however, because of suspected functional neurological disorder, or having psychogenic nonepileptic seizures (PNES). These seizures don't result from electrical activity in the brain but instead from psychological

distress. So, when the client has one of these seizures, it will not register on the EEG like an epileptic seizure.

One afternoon I was called to a client's room and told they wanted to speak to the charge nurse. The client was a thirty-six-year-old female who had been on the epilepsy monitoring unit for four days and, based on her clinical assessments and testing, she appeared to be having nonepileptic seizures. She was tearful and angry when I entered the room. She informed me that she had heard two employees talking in the hallway right outside her door. One of the employees mentioned to the other that the client was not having "real" seizures and was, instead, "faking" them to get attention. The client was hurt and offended and felt like nursing staff did not believe her. She felt like she could no longer trust nursing staff with her care. I assured the client that we did care about her and as a unit were invested in providing her with accepting and nonjudgmental care. I told her that her nonepileptic seizures did not mean she was "faking it" and told her that I would provide her with some client education regarding functional neurological disorder. I also told her that I would educate all of the nurses on the floor to ensure they were providing understanding, supportive, and nonjudgmental care.

The client was still hurt but thanked me for listening to her. I spoke with both staff members who were involved individually. I provided them with information on FND and educated them on why clients are not "faking it." Both staff members chose to apologize to the client, which she appreciated. I also made sure to lead staff huddles each shift for the rest of the week to provide the staff with education on FND and to ensure that they were not talking about clients in the hallway. FND is a psychiatric disorder and nurses will not encounter it in everyday medical client care; they should be educated on its signs and symptoms and how to educate clients and staff on how to manage it.

Nursing Assessment

The nurse should approach the assessment of the FND client with a comprehensive and compassionate mindset. Perform a thorough physical and psychological assessment to understand the client's symptoms, their impact on daily functioning, and any underlying emotional or psychological factors contributing to the symptoms. Evaluate the client's mental health status, including any history of anxiety, depression, or trauma. Assess their emotional well-being, coping strategies, and levels of stress.

Obtain a detailed history of the client's symptoms, including their onset, duration, and any potential triggers or stressors. Ask the client about their perception of their symptoms and any previous medical evaluations or treatments they have undergone. Assess the specific neurological symptoms experienced by the client, such as motor abnormalities, sensory disturbances, or nonepileptic seizures. Perform a thorough physical examination to rule out any organic causes of the client's symptoms. Pay close attention to neurological findings, reflexes, and coordination. Observe and document the characteristics of these symptoms, including their frequency, duration, and any pattern or association with emotional or psychological factors.

Some assessment tools used within the interdisciplinary team may include observation of specific body regions and functions, or interviews with the client to evaluate improvements, such as the Simplified Functional Movement Disorders Rating Scale (S-FMDRS), and the Clinical Global Impression (CGI) scale (Keatley & Molton, 2022).

Assess the impact of FND on the client's daily functioning, relationships, and overall quality of life. Explore any occupational, social, or personal difficulties they may be experiencing as a result of their symptoms. This assessment helps guide the development of individualized care plans. Observe boundaries within the therapeutic relationship so as not to reinforce behaviors.

Approaches to Treating Functional Neurological Disorder

Managing FND is complex. As with many somatic disorders, individuals may face challenges in receiving an accurate diagnosis, finding appropriate health-care providers who understand the condition, and accessing effective treatments (Keatley & Molton, 2022). Education helps clients understand the nature of their symptoms, the mind-body connection, and the absence of an underlying organic pathology. By increasing clients' knowledge and understanding, nurses can empower them to participate in their treatment and self-management.

CBT is an evidence-based psychological therapy used in the treatment of FND. It aims to address maladaptive thoughts, emotions, and behaviors associated with FND. By targeting anxiety, fear, and avoidance behaviors, CBT can help clients regain control over their symptoms and improve overall functioning.

Physical therapy plays a crucial role in the treatment of FND. It focuses on improving physical functioning and

minimizing functional limitations caused by FND symptoms. Rehabilitation programs also emphasize functional restoration and quality of life. And while medications are not typically used as the primary treatment for FND, they may work to address comorbid psychiatric conditions, such as anxiety or depression.

Importantly, collaboration among health-care professionals, including nurses, physicians and advance practice providers, psychologists, physical therapists, and occupational therapists, is vital in managing FND. A coordinated and integrated approach centered around the client ensures a holistic treatment plan tailored to the needs of the individual. Regular communication, joint treatment planning, and shared decision-making help optimize outcomes and promote continuity of care.

21.3 Factitious Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the *DSM-5-TR* diagnosis relative to factitious disorder
- Identify risk factors for factitious disorder
- Give examples of client symptoms and behaviors associated with factitious disorder
- Describe stress responses of clients due to types of factitious disorder
- Plan nursing and collaborative care for clients seeking treatment for factitious disorder

Factitious disorder and its counterpart, factitious disorder imposed on another, involve individuals who feign illness or intentionally make others believe they are sick. Factitious disorder, also known as Munchausen syndrome (named after Baron von Munchausen, a German military officer who was a "teller of tall tales"), is characterized by a desire for attention and validation through self-inflicted illness. Meanwhile, factitious disorder imposed on another, formerly known as Munchausen by proxy, involves caregivers who fabricate or induce illness in another person, often their own child. This part of the chapter delves into the psychology behind these behaviors, covers assessment skills to identify factitious behavior, and touches upon the ethical challenges that arise in providing care for individuals with these disorders.

Medical Diagnosis

The mental health condition in which individuals intentionally and consciously fabricate or induce physical or psychological symptoms in themselves or another is called **factitious disorder**. The primary motivation behind this behavior is to assume the role of a client or caregiver and receive medical attention, sympathy, or support. The defining feature of factitious disorder is the conscious fabrication or induction of symptoms with no external incentives, such as financial gain. There are two main types of factitious disorder (Carnahan & Jha, 2023; Cleveland Clinic, 2021). Factitious disorder imposed on self involves individuals who purposely exaggerate, simulate, or self-inflict physical or psychological symptoms to assume the sick role. They may go to great lengths to deceive medical professionals, including faking or inducing symptoms, manipulating medical tests, or even undergoing unnecessary medical procedures. The underlying motive is to obtain medical care, attention, and validation for their concerns. The condition in which an individual intentionally causes illness or symptoms in another person under their care, often a dependent, such as a child, older parent, or other vulnerable individual, even a pet, is called **factitious disorder imposed on another (FDIA)**. The person with factitious disorder imposed on another may falsify symptoms, tamper with medical tests, administer medications or substances, or engage in other deceptive behaviors to make the dependent appear, become, or remain sick. The motivation may be to gain attention, sympathy, or a sense of control in the caregiver role, or even to obtain controlled substances.

LINK TO LEARNING

This case study investigated factitious disorder on the internet (https://openstax.org/r/77factitiousdis) with online behavior of a member of a breast cancer support group.

Risk Factors for Factitious Disorder

The risk factors for factitious disorder are multifactorial but center around a history of childhood trauma as well as attention-seeking behavior. Known risk factors are limited because obtaining reliable data is difficult due to the

nature of factitious disorder.

LINK TO LEARNING

Visit this website for further information regarding the two main types of factitious disorder (https://openstax.org/r/77factitioustyp) provided by the Cleveland Clinic.

Psychosocial Risk Factors

Adverse experiences during childhood, such as abuse, neglect, or significant disruptions in attachment, have been associated with an increased risk of developing factitious disorder. These adverse experiences can impact an individual's emotional development, self-esteem, and coping mechanisms, potentially leading to the development of maladaptive behaviors to gain attention or control.

Individuals with factitious disorder often have a strong need for attention and validation. They may feel a sense of emptiness, insecurity, or low self-worth and use the fabricated symptoms or illness as a way to receive the attention and care they desire. If the individual has experienced positive reinforcement, such as sympathy or validation for displaying symptoms or illness behavior, they may be more likely to develop factitious disorder.

Certain personality traits may increase the susceptibility to developing factitious disorder. Individuals with histrionic personality traits, for example, may have a strong need for attention, drama, and a desire to be the center of attention. Other characteristics, such as narcissistic traits or borderline personality disorder, may also play a role in seeking attention and validation through the fabrication of symptoms. Difficulties in regulating and expressing emotions can also contribute to the development of factitious disorder as can depression and poor self-esteem. Individuals may use the fabrication of symptoms or illness as a way to cope with unresolved emotional pain, distress, or to avoid other challenging life situations.

Behavioral Risk Factors

Behavioral risk factors for factitious disorder refer to specific behaviors or patterns of behavior that may increase the likelihood of developing or maintaining the disorder, such as:

- childhood trauma, such as emotional, physical, or sexual abuse
- a serious illness during childhood
- the loss of a loved one through death, illness, or abandonment
- past experiences during a time of sickness and the attention it brought
- the desire to be associated with doctors or medical centers
- work in the health-care field (Mayo Clinic, 2019)

Some individuals who assume the caregiver role for someone with a genuine illness or disability may develop factitious disorder imposed on another as a way to maintain their involvement in the medical system, gain attention, or fulfill a need for control. This may occur when the individual feels threatened by the improvement or recovery of the person for whom they are caring.

Behaviors and Symptoms of Factitious Disorder

Individuals with factitious disorder engage in deceptive behaviors to fabricate or induce symptoms. They may exaggerate existing symptoms, simulate new symptoms, or tamper with medical tests to maintain the appearance of illness. Deception and manipulation become habitual and central to their behaviors, serving as a means to assume the sick role and receive attention or care. Individuals with factitious disorder tend to be resistant to disclosing the truth about their fabricated symptoms. They may be evasive or provide inconsistent information during medical evaluations, making it challenging for health-care providers to reach an accurate diagnosis. This reluctance to reveal the truth perpetuates the cycle of deception and maintains their identity as a client.

Individuals with factitious disorder may establish a close relationship with health-care professionals, seeking their approval, validation, and attention. They may exhibit ingratiating behaviors, such as excessive praise, flattery, or compliance, to maintain a favorable rapport with medical staff. This behavior is aimed at reinforcing the perception of being a cooperative and deserving client.

Individuals with factitious disorder may persist in their deceptive behaviors despite negative consequences, such as repeated medical evaluations, exposure to unnecessary treatments or procedures, financial strain, or difficult relationships with health-care providers and loved ones. Their desire for attention and validation overrides concerns about the potential harm caused by their actions.

It is important to note that factitious disorder is different from **malingering**, where individuals feign symptoms for external incentives, such as financial compensation or avoiding legal responsibilities. Individuals with factitious disorder feign symptoms for intrinsic incentives, such as attention and validation from health-care providers or others.

The symptoms of factitious disorder can vary depending on the individual and the specific presentation of the disorder. Some individuals with factitious disorder go beyond fabrication and actually induce physical or psychological symptoms in themselves. They may engage in self-harm or self-poisoning, deliberately manipulate their body to create physical signs of illness or injury, or intentionally cause themselves pain or discomfort.

Individuals with factitious disorder often possess wide-ranging knowledge of medical conditions, procedures, and treatments. They may acquire this knowledge through personal experience, professional background in health care, or extensive research. This knowledge enables them to present their symptoms convincingly, manipulate medical professionals, and navigate the health-care system to their advantage.

Stress Responses

Stress responses are broken down into those experienced by clients with factitious disorder and those diagnosed and involved with factitious disorder imposed on another; they can vary widely.

Stress Responses in Factitious Disorder

Maintaining a facade of illness and deception can negatively affect relationships with family, friends, and health-care providers. Loved ones may become frustrated, confused, or even distrustful as they try to understand the motivations behind the client's behavior. Health-care providers may also feel frustrated or deceived, which can impact the quality of care and support they provide. Individuals with factitious disorder may isolate themselves or become alienated from others due to the complexities and secrecy surrounding their condition. They may fear discovery or judgment, leading to social withdrawal and a sense of isolation. This isolation can exacerbate feelings of loneliness and reinforce the cycle of seeking medical attention as a primary source of social interaction.

The extensive medical attention sought by individuals with factitious disorder can result in frequent absences from work, loss of employment, or financial strain. Hospitalizations, medical tests, and treatments can disrupt employment stability and financial security. Additionally, the financial burden of unnecessary medical expenses can accumulate over time.

Factitious disorder is often associated with underlying psychological distress. The motivations behind the disorder may be rooted in unresolved emotional pain, trauma, low self-esteem, or a need for control or validation. These underlying psychological issues can contribute to ongoing distress, self-doubt, and a diminished sense of self-worth if left untreated.

Stress Responses in Factitious Disorder Imposed on Another

Factitious disorder imposed on another is a serious form of factitious disorder that can have profound and devastating effects on the lives of both the victim and the perpetrator. Here's how factitious disorder imposed on another affects the lives of clients and others involved:

Impact on the victim includes the following (Cleveland Clinic, 2021):

- Physical and emotional harm: The victim, usually a child or vulnerable adult, is subjected to unnecessary medical procedures, treatments, and interventions. This can cause physical harm, pain, and distress, potentially leading to long-term health complications.
- Medical trauma: Repeated medical evaluations, hospitalizations, and invasive procedures can lead to medical trauma for the victim. They may develop a fear or aversion to medical settings and procedures, which can have lasting psychological and emotional consequences.
- Disrupted development: Factitious disorder imposed on another can disrupt a child's physical, emotional, and social development. It may compromise their normal developmental milestones, and they may experience

delays in education, socialization, and overall growth.

Impact on the perpetrator includes the following:

- Legal consequences: Perpetrators of factitious disorder imposed on another can face legal repercussions for their actions. They may be charged with child abuse, neglect, or other criminal offenses, like battery. Legal interventions, child protective services, and court proceedings may be involved to ensure the safety and well-being of the victim.
- Loss of trust and relationships: Factitious disorder imposed on another can lead to a breakdown of trust and relationships for the perpetrator. Friends, family members, employers, and health-care providers may become aware of the deception and may distance themselves from the individual. The perpetrator may face significant social isolation and stigmatization.

Impact on family and support systems includes the following:

- Family dynamics: Factitious disorder imposed on another can severely disrupt family dynamics and relationships. Other family members may be unaware of the deception or may become complicit in it, leading to strained relationships and conflicts within the family.
- Emotional distress: Family members who discover the truth may experience significant emotional distress, ranging from shock and disbelief to guilt, anger, and betrayal. The revelation of such abuse can have a profound and lasting impact on their emotional well-being.
- Need for support and healing: The entire family may require therapeutic support and counseling to heal from the trauma and to rebuild trust and healthy relationships. Support systems, including mental health professionals and support groups, can play a vital role in facilitating the healing process.

Nursing Care

Building trust and rapport with the client is a crucial first step in the care of the client with factitious disorder, even though the client's behaviors may seem deceptive. Nurses should create a nonjudgmental and empathetic environment where clients feel safe discussing their concerns, while still setting clear boundaries and limits with the client. Nurses are cautioned to remain aware of personal involvement.

The goal of treatment is to replace maladaptive attention-seeking behavior with positive behaviors. Treatment usually involves long-term psychotherapy. Nurses can offer stress coping skills as alternatives to expression of illness symptoms.

PSYCHOSOCIAL CONSIDERATIONS

Client Empowerment

In this scenario, the nurse builds trust with a client with factitious disorder while still maintaining clear boundaries.

Nurse: Good morning, AJ, how was your night?

Client: Another sleepless eight hours! I guess I just don't deserve a good night's sleep!

Nurse: You don't deserve it?

Client: Well, I can't catch a break in any part of my life, why would sleep be any different?

Nurse: (using silence and active listening)

Client: Hey nurse, you said you were here to help me, right? Like get the doctor to give me something at bedtime? Or maybe you could, you know, just get me something?

Nurse: Sounds like this is a problem for you, is that accurate?

Client: Yes, it is! If you're not going to help me, just say so.

Nurse: AJ, I support your concern. Let's review the plan we discussed together. We talked about some relaxation techniques. You had some suggestions.

Client: Oh, yeah, I was going to try meditation . . .

Nursing Assessment

Begin by gathering a thorough medical history, including past hospitalizations, surgeries, and treatments. Pay attention to inconsistencies or discrepancies in their reported medical history and observe any discrepancies between reported symptoms and medical findings. Inquire about their health-care-seeking behaviors, including frequent visits to different health-care providers or hospitals. In factitious disorder imposed on another, the abuser is the client. This disorder is a form of maltreatment toward a child, adult, or elder. The recipient of actions by the abuser may also experience mental illness due to the abuse.

Observe the client's behavior and physical presentation during the assessment. Note any indications of intentionally induced symptoms or fabrication of symptoms. Be attentive to any evidence of self-harm or manipulation of medical devices or test results. Assess the client's mental health status, including any history of personality disorders, past trauma, or emotional distress. Evaluate their understanding of the mind-body connection and their motivations for seeking medical attention. Observe for any signs of secondary gain, such as attention-seeking behavior or a desire to assume the "sick role."

Collaborate with other health-care professionals, such as psychiatrists or social workers, to gather additional information and perspectives. Seek collateral information from family members, friends, or previous health-care providers to validate or refute the client's reported medical history and behaviors.

Throughout the assessment, maintain a professional and nonjudgmental approach. Document all observations and findings accurately and objectively. Clients may sometimes withhold information, lack trust, or be fearful. Some clients will pause the assessment and ask the nurse's opinion on past or present treatment options, choices in their care, or for the nurse to provide a diagnosis. The nurse should respond to the client's questions by acknowledging their feelings and educating the client on the treatment process. The nurse can reflect upon the client's own words, such as, "You mentioned you have a therapist you like," or, "You shared with me that your Dad offered you a place to live." This identifies the client's strengths and encourages the client's participation.

Approaches to Treating Factitious Disorders

According to Weber (2023), a multidisciplinary approach is most effective when treating factitious disorder. Nurses should engage in collaboration with psychiatrists and primary care providers, social service professionals, and therapists. The client's family members are included. A multidisciplinary approach allows for comprehensive assessment, coordinated treatment planning, and ongoing support for the client. Regular communication and information sharing are vital to ensuring a consistent and integrated approach to care.

It is crucial to address any underlying psychiatric conditions, such as personality disorders or trauma-related disorders, that may contribute to the development or maintenance of factitious disorder. Treating co-occurring mental health conditions can help improve overall well-being and decrease the motivation for engaging in deceptive behaviors. Psychotherapy, particularly CBT, can be especially beneficial in treating factitious disorder. CBT aims to address the underlying psychological factors and motivations that drive behavior. It helps clients identify and modify unhelpful thoughts, beliefs, and behaviors associated with factitious disorder. Therapy can also focus on developing healthier coping mechanisms and addressing underlying emotional distress or trauma.

Providing a supportive and nonjudgmental environment is also critical when treating factitious disorder. Nurses can play a key role in building trust, establishing therapeutic relationships, and demonstrating empathy toward the client. By creating a safe space for open communication, clients may feel more comfortable sharing their motivations and experiences, which can aid in treatment progress.

Nurses can also assist by providing education about factitious disorder to help clients gain insight into their behavior and understand the potential consequences of their actions. By increasing their knowledge and awareness, clients may be more motivated to engage in treatment and make positive changes. Education can also be extended to family members or caregivers to help them better understand the condition and provide appropriate support.

As discussed in Mood Disorders and Suicide, potential for self-harm is part of the mental health assessment. Client safety is a high priority in nursing care of clients with factitious disorder, or factitious disorder imposed on another. Social and Emotional Concerns presents the legal responsibility of the nurse, as a mandatory reporter, to report

suspected or known abuse and neglect.

Setting clear boundaries and limits is essential in managing factitious disorder. Health-care providers must establish guidelines for appropriate care and interventions, such as planning with the client which topics to be discussed during therapy sessions or nursing interactions. Consistent monitoring, strict adherence to protocols, and verifying information can help prevent unnecessary procedures or treatments, and assist to resolve factitious behavior.

PSYCHOSOCIAL CONSIDERATIONS

Factitious Disorder Imposed on Another

Nursing care for factitious disorder imposed on another is a highly complex and challenging situation. It involves a caregiver, typically a parent, intentionally fabricating or causing illness in a child or other dependent person to assume the sick role and seek medical attention. Here are some important considerations for nursing care in these cases:

- Recognize the signs: Nurses should be vigilant in recognizing the signs and symptoms of factitious disorder imposed on another. These may include inconsistent or unexplained medical presentations, failure to respond to treatment, unusual symptoms, and a history of multiple hospitalizations or medical interventions.
- Protect the victim: The primary focus in these cases is to ensure the safety and well-being of the victim. If there are concerns of abuse or neglect, follow appropriate reporting protocols and involve the appropriate protective services.
- Collaborate with the health-care team: Work closely with the health-care team, including physicians and advanced practice providers, child protection specialists, social workers, and psychologists, to develop a comprehensive approach to care. Collaboration and regular communication are crucial for the welfare of the vulnerable party and the effectiveness of interventions.
- Gather information: Obtain information from multiple sources, such as previous medical records, other health-care providers, and school personnel, to gain a comprehensive understanding of the victim's medical history and potential discrepancies or inconsistencies.
- Document carefully: Maintain accurate and detailed documentation of all assessments, interventions, and observations. This documentation is essential for the continuity of care, legal purposes, and the well-being of the victim.
- Focus on the victim's needs: Provide appropriate medical care and support for the victim's genuine health needs while avoiding unnecessary interventions related to fabricated or induced symptoms. The victim's well-being should always be the top priority.
- Monitor and observe: Continuously monitor the victim's condition and response to treatment. Be vigilant for any signs of the caregiver's interference or manipulation of medical information or treatment.
- Educate and support the family: Provide education and support to family members, including the caregiver, to help them understand the disorder and its consequences. Offer resources for psychological support and therapy to address underlying psychological factors.
- Promote safety and security: Create a safe and supportive environment for the victim and the family. Ensure that appropriate security measures are in place to prevent further harm or manipulation.
- Ethical considerations: Recognize and address the ethical dilemmas that arise in caring for child victims. Balancing the provision of appropriate care, protecting the victim's well-being, and addressing legal and ethical considerations can be complex. Consult with the health-care team, follow institutional protocols, and seek guidance from ethics committees as needed.
- Legal and child protection involvement: Cooperate with legal authorities and child or adult protection agencies. Provide accurate and objective information to aid in the investigation and protection of the victim.
- Ongoing assessment and support: Nursing care for factitious disorder imposed on another requires ongoing assessment and vigilance. Continuously evaluate the victim's progress, collaborate with the health-care team, and provide support for the victim and family during and after interventions.

It is important to note that nursing care for factitious disorder imposed on another is highly complex and requires a multidisciplinary approach. The primary goal is to protect the victim from harm and provide appropriate care while

addressing the underlying psychological factors contributing to the caregiver's behavior.

(Zaky, 2015)

21.4 Illness Anxiety Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss *DSM-5-TR* diagnosis relative to illness anxiety disorder
- Identify risk factors for illness anxiety disorder
- Give examples of client symptoms and behaviors associated with illness anxiety disorder
- Describe stress responses reported by clients due to illness anxiety disorder
- Plan nursing and collaborative care for clients in treatment for illness anxiety disorder

Illness anxiety disorder is a condition that also involves the complex relationship between physical health and psychological well-being. Nurses' understanding of illness anxiety disorder is essential for providing compassionate care and support to individuals who experience excessive worry and anxiety about their health. This section discusses the details of illness anxiety disorder, examining its causes, symptoms, and impact on individuals' lives. It explores evidence-based nursing interventions and strategies that can empower nurses to assist individuals in managing their health anxieties, promoting their overall well-being, and fostering a therapeutic relationship grounded in empathy and understanding.

Medical Diagnosis

The mental health condition characterized by excessive worry and fear about having a serious medical condition, despite having little or no medical evidence to support the belief, is called **illness anxiety disorder (IAD)**. With illness anxiety disorder, somatic symptoms are not present, or if they are, are mild in intensity. The client's concerns persist despite lack of symptoms and despite medical reassurance, and often cause significant distress and impairment in daily functioning. The key features/diagnostic criteria of illness anxiety disorder include:

- illness preoccupation must be present for six months for diagnosis
- clients often misinterpreting or exaggerating normal bodily sensations, such as dizziness or belching, as evidence of an underlying illness
- excessive health-related behaviors done as a result of their fears and driven by the need for reassurance and validation of their concerns
- high levels of anxiety, distress, and preoccupation with illness that impairs their ability to function normally in various aspects of daily life
- seeking out multiple, different providers for various opinions or exhibiting avoidance behaviors due to fears about a "worst-case scenario" diagnosis or being dismissed as overly anxious
- excessive reassurance-seeking, which either briefly decreases or fails to decrease their anxiety
- heightened awareness and continuous self-examination for signs and symptoms of illness

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2019)

Risk Factors

The risk factors for illness anxiety disorder include a history of trauma, learned behavior, and stress. History of experience with serious illness also increases the likelihood of developing IAD.

Psychosocial Risk Factors

Certain developmental and familial factors may increase the likelihood of developing illness anxiety disorder, such as traumatic experiences in childhood. Having a family member with a history of anxiety disorders or somatic symptom disorders may also increase the likelihood of developing illness anxiety disorder. Observing family members or close friends who exhibit excessive health concerns or engage in frequent doctor visits for minor issues can also influence its development.

Constant exposure in the home environment to medical information, particularly from the internet or media, can lead to excessive health-related concerns. Misinterpretation of medical information or exposure to stories of severe

illnesses from family or others can fuel anxiety and hypervigilance.

Specific personality traits and coping styles may be associated with a higher risk of developing illness anxiety disorder. These include high levels of anxiety, neuroticism, and a tendency to catastrophize or amplify physical sensations. Significant life stressors, such as major life changes, job loss, relationship difficulties, or financial problems, can contribute to the onset or worsening of illness anxiety disorder, especially in those with poor coping skills.

Negative experiences with the health-care system, such as misdiagnosis or inadequate medical care, may contribute to the development of illness anxiety disorder. Additionally, individuals who have experienced a genuine medical condition in the past may develop a heightened fear of recurrence or new illnesses.

Behavioral Risk Factors

Certain behaviors may predate, reinforce, and maintain excessive health concerns. Individuals with illness anxiety disorder have often engaged in other excessive behaviors, such as worrying and seeking reassurance from others. People with illness anxiety disorder may spend excessive time online researching medical conditions or diseases, contributing to IAD. Misinterpretation of information or exposure to alarming stories can further fuel anxiety.

Behaviors and Symptoms Associated with Illness Anxiety Disorder

Individuals with illness anxiety disorder may frequently schedule medical appointments, seeking validation or reassurance about their perceived symptoms. They may consult multiple health-care providers or request numerous diagnostic tests and procedures, even in the absence of medical indications. Yet while some clients with illness anxiety disorder actively seek out medical information, others may avoid it altogether to prevent further anxiety or triggering their health-related worries. They may avoid reading or watching news about diseases or medical conditions because it can increase their anxiety and reinforce their fears.

People with illness anxiety disorder tend to be hyperaware of bodily sensations and may interpret normal bodily functions as signs of a severe illness. They may constantly monitor their bodies for any perceived abnormalities and attribute them to serious medical conditions. Individuals with IAD often seek reassurance from others, including health-care professionals, family members, or friends, regarding their health concerns. They may repeatedly ask for confirmation that their symptoms are not indicative of a serious illness.

The preoccupation and anxiety associated with illness anxiety disorder can significantly affect a person's daily functioning. They may experience difficulty concentrating on tasks, have impaired social interactions due to excessive health-related discussions, or experience interference in work or relationships. Some individuals with illness anxiety disorder may develop strict routines or rituals that provide a sense of control and temporary relief from stressors and concerns.

CLINICAL JUDGMENT MEASUREMENT MODEL

Recognizing and Analyzing Cues: Illness Anxiety Disorder

Dimi is a thirty-five-year-old female referred to psychiatry from the hospital emergency department (ED) where she presented demanding diagnostic imaging. The client stated that she was fired from her job for attendance and performance issues and wanted to have "proof" to take to the employer. Before meeting Dimi in the mental health unit admission room, the nurse reviews the electronic record from the ED, noting client vital signs and other examination elements to be normal, except for heart rate of 106. The nurse plans to spend an hour completing the admission interview and assessment while establishing a therapeutic relationship with the client.

The nurse introduces themself, describes the environment, asks the client to share what has brought her here today, and begins the nursing data collection.

Client's responses: "Well, I was fired because of my health problems. I know I have some disease and I'm tired all the time and I need a special diet because of my medical problems. I have a lot of doctor's appointments, so I miss work. I live by myself and I really can't date or go out because I never know how I'll be feeling. I've lost three jobs this year."

The client begins to cry, and the nurse offers her some tissues and waits for her to continue.

"I just really don't want to have cancer or something bad! I can't help it if I'm sick, can I? Doctors don't listen to you! I can't find one I really like. They do a bunch of tests, but they never find anything. I go online and I see those commercials and I know I have something wrong with me!"

The client is restless in the chair, wringing hands, shaking head. "I try to keep my mind off it . . ."

The nurse collects the data as listed in Table 21.1.

Recognized Cues from Assessment	Nursing Thought Process: Analyze Cues Using Objective and Subjective Data	Present in Somatic Symptom Disorder	Present in Illness Anxiety Disorder
Objective			
Heart rate 106	Anxiety	✔	✔
Crying, restless in the chair, wringing hands, shaking head	Anxiety	✔	✔
Demanding diagnostic imaging; wanted to have "proof"	Seeking validation; high levels of services utilization	✔	✔
Fired from job for attendance and performance issues	Interferes with daily life	✔	✔
Subjective			
Was fired because of health problems	Interferes with daily life Somatic symptoms are not present	✔	✔ ✔
I have a lot of doctor's appointments, so I miss work	Interferes with daily life; high levels of services utilization	✔	✔
I know I have some disease and I'm tired all the time and I need a special diet because of my medical problems	Excessive worry and fear about having a serious medical condition		✔
I live by myself and I really can't date or go out because I never know how I'll be feeling	Interferes with daily life	✔	✔
I've lost three jobs this year	Interferes with daily life	✔	✔
I just really don't want to have cancer or something bad! I can't help it if I'm sick, can I?	A tendency to catastrophize	✔	✔

TABLE 21.1 Nursing Data Collection/Cues

Recognized Cues from Assessment	Nursing Thought Process: Analyze Cues Using Objective and Subjective Data	Present in Somatic Symptom Disorder	Present in Illness Anxiety Disorder
Doctors don't listen to you! I can't find one I really like. They do a bunch of tests, but they never find anything. I go online and I see those commercials and I know I have something wrong with me!	Somatic symptoms are not present; no medical evidence; high levels of services utilization Exposure to and misinterpretation of medical information		✔ ✔
I try to keep my mind off it . . .	Ineffective coping		✔

TABLE 21.1 **Nursing Data Collection/Cues**

Stress Responses Reported by Clients

Illness anxiety disorder can have varied and serious effects on the lives of clients. People with illness anxiety often experience persistent worry and preoccupation with the idea of having a serious medical condition. This preoccupation can consume a significant amount of their time, attention, and mental energy, making it difficult for them to focus on other aspects of their lives. Individuals may constantly feel on edge, experience panic attacks, or be overwhelmed by fear and worry about their health. This anxiety can interfere with their ability to relax, enjoy activities, or maintain positive relationships. Individuals may withdraw from social interactions or avoid social events due to their health-related fears. They might be reluctant to share their concerns with others or may seek reassurance excessively, which can strain relationships with family, friends, and health-care providers.

While illness anxiety disorder is primarily a psychological condition, the constant stress and anxiety associated with it can have physical effects on the body. Chronic stress can lead to fatigue, sleep disturbances, muscle tension, headaches, and other physical symptoms, further adding to the individual's distress.

The preoccupation with health concerns and the associated anxiety can interfere with occupational or academic functioning. Individuals may have difficulty concentrating on tasks, experience reduced productivity, or miss work or school due to medical appointments or health-related worries. This can have a negative impact on their career or educational progress.

People with illness anxiety often seek repeated medical evaluations and undergo numerous medical tests, even when there is no evidence of an underlying medical condition. This excessive health-care utilization can lead to increased medical expenses, time spent in health-care settings, and unnecessary procedures, potentially straining the health-care system.

The persistent worry and preoccupation with health, along with the associated anxiety, can significantly reduce the overall quality of life for individuals with illness anxiety. They may feel trapped in a cycle of fear, distress, and uncertainty, which can impact their overall well-being and satisfaction with life.

Nursing Care

Nursing care of the individual with illness anxiety disorder begins with building a trusting relationship. The nurse should foster an environment where the client feels comfortable expressing their concerns, fears, and anxieties openly. The nurse should actively listen, validate their feelings, and provide reassurance that their concerns are being taken seriously.

Assessment/Screening Tools

When assessing and screening clients with illness anxiety, it is important for nurses to employ a comprehensive and

sensitive approach. Begin by conducting a thorough medical history, paying attention to the individual's health concerns, past medical experiences, and any significant life events that may have contributed to their anxiety. Explore their thoughts, ideas, and beliefs about their symptoms.

Assess the specific symptoms that are causing distress for the individual. Document the nature, duration, severity, and impact of these symptoms on their daily life. Use open-ended questions to encourage the individual to express their concerns and fears regarding their health. Evaluate the impact of illness anxiety on the individual's daily functioning, relationships, and quality of life. Determine if the anxiety is causing significant distress, avoidance behaviors, or interference with their ability to engage in normal activities.

Evaluate the individual's mental health status, including any history of anxiety disorders, depression, or previous psychological treatments. Assess their overall emotional well-being, coping strategies, and stress levels. Determine if there are any significant life stressors that may be contributing to their anxiety. Observe the individual's behavior and communication patterns during the assessment. Document their nonverbal cues, such as body language or physical manifestations of anxiety, which can provide additional insights into their condition.

Utilize validated screening tools/questionnaires, such as the Health Anxiety Inventory, the Illness Attitude Scale, or the Whiteley Index, to assess illness anxiety symptoms and severity. These tools can help quantify the level of anxiety and provide a standardized measure for monitoring changes over time.

LINK TO LEARNING

Access the Health Anxiety Inventory (https://openstax.org/r/77HltAnxyInvtry) to see an example of a standardized screening tool for IAD.

Make sure to engage the individual in a collaborative discussion, allowing them to express their concerns, fears, and beliefs openly. Be mindful of cultural factors that may influence the individual's beliefs, attitudes, and expression of health concerns. Respect cultural diversity and incorporate cultural sensitivity into your assessment approach. Foster a nonjudgmental and empathetic environment that encourages trust and promotes effective communication.

Approaches to Treating Illness Anxiety Disorder

The treatment of illness anxiety disorder aims to alleviate the excessive health-related worries and anxiety experienced by individuals and restore maximum functioning. Here are some approaches commonly used in treating IAD (French & Hameed, 2023):

- Cognitive behavioral therapy: CBT helps individuals identify and challenge their irrational thoughts and beliefs about health concerns. The therapist works with the individual to reframe catastrophic thinking patterns and replace them with more realistic and balanced thoughts.
- Exposure and response prevention (ERP): ERP is a component of CBT with specific focus on prevention, that is, confronting anxious thoughts, objects, or situations and making a choice not to respond. It involves gradually exposing individuals to situations that trigger health-related anxiety and allowing them to confront their fears in a controlled manner.
- Mindfulness techniques: Mindfulness techniques, such as "here and now" exercises, meditation, and breathing exercises, can be helpful in managing anxiety and reducing the preoccupation with physical symptoms.
- Education: Providing education about illness anxiety disorder and how it differs from genuine medical conditions can be beneficial. It also helps clients recognize triggers and develop strategies to cope with anxiety effectively.
- Supportive therapy: Supportive therapy focuses on providing emotional support, empathy, and validation to individuals with illness anxiety disorder. Supportive therapy can help individuals feel understood and can facilitate the development of a trusting relationship with health-care providers.
- Medication: In some cases, medication may be part of the treatment plan for illness anxiety disorder. Antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), can help manage associated anxiety. A psychiatrist or advance practice provider should collaborate to evaluate and monitor medication carefully.

Summary

21.1 Psychological and Behavioral Factors in Somatic Symptom Disorders

Somatic symptom disorder (SSD) is a condition that occurs when a client is focused on physical symptoms to the point of significant distress and disruption of normal functioning. Risk factors include a history of childhood trauma, family history of SSD or mental health disorders, certain personality traits, and sociocultural traits affecting views on illness. Examples of behaviors commonly associated with SSD include excessive preoccupation with physical symptoms, high utilization of health-care services, disproportionate distress and anxiety, and impairment in daily functioning. The level of impairment to the client's daily life can vary from mild to severe, depending on the severity and frequency of the symptoms. Nursing care for clients with SSD includes a nonjudgmental approach, a thorough history and assessment, collaborative planning with the health-care team, and goal setting so the client can live the most functional life possible.

21.2 Functional Neurological Disorder

Functional neurological disorder (FND) is a condition where an individual experiences one or more altered motor or sensory neurological symptoms that cannot be attributed to a specific medical or neurological condition. Risk factors for FND include a history of trauma; previous medical conditions; other mental illness, such as anxiety or depression; family history; and certain sociocultural factors. Client symptoms include dizziness, gait disturbance, numbness and tingling, and psychogenic seizures. FND affects clients' lives in numerous ways, including interpersonal relationships, employment status, financial status, and more. Nursing care involves a nonjudgmental approach with education to help the client understand the condition and access effective evidence-based treatments, such as CBT.

21.3 Factitious Disorder

Factitious disorder is a mental health condition in which individuals intentionally and consciously fabricate or induce physical or psychological symptoms in themselves or another. Risk factors include a history of trauma, an underlying personality disorder, and a desire for attention and sympathy. Client behaviors associated with factitious disorder include intentionally fabricating symptoms, sometimes to the point of self-injury (or injuring the victim), and manipulative behavior, especially around health-care professionals.

Factitious disorder can create serious and lifelong issues for the client and for the victim. Factitious disorder can lead to psychological disorders, permanent physical problems, dysfunctional interpersonal relationships, legal issues, and more. Nursing care for factitious disorder involves a nonjudgmental, interprofessional approach, supportive care, referral to appropriate counseling and medical services, boundaries and ethical considerations, and long-term follow up, management, and monitoring.

21.4 Illness Anxiety Disorder

Illness anxiety disorder is a mental health condition characterized by excessive worry and fear about having a serious medical condition, despite having little or no medical evidence to support the belief. Clients with illness anxiety have few to no somatic symptoms. Risk factors include anxiety or depression, childhood experiences with illness, life stressors, personality traits, and excessive use of medical information. Behaviors associated with illness anxiety disorder include intense focus on mild or normal physical sensations, regular checking of the body, frequent medical visits and excessive testing and diagnostics, too much online research, or unwarranted avoidance of activities perceived as risky for one's health. Illness anxiety can cause disruptions in a person's everyday functioning, having a negative impact on social and occupational functioning, emotions, and overall quality of life. Nursing care for someone with illness anxiety disorder focuses on providing support, education, and reassurance to help the individual manage their anxiety and concerns about their health and maximize functioning.

Key Terms

factitious disorder mental health condition in which individuals feign illness or intentionally make others believe they are sick, characterized by a desire for attention and validation

factitious disorder imposed on another (FDIA) form of factitious disorder where an individual intentionally causes illness or symptoms in another person under their care, often a dependent, such as a child, older parent,

or other vulnerable individual

functional neurological disorder (FND) condition in which a person experiences neurological symptoms in the form of one or more altered motor or sensory symptoms that cannot be attributed to a specific medical or neurological condition

globus sensation of a lump in the throat associated with functional neurological disorder

illness anxiety disorder (IAD) mental health condition characterized by excessive worry and fear about having a serious medical condition, despite having little or no medical evidence to support the belief and few to no somatic symptoms

malingering individuals feign symptoms for external incentives, such as financial compensation

pseudoseizures seizure-like episodes without the characteristic electrical abnormalities observed in epilepsy on an electroencephalogram (EEG)

secondary gain inadvertent advantages derived from adopting a sick role, such as receiving attention, sympathy, or support from others, or avoiding responsibilities or stressful situations

services utilization use of health-care services

somatic relating to or affecting the body

somatic symptom disorder (SSD) condition that occurs when a client is focused on physical symptoms to the point of significant distress and disruption of normal functioning

Assessments

Review Questions

1. What is the defining feature of somatic symptom disorder?
   a. the absence of a medical explanation for the client's physical symptoms
   b. the presence of chronic pain
   c. significant focus on physical symptoms to the point of major emotional distress and problems functioning
   d. the presence of at least one diagnosed chronic medical illness

2. What is one risk factor for development of somatic symptom disorder?
   a. deep denial of a physical cause of distressing symptoms
   b. a history of substance misuse
   c. a history of deceptive and manipulative behavior
   d. a history of schizophrenia

3. Why is teaching a client diagnosed with SSD to focus on the "here and now" such an effective strategy?
   a. It emphasizes the present moment and encourages clients to redirect their attention away from distressing or anxious thoughts to the present experience.
   b. It reminds clients that they're fabricating their symptoms for attention.
   c. It prevents clients from thinking too much about future goals and plans.
   d. It keeps the clients focused on the overall goal of complete symptom remission.

4. What is one of the defining characteristics of functional neurological disorder?
   a. There is one or more confirmed neurological diagnoses.
   b. The symptoms being exhibited are not being "faked;" they occur subconsciously.
   c. It is treatable using traditional neurological therapies.
   d. It is typically chronic and lifelong.

5. How can cultural factors act as risk factors for the development of functional neurological disorder?
   a. Some cultures forbid physical manifestations of distress.
   b. They encourage doctor shopping.
   c. Family members may inadvertently reinforce or encourage symptoms.
   d. They may encourage the client to seek end-of-life care prematurely.

6. What is the term for the sensation of a lump in the throat associated with functional neurological disorder?

a. esophageal stricture
b. dysphagia
c. esophageal narrowing
d. globus

7. What is one of the main differences between somatic symptom disorder (SSD) and factitious disorder?
   a. People with SSD need empathy and understanding while those with factitious disorder should be approached with caution.
   b. Clients with factitious disorder should be encouraged to voice their fears and concerns over illness, while nurses should enforce strict boundaries with clients with SSD.
   c. The symptoms and distress experienced by clients with SSD are not factitious or feigned, while signs of illness and injury in clients with factitious disorder are purposefully fabricated and/or exaggerated for attention.
   d. A history of trauma is a risk factor for SSD but not for factitious disorder.

8. What is the purpose of enforcing strict boundaries with clients with factitious disorder?
   a. to limit their access to unnecessary tests and treatments and attempts at manipulative behavior with health-care providers
   b. to prevent them from seeking care
   c. to let them know that they are not to be believed
   d. to cure them of their disorder

9. When assessing a client with factitious disorder, what is an important thing to note?
   a. any sincere feelings that the client may seem to exhibit
   b. whether or not you agree with what the client states as their medical history
   c. inconsistencies in their stories
   d. clients cause health-care providers to lose compassion

10. During the admission nursing assessment, what will the nurse identify as risk factors for illness anxiety disorder?
    a. verbalizing feelings about a job the client has held for the last five years
    b. expressing fear of fatal disease that interferes with activities of daily living
    c. stating no other family members have medical problems
    d. describing a daily schedule that changes as necessary

11. Why would persons diagnosed with illness anxiety disorder develop rituals or strict routines?
    a. to prove their independence in self-care
    b. to discover a cure for rare diseases
    c. to gain control and relief from stressors
    d. to complement medical advice

12. What statement by the client would cause the nurse to recognize behaviors associated with illness anxiety disorder?
    a. “Tara rarely calls me—I don’t hear from her unless she needs money.”
    b. “Tara texts me daily to ask if I think she has some terrible disease.”
    c. “I’m concerned about Tara’s friends who seem to party a lot.”
    d. “I’m sure Tara will continue with her college courses this term.”

Check Your Understanding Questions

1. Describe the different behaviors associated with clients diagnosed with somatic symptom disorder.
2. Describe examples of behavioral symptoms that occur with FND.
3. Describe examples of behaviors demonstrated by clients with factitious disorder.

4. Describe stress responses reported by clients due to illness anxiety disorder.

Reflection Questions

1. Why might clients who are diagnosed with somatic system disorder struggle with feelings of loneliness and isolation?
2. Why is education so important for clients diagnosed with FND?
3. What is the nurse's primary goal when dealing with a case involving a client with factitious disorder imposed on another?
4. How might you respond to a nurse who is just learning of factitious disorder, when the nurse says, "Those people should be held accountable for lying and taking up everyone's time. We have people here who are *really* sick!"
5. How would you approach a client with factitious disorder who denies any intent to deceive or manipulate health-care providers? How can nurses build trust while maintaining a focus on the client's well-being?
6. How would a nurse build a trusting relationship with a client diagnosed with illness anxiety disorder?

What Should the Nurse Do?

You are the RN working with twenty-four-year-old Carey, who is diagnosed with somatic symptom disorder. Carey has withdrawn from college courses due to inability to drive to school and stay seated through class because of back pain. You evaluate Carey's medical record, which contains diagnostic imaging, vital signs, and blood work, all with normal results. You find no medical history of injury. Carey's self-report: "I have something wrong with my back. The doctors can't figure out what is wrong with me." Carey sits slumped in the chair with downcast gaze and states, "Only my mom understands me. She takes care of me."

1. How will you show nursing sensitivity to the client's report?
2. From where should you be gathering your information for a full and accurate assessment of this client and what information might you obtain?
3. Which assessment questions would be important to ask Carey in gathering information for a full and accurate assessment?
4. What are some signs and symptoms that might suggest the presence of SSD in this client?
5. What are some potentially helpful interventions for this client?

Competency-Based Assessments

1. As a nurse, come up with a plan to approach a client who denies the psychological components of their somatic symptoms. How can you promote trust and collaboration in the therapeutic relationship?
2. Discuss a scenario where a client with somatic symptom disorder expresses frustration with their health-care providers. How can nurses advocate for improved communication and coordination among the health-care team to enhance client satisfaction and outcomes?
3. Think about a scenario in which a client with functional neurological disorder is resistant to psychiatric interventions. How can nurses explore alternative therapeutic approaches and engage the client in their care plan?
4. As a nurse working on an interdisciplinary team, how would you advocate for effective communication and coordination among team members to provide holistic care for a client with functional neurological disorder?
5. Think about the ethical considerations related to caring for a client with factitious disorder. List at least two resources within the workplace and two personal behavior changes nurses can make to assist professional interactions with these clients. Share your list with one peer.
6. Imagine a scenario where you are seeing a client with illness anxiety disorder who insists on multiple medical tests despite consistently negative results. How can you engage the client in a collaborative discussion to explore underlying concerns and develop a holistic care plan?
7. Ethically, how should nurses balance the provision of reassurance to clients with illness anxiety disorder

without reinforcing maladaptive behaviors? What strategies should nurses use in order to maintain ethical boundaries while promoting the client's well-being?

References

Agarwal, V., Nischal, A., Praharaj, S. K., Menon, V., & Kar, S. K. (2020, January). Clinical practice guideline: Psychotherapies for somatoform disorders. *Indian J Psychiatry, 62*(Suppl 2), S263–S271. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_775_19

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Barranco, R., Caputo, F., Ricci, P., Gratteri, S., Frigiolini, F. M. E., Rocca, G., & Ventura, F. (2021). An unusual case of functional neurological disorders and psychogenic coma following physical assault: Clinical and medico-legal considerations. *Journal of Forensic Science and Medicine*, *7*(1), 36. https://doi.org/10.4103/jfsm.jfsm_62_20

Canna, M., & Seligman, R. (2020). Dealing with the unknown. Functional neurological disorder (FND) and the conversion of cultural meaning. *Social Science & Medicine*, *246*. https://doi.org/10.1016/j.socscimed.2019.112725

Carnahan, K. T., & Jha, A. (2023, January 2). Factitious disorder. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK557547/

Cleveland Clinic. (2020). *Factitious disorders*. https://my.clevelandclinic.org/health/diseases/9832-an-overview-of-factitious-disorders

Cleveland Clinic. (2021). *Factitious disorder imposed on another (FDIA)*. https://my.clevelandclinic.org/health/diseases/9834-factitious-disorder-imposed-on-another-fdia

D'Souza, R. S., & Hooten, W. M. (2023, March 13). *Somatic syndrome disorders*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK532253/

Dunphy, L., Penna, M., & EL-Kafsi, J. (2019). Somatic symptom disorder: A diagnostic dilemma. *BMJ Case Reports*, *12*(11). https://doi.org/10.1136/bcr-2019-231550

French, J. H., & Hameed, S. (2023, July 16). Illness anxiety disorder. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK554399/

Keatley, E., & Molton, I. (2022). A shift in approach: Assessment and treatment of adults with functional neurological disorder. *J Health Serv Psychol, 48*(2),79–87. https://doi.org/10.1007/s42843-022-00061-w

Leventhal, H. (2001). In Illness behavior and care seeking, International Encyclopedia of the Social & Behavioral Sciences (pp. 7185–7190). https://doi.org/10.1016/B0-08-043076-7/03894-8.

Mayo Clinic.org. (2019). *Fictitious disorder*. https://www.mayoclinic.org/diseases-conditions/factitious-disorder/symptoms-causes/syc-20356028

NHS Inform. (2024). *Functional neurological disorder*. Scottish Government. https://www.nhsinform.scot/illnesses-and-conditions/brain-nerves-and-spinal-cord/functional-neurological-disorder/

Patterson, E. (2022). *Illness anxiety disorder: Signs, symptoms, & treatments*. Choosing Therapy. https://www.choosingtherapy.com/illness-anxiety-disorder/

Peeling, J. L., & Muzio, M. R. (2023, May 8). *Conversion disorder*. National Center for Biotechnology Information. https://pubmed.ncbi.nlm.nih.gov/31855394/

Quality and Safety Education for Nurses. (2022). QSEN Institute Competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Substance Abuse and Mental Health Services Administration. (2019, June). Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); Table 3.32, DSM-IV to DSM-5 Illness Anxiety Disorder Comparison. https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t32/

Vaziri, A., Esmaeilinasab, M., Hamdieh, M., & Farahani, H. (2019). Cultural obstacles in emotion expression among patients with somatic symptom disorder (SSD) in an Iranian sample: A qualitative study. International Journal of Behavioral Sciences, 13(1), 8–13.

Weber, B., Gokarakonda, S. B., & Doyle, M. Q. (2023, July 4). Munchausen syndrome. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK518999/

Zaky, E. A. (2015). Factitious disorder imposed on another (Munchausen syndrome by proxy), a potentially lethal form of child abuse. *J Child Adolesc Behav, 3,* e106. https://doi.org/10.4172/2375-4494.1000e106

CHAPTER 22
Sexual Dysfunction and Gender Dysphoria

FIGURE 22.1 The etiology of psychological and mental health disorders can be multifaceted, ranging from genetic and biological to environmental; often, specific causes are a combination of the types of factors or remain a mystery. (credit: "National Nurses Week: Capt. Stephanie Smiddy" by Staff Sgt. Shane Hughes/Air Force Medical Service, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Sexuality is a central aspect of human identity. As children grow and develop, they are socialized into categories dictated by the dominant culture by things such as their name, their clothes, and their toys. Young children soon learn to identify with a particular gender, denoting a masculine or feminine status according to cultural expectations. Gender identity continues to develop through the process of puberty to be sexually mature, capable of giving rise to the next generation of human beings (Testa et al., 2015).

The concept of sexuality and its many dimensions is extremely complex and varied. Consider recent changes in completing demographic forms. No longer are individuals asked to identify as merely male or female, but now have many other choices, such as neither male nor female, binary, nonbinary, or prefer not to state. Regardless of these changes in terminology, the concepts of sexuality and identity, and their overlap, are rife with emotion for many people. Nurses are entrusted with many of the intimate details of people's lives, and issues surrounding these concepts frequently arise. Nursing education programs vary in their approach to human sexual development and sexual behavior. Regardless of any formal preparation and knowledge about human sexuality, psychiatric nurses sooner or later find themselves drawn into a conversation where a client is experiencing distress related to their sexual identity, orientation, health, illness, or specific behavior.

Nurses are encouraged to think and speak in terms of gender inclusivity, and to welcome those in their care to share

their preferences. This positively affects access to health care by supporting inclusivity.

22.1 Categories of Sexual Dysfunction

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss terminology from the *DSM-5-TR* relative to sexual dysfunction
- Describe stressors reported by clients associated with sexual dysfunction
- Identify nurses' potential reactions to clients with sexual dysfunction issues
- Apply evidence-based nursing interventions of client/family distress as related to these conditions

According to the World Health Organization (WHO), sexual health is a critical aspect of human development and well-being (2023a). To realize sexual health, individuals must have sufficient and accurate knowledge about sex and human sexuality and the ability to access health care that affirms sexual health. The term *sexual health* refers to the absence of reproductive infections and diseases, unintended pregnancy, sexual dysfunction, and harmful practices, such as female genital mutilation and sexual violence.

Although external genitalia play important roles in the arousal and expression of human sexuality, the brain plays a dominant role in sexual arousal. Sexual arousal includes not only physiological responses to stimulation of the external genitalia, but also sexual fantasy and imagination. Here the brain plays a central role in organizing sensory stimuli, including touch, sight, smell, taste, and sound. The brain also processes the role that society and culture play in the experience of sexual arousal and sexual behavior.

The term **sexual dysfunction** is used to describe difficulties that individuals and couples experience in terms of sexual desire, arousal, physical and psychological response, and specific sexual behavior. Sexual difficulties may occur in myriad ways within the individual and/or between sexual partners. Some such difficulties are associated either directly or indirectly with medical conditions or surgical treatments for specific diseases, such as cancer or metabolic disease. Not all sexual dysfunctions result in diagnosis of a psychiatric condition. Many circumstances of sexual dysfunction are common and temporary. Some remit spontaneously and others may require the professional assistance from a licensed sex therapist (Wincze & Weisberg, 2015).

DSM-5-TR Terminology Related to Sexual Dysfunction

The *DSM-5-TR* (American Psychiatric Association [APA], 2022) provides detailed descriptions of eight specific sexual dysfunctions:

- delayed ejaculation
- erectile disorder
- female orgasmic disorder
- female sexual interest/arousal disorder
- genito-pelvic pain/penetration disorder
- male hypoactive sexual desire disorder
- premature (early) ejaculation
- substance/medication-induced sexual dysfunction

Two additional categories included in the *DSM-5* are other specified sexual dysfunction and unspecified sexual dysfunction (p. 509). These categories are identified to address symptoms of a sexual dysfunction that do not include all of the criteria identified for the eight categories in the preceding list. The *DSM-5* descriptions include diagnostic criteria and features of each disorder; associated features, such as greater detail about the specificity of symptoms a person experiences; prevalence; how the dysfunction typically develops; factors that increase risk for and predict prognosis of the disorder; information about comorbidities; and gender- and culture-related diagnostic issues. Each description also carries important information about differential diagnosis to help the practitioner distinguish between the disorder and other conditions with similar symptoms.

Sexual dysfunctions constitute a group of disorders wherein a person's ability to experience sexual pleasure or to respond sexually to erotic stimuli are diminished or missing. Such experiences cause the individual ongoing and often serious distress. Although sexual dysfunctions have many characteristics in common with one another, they are a group of disorders with wide variation. Sexual dysfunctions affect all sexes and include subtypes such as

lifelong, which refers to a dysfunction that has existed since an individual's first sexual experience, or acquired, which refers to a dysfunction that becomes apparent after the individual has had normal sexual function or behavior for some period of time. Other subtypes include generalized versus situational. Generalized dysfunctions mean that the experience occurs regardless of the circumstances or settings, including one's partner(s) or with any or all types of stimulation, whereas situational disorders mean that the dysfunction occurs in only select circumstances or settings, with specific types of stimulation, or only with a specific partner or partners. In addition to these subtypes, some of the disorders are further specified as mild, moderate, or severe, referring to the extent of the clinical distress experienced by the individual with the disorder.

Sexual Response Cycle

To understand sexual dysfunction, it is critical to have some understanding of the **sexual response cycle**, which is a uniquely human process that is the pattern of physiological changes that occur in the human body during sexual arousal, stimulation, and engagement in sexual behavior (Crooks & Baur, 2017). Regarding the physical aspects of this cycle, the research team of obstetrician/gynecologist William Masters and therapist Virginia Johnson pioneered a study of human sexuality characterized by direct observation. Masters and Johnson described a four-phase model for males and females in 1966: excitement, plateau, orgasm, and resolution. There are distinctive differences between males and females. There is also much variation among individuals and their response to actual or imagined sexual activity. Two common physiological processes do occur in both males and females during sexual arousal, however: **vasocongestion** and **myotonia**. Vasocongestion refers to the swelling and filling of specific bodily tissues with blood as arteries in the body dilate in areas, such as the penis, clitoris, and nipples. Myotonia refers to muscle tension that occurs in the body throughout sexual arousal and excitement. This tension can be found in both voluntary and involuntary muscles throughout the body and is most evident in the muscle spasms characteristic of orgasm.

In sexual arousal, arteries dilate throughout the body, but particularly in the external genitalia, and these tissues become swollen, red, and engorged with blood. In males, this is manifest in the erection of the penis, whereas in females this is manifest in enlargement of the clitoris as well as in enlargement of the labia and nipples. This first phase of the sexual response cycle is known as excitement. In this first phase, vaginal lubrication also begins.

The second phase of sexual arousal is known as plateau and is characterized by several physiological changes in the body. Involuntary muscle contractions in the hands and feet begin to occur and cardiorespiratory changes are apparent in increased heart rate, elevated blood pressure, and more rapid breathing. The third phase, orgasm, is marked by involuntary muscle spasms throughout the body, including contractions of the uterus and rectal sphincter. Cardiorespiratory mechanisms continue to be elevated and reach their peaks. During this phase, the male ejaculates seminal fluid into the urethra and out the urinary meatus. Following orgasm, males, but generally not females, experience a refractory period in which orgasm cannot occur again until the tissues return to their pre-arousal states. The length of this period is quite varied, ranging from minutes to hours or days. In contrast to males, females can experience multiple orgasms in quick succession, but this varies depending upon factors, such as age and emotional attraction to one's partner.

The final phase of sexual arousal, according to Masters and Johnson (1966), is known as resolution and is characterized by genitalia returning to pre-arousal states, the lowering of cardiorespiratory responses, and an overall period of relaxation. There is variation among individuals for each of these phases. In general, however, there is greater variability in the sexual response patterns of females than of males (Crooks & Baur, 2017).

Many sexual dysfunctions are related to one or more chronic conditions, such as spinal cord injury, stroke, diabetes mellitus, sleep apnea, depression, and alcohol abuse. In many cases, the diagnosis of substance use disorder, for example, is made instead of the sexual dysfunction diagnosis. These chronic conditions often compromise the two biological functions of vasocongestion and myotonia, and once the biological condition improves, the sexual dysfunction may improve as well. In some cases, the diagnostic symptoms may actually be attributable to some other nonsexual mental disorder, such as post-traumatic stress disorder.

Sexual dysfunction may be related to a number of psychological factors alone or in combination with the preceding chronic conditions noted. Stressors related to daily living may lead to generalized anxiety, thus forming a deterrent to sexual arousal. Anxiety, for example, may arise out of concern for unplanned pregnancy and result in the lack of sexual desire or arousal. Interpersonal relationships or communication issues between sexual partners may

contribute to sexual dysfunctions. A mental disorder such as major depressive disorder is another source of some sexual dysfunctions. Periods of social isolation, such as incarceration or the COVID-19 pandemic, may also contribute to the development of sexual dysfunctions. The experiences of childhood sexual abuse or exploitation (e.g., trafficking) or interpersonal violence in adolescence or adulthood may also result in diagnosable sexual dysfunctions.

Male Sexual Dysfunction

Male sexual dysfunctions include (1) hypoactive sexual desire disorder, (2) erectile disorder, (3) delayed ejaculation, and (4) premature (early) ejaculation. It is important to mention here that the diagnoses of sexual dysfunctions as described in the *DSM-5* may appear not to fit gender-diverse individuals. In most instances, the diagnosis is made based on the person's current anatomy and not on the basis of their sex assigned at birth. This is an area that requires sensitive clinical judgment, which includes serious consideration of the moral and ethical questions that accompany the provision of gender-affirming care. Such care depends on a multidisciplinary approach, including nursing, and a need for more research (Gerritse et al., 2018; Gerritse et al., 2022).

Hypoactive Sexual Desire Disorder

Hypoactive sexual desire disorder includes the lack or negligible experience of sexual desire either prior to or during the sexual experience. This condition of hypoactive desire applies to thoughts and fantasies as well as to actual behavior. To meet the diagnostic criteria, the condition must have persisted for at least six months and cause a clinically significant amount of distress. As in other sexual dysfunctions, it may be further specified as mild, moderate, or severe. Decreased activity of the ovaries or testes, or **hypogonadism**, can cause endocrine disorders, such as low levels of testosterone. Some prolactin-producing pituitary tumors may result in hypoactive sexual desire.

The prevalence of this disorder increases with age and with alcohol use and may occur with smoking and obesity. It is found more often in males older than sixty years of age than in those under age twenty-five. The prevalence varies across cultures and appears to be higher in males from Southeast Asia than in those from Northern Europe. This disorder is also reported more often by homosexual males than by heterosexual males (APA, 2022).

Hypoactive sexual desire disorder may co-occur with erectile and/or ejaculation disorders as well as depression. An **erectile disorder** is difficulty in obtaining or maintaining a penile erection or experiencing a significant decrease in the rigidity of the erection during sexual activity. An **ejaculation disorder** is a pattern of ejaculation occurring either prematurely or delayed. The experience of prolonged difficulty in achieving or maintaining an erection may lead to a person's loss of interest or desire in sexual activity. The condition may also be influenced by the characteristics of the person's relationship with a sexual partner whose interest in sexual activity may be altogether different. When making this diagnosis, it is important to be mindful of communication and sexual desire patterns of the person as well as situational stressors, such as the loss of a job or death of a close family member or friend. Consider also conservative religious beliefs and practices when describing and treating this disorder. For example, in a study of Orthodox Jewish couples, Friedman (2019) found that one of the most frequently reported problems was inhibited arousal and orgasm in the males related to their religious belief system and attitudes toward sexuality. Moreover, Friedman pointed out that sex education was limited among Orthodox Jewish couples and that they often do not know how to talk with one another about their sexual needs and desires.

Until recently, clinicians, researchers, and the general public have viewed the sexual response cycle of males to be relatively uniform. Researchers in one study, however, documented five different classes of arousal and response that are unique to males, different in duration of sexual experiences, and variable in terms of relationship satisfaction (Busby et al., 2020). These researchers found that despite differences in arousal and desire, the groups of males in this study did not differ significantly from each other by age, income, educational level, religiosity, number of children, or sexual orientation. Although this study was limited by not including a representative sample, it does provide findings that could help reduce the stigma or pressure some males may feel surrounding this disorder.

Erectile Disorder

Erectile disorder refers to a person's difficulty in obtaining or maintaining a penile erection or a significant lack of rigidity of the erection during sexual activity at least 75 percent of the time they engage in sexual activity. This disorder may be further classified as mild, moderate, or severe in terms of the amount of distress it causes.

Erectile disorder has been implicated in fertility problems among males and may be identified in individuals with other sexual dysfunctions, such as early ejaculation. In addition, many individuals who experience erectile disorder may experience reduced self-esteem and self-efficacy. They may also feel a loss of masculinity and an increase in anxiety and depression.

The condition varies by age. It is seen more often in males over seventy years of age and much less often in those under forty years of age. When erectile disorder occurs in younger populations, the distress associated with it is higher than when it occurs in older populations. Although relatively less is known about childhood sexual abuse in boys compared with what is known about girls, boys who are victims of sexual abuse often suffer from altered feelings of masculinity, shame, and guilt (Gewirtz-Meydan & Ofir-Lavee, 2021). According to literature reviewed by Gewirtz-Meydan and Ofir-Lavee (2021), males who have experienced childhood sexual abuse are much more likely than other males to experience sexual dysfunction accompanied by feeling anxious and distressed. In addition, as children, the survivors of sexual abuse may lack the ability to trust others and thus develop difficulties with intimate relationships.

Certain surgical and medical factors can play a substantial part in the occurrence of acquired erectile disorder later in life. For example, transurethral resection of the prostate (TURP) and diabetic neuropathy are known causes of erectile dysfunction in males. In the case of TURP, prostate tissue is removed through the urethra, and often causes swelling and pain or it may result in damage to nerves that affect the process of erection. More recent robotic surgery for prostate cancer has reduced the damage to the urethra, but urinary problems remain to some extent during the healing process, which may lead to erectile difficulties in some males (Feng et al., 2020). In diabetes mellitus type 2 (T2DM), elevated blood sugars over a long period of time damage nerves and blood vessels in the penis. Males with erectile dysfunction related to T2DM may find improvement with better glucose control, weight loss, decreased intake of alcohol, and increased exercise.

Difficulty in obtaining and/or maintaining sufficient erection of the penis for sexual activity may also be related to the use of both legal and illicit drugs. It is likewise not uncommon among clients who have cardiovascular, endocrine, and/or neurological conditions, including those with spinal cord injuries. Users of enzyme inhibitors and neuropsychiatric medications report a high incidence of adverse effects in this regard (Kaplan-Marans et al., 2022).

LIFE-STAGE CONTEXT

Age Differences between Client and Nurse

The sexual response cycle in adulthood has both biological and psychosocial underpinnings. After reaching sexual maturity, physiological changes in hormones, muscles, and the circulatory system may contribute uniquely to the development of a sexual dysfunction. For example, an adult with cancer may experience changes in sexual functioning (e.g., difficulty with erection of the penis) related to the location of the disease or the negative effects of the treatment.

Many nursing students and new graduate nurses may have only recently completed puberty. They may still be trying to figure out their own sexual orientation and gender identity when they find themselves observing the struggles of clients with concerns about sexuality. Given that sexual dysfunctions tend to increase with age, discussing this diagnosis with clients may be particularly difficult for young nurses. Similarly, older nurses may find that a client who is experiencing a sexual dysfunction is near their own age, or the age of their parents. An encounter with such a client may trigger conflicting feelings within the nurse. Nevertheless, whereas it is important for the nurse to acknowledge their own feelings and concerns, the focus should be on giving the client permission to express their feelings about their condition and working together to seek a solution.

Having a support group of other nurses may help them to process their feelings and thoughts about how to give supportive care to others. It is important to remember, as well, that many of the sexual dysfunctions may be secondary to another disorder, such as substance misuse or spinal cord injury. Thus, it is possible to discover, for example, that a young male who sustained a spinal cord injury from a skiing accident also experiences an erectile dysfunction. It is good to remember that sexual dysfunction, in general, may have multiple causes.

Premature and Delayed Ejaculation

Premature or early ejaculation is the most common sexual dysfunction, seen almost universally in males' first sexual experiences. It is defined as ejaculation that occurs within one minute of penetration. To be a dysfunction, the concern must have been apparent 75 to 100 percent of the time for at least six months (APA, 2022). It may also occur in nonvaginal sexual contact (e.g., males having sex with males). Some estimates state that 20 to 30 percent of males ejaculate early at some time in their lives. As with any sexual dysfunction, it is important to consider the many factors that may be contributing to the dysfunction. These factors include the partner's health, communication patterns, one's history of sexual or emotional abuse, comorbidities, such as anxiety or depression, and medical history. The condition is more common in cultures where arranged marriages are the norm (APA, 2022).

Delayed ejaculation means that an individual experiences either a marked delay or absence of ejaculation. To be diagnosed with this, according to the *DSM-5*, the client must have experienced these symptoms for a period of at least six months and it must cause the client serious distress. The term "marked delay" does not have a precise definition and could vary with the male's sexual partner at a given time.

The lifelong subtype begins with early sexual experiences and the prevalence of the condition increases with age. Delayed ejaculation has been associated with reduced androgen levels within the aging process. Several medical conditions may interfere with one's ejaculatory function. Endocrine and neurological disorders, such as spinal cord injury, epilepsy, and stroke, may lead to delayed ejaculation. Similarly, several drugs, including alcohol, may disrupt ejaculation. It is not unusual to find older adult males who stop taking their antihypertensive medications because of the associated delayed ejaculation experience.

Delayed ejaculation causes substantial psychosocial distress in males and in their partners. In couples who hope to have children, this disorder might be a major hurdle and needs to be discussed during fertility assessment. Although the issue might not meet the full set of criteria as a psychiatric diagnosis, it is a treatable condition well known to psychotherapists.

Female Sexual Dysfunction

Female sexual dysfunctions include (1) female orgasmic disorder, (2) sexual interest/arousal disorder, and (3) genito-pelvic pain/penetration disorder. The female sexual response cycle has been shown to be highly variable, but many practitioners have historically been unaware of this, leading to erroneous labeling of female arousal as "dysfunctional" (Leavitt et al., 2019).

PSYCHOSOCIAL CONSIDERATIONS

Literature Review of Stress Related to Sexual Dysfunction in Females

A systematic literature review showed that female sexual dysfunction is more strongly related to relationship stress than it is for males (McCabe & Connaughton, 2017). In this paper, the authors reviewed studies of sexual dysfunction in both males and females. They found that females who experienced sexual dysfunction also reported high degrees of stress in their relationships. Based on this review of studies, however, they were not able to conclude whether the stress caused the sexual dysfunction or the sexual dysfunction caused the stress in the female's relationship with her partner. One of the studies reviewed did show that relationship stress was a predictor of low sexual desire and arousal in females. They suggested that, for females in particular, treatment of sexual dysfunction would be more successful if the treatment also included working on improvement of their relationship. This phenomenon did not hold true for males with sexual dysfunction in the studies included in this systematic review.

Orgasmic Disorder

An **orgasmic disorder** is disordered frequency or intensity of orgasm during sexual arousal and stimulation. The diagnosis of female orgasmic disorder is made when a client has either infrequent, delayed, low-intensity, or absent orgasm the majority (i.e., 75 to 100 percent) of the time the client engages in sexual activity. This situation must have existed for at least six months at the time of diagnosis and caused a great deal of stress in the client. As with many other sexual dysfunctions, this disorder may be classified as mild, moderate, or severe (APA, 2022).

Female orgasm is a highly unique and varied phenomenon. Some females require stimulation of the clitoris to

experience orgasm whereas others may have this experience solely through penile-vaginal intercourse. For many females, orgasm may be consistently stronger and satisfying with self-stimulation than with sexual intercourse. As a diagnosed sexual dysfunction, female orgasmic disorder is accompanied by anxiety and is frequently associated with relationship problems. Physical health problems, such as spinal cord injury, radical hysterectomy, diabetes, or multiple sclerosis and medications used to treat these conditions may contribute to the development of this disorder. Sociocultural factors, such as religion or arranged marriages, may also contribute to the development of this disorder.

Although sexologists have studied the female sexual response cycle for decades, there is no precise definition of what female orgasm is. Individual females describe the sensation of orgasm in different terms and have unique expectations for what it "should" be. As already noted, the sexual response cycle consists of two physiological processes of vasocongestion and myotonia. In the models described by Masters and Johnson as well as Bancroft and Janssen, female orgasm occurs when cardiorespiratory rates reach a peak during sexual activity and the female experiences involuntary muscle spasms in areas throughout the body, including the muscles of the pelvic floor and the uterus. Sexologists have investigated the reports that numerous females have made about experiencing orgasm that is connected to an area of sensitivity in the anterior wall of the vagina. This area is known as the Gräfenberg spot (a.k.a. "G-spot"), named for the gynecologist who first described this erotic area (Crooks & Baur, 2017). The phenomenon of the "G-spot" remains controversial. Physicians from Yale Medical School conducted a systematic review of literature and concluded that there is "no irrefutable evidence" for its existence (Kilchevsky et al., 2012, p. 724). These researchers also confirmed that the anterior wall of the vagina is quite sensitive and that scientific attention to this phenomenon has contributed to a more positive view of female sexuality by the public.

Sexologists' descriptions of female orgasms simply address the physiological changes that occur in the body, but the individual brings myriad psychosocial factors into the experience of orgasm, and there is undoubtedly much variation in expectations and outcomes among diverse females (Vieira-Baptista et al., 2021). As noted in the descriptions of other sexual dysfunctions, psychosocial factors, such as cultural and religious upbringing, adverse childhood experiences, and sex education or the lack thereof, may converge to form the context in which the individual anticipates and experiences orgasm.

Female Sexual Interest/Arousal Disorder

A **sexual interest/arousal disorder** is greatly reduced or lack of interest in or arousal by sexual stimulation. To meet *DSM-5* diagnostic criteria of female sexual interest/arousal disorder (APA, 2022), the client must exhibit at least three of the following six symptoms:

- absence or reduction of interest in sexual activity
- absence or reduction of erotic or sexual thoughts and fantasies
- absence or reduction of initiating or responding to sexual activity with a partner
- absence or reduction of pleasure or excitement during sexual activity
- absence or reduction of sexual interest or arousal to a variety of visual, written, or verbal erotic cues
- absence or reduction of physical sensations in genital and nongenital areas of the body during sexual encounters

This arousal disorder is estimated to exist in about one of every three females (APA, 2022) and is often found in tandem with other female sexual dysfunctions, such as dyspareunia (painful intercourse) and orgasmic disorder. These conditions depend a great deal on context and a complete assessment of the client's biopsychosocial history, relationships, communication patterns, levels of stress, and mood disorders. Religion and cultural beliefs may also play a major role in the development or continuation of this disorder. The condition is also affected by age; duration of symptoms is an important feature to consider.

Sexual Pain Disorders

In females, genito-pelvic pain/penetration disorder is also known as **dyspareunia**. Genito-pelvic pain/penetration disorder may be attributed to a female's frequent and persistent experience of (a) pain with vaginal penetration, (b) anxiety or actual pain felt in the vulva, vagina, or pelvis during attempts at vaginal penetration, (c) anticipation of such pain, leading to anxiety or fear, or (d) intense tightening of the pelvic floor muscles (vaginismus) during attempts or actual vaginal penetration (APA, 2022). Very strong, involuntary contractions of the pelvic muscles during vaginal penetration is called **vaginismus**.

Approximately one out of every ten females experience **vestibulodynia**, which refers to an experience of severe pain at the entrance to the vagina (Crooks & Baur, 2017). A recent randomized clinical trial showed that a multimodal treatment of physical therapy combined with biofeedback and dilation had better treatment outcomes than application of topical lidocaine ointment in reducing this pain (Morin et al., 2021). Other conditions that can cause pain deep in the pelvis during intercourse include stretching of the uterine ligaments and endometriosis. Painful intercourse may be related to a wide variety of other factors: inadequate arousal, lack of adequate lubrication, hormonal changes throughout the menstrual cycle and aging process, and sexual transmitted infections (STIs). Painful intercourse has also been found to be related to the client having a negative self-image of her genitalia (Crooks & Baur, 2017).

Both males and females can experience dyspareunia, but it is more common among females. In males, dyspareunia may be associated with uncircumcised foreskin that is too tight. Infections of the genitourinary system can also lead to experiences of dyspareunia in either sex. Males who are diagnosed with Peyronie disease also experience dyspareunia. This condition is the result of calcium deposits in the shaft of the penis, and it often leads to a curved or "bent" position of the shaft, which may interfere with erections and sexual intercourse (Crooks & Baur, 2017).

Chronic pelvic pain (CPP) in females as well as males has been associated with opioid use disorder (OUD) and its treatment and is worthy of investigation in populations undergoing OUD treatment (Reichmann et al., 2022). For females, CPP may be associated with menstrual cramping as well as sexual intercourse. For males, CPP is generally associated with prostatitis and sexual dysfunction. In both sexes, CPP diminishes quality of life.

Stressors Reported by Clients Associated with Sexual Dysfunction

Clients with sexual dysfunctions have reported a wide range of stressful experiences, which they may view as antecedents or consequences of the specific disorder. Sexual behavior is intimately connected to one's sexual identity and is highly visible in American society. Childhood experiences of sexually curious exploration are normative, but other childhood experiences of abuse and exploitation are traumatic and may leave indelible and damaging impressions on individuals. The adolescent phase of development is characterized by an expanded view of oneself as a sexual being. Learning to accept the changes of one's physical body from that of a child to that of an adult, capable of reproduction, is a significant part of this development. Sexual awareness and arousal become more important as puberty unfolds. When sexual expectations are met, human sexuality can become an exciting and valuable part of life, while unmet expectations may create stress.

Some individuals experience great conflict if they are prescribed medications that are intended to enhance their quality of life but result in a sexual dysfunction. Some of these drugs, including antihypertensives, have unintended consequences that affect sexual arousal and functioning. Experiencing a sexual problem in response to taking prescribed drugs may be very stressful to some people. Similarly, some individuals who experience chronic pain may develop sexual difficulties in response to their pain, or the pain may exacerbate an existing sexual dysfunction (Wincze & Weisberg, 2015). The lack of estrogen may result in vaginal dryness that is then accompanied by pain with vaginal penetration. Although this is not an uncommon complaint as people age, it may be associated with other symptoms of sexual dysfunction and become an added stressor for the client. There is also confusion about terminology to address the experience of pain. Such terms include vulvodynia, vaginismus, and vestibulodynia, which are not included in the *DSM-5* (APA, 2022).

Clients with serious mental illnesses may seek to maintain intimate relationships, including sexual activities, with partners. Stress related to expressing this wish honestly to family and health-care providers, and utilizing treatment strategies, can be overwhelming. This could result in the client ignoring their sexual needs. Nurses can provide permission for these clients to open up about their needs for intimacy. They can also provide staff education to promote the sexual health and safety of their psychiatric clients (Hortal-Mas et al., 2020).

Stressors Reported by Males

Sexual dysfunctions in males may occur at any stage of development, but they tend to increase with age. As already noted, however, some dysfunctions are temporary and may be related to intrapersonal and interpersonal experiences. For example, low self-esteem or a feeling of weak masculinity may result in lack of confidence in the ability to attain or maintain an erection of sufficient rigidity or time to satisfy the partner. Thus, the intrapersonal psychological state will influence the interpersonal sexual relationship. This complexity of factors blends with biological and cultural factors to create perplexing situations related to sexual functioning. Comorbidities, such as

diabetes and hypertension, may contribute to the increased prevalence of sexual dysfunctions in older males. Sociocultural influences, such as the use of drugs, including alcohol and marijuana, may also contribute to the sexual dysfunction experience (Ghadigaonkar & Murthy, 2019).

The development of sexual dysfunctions in males depends, in part, on several of the social determinants of health, including knowledge deficit. Despite their overall educational level, many males lack knowledge about their sexual anatomy and physiology that can lead to an undesired alteration in sexual functioning. Inadequate role models during critical times of sexual development may subsequently impact both knowledge, skills, and confidence in pursuing sexual activity with a consenting partner. Early childhood experiences that included trauma may contribute to sexual dysfunction. Children who have been sexually abused can often develop feelings of guilt and shame (Gewirtz-Meydan & Ofir-Lavee, 2021). Depending on the situation and the communication patterns within the family, these victims may not have received help. Communication skills are essential for effective sexual expression, and these skills have their origins in early childhood.

Persons who have diagnosable sexual dysfunctions experience distress that may include (Gewirtz-Meydan & Ofir-Lavee, 2021):

- feeling guilt or shame
- feeling anxiety or anger associated with sexual behavior
- being afraid of being touched by a potential sexual partner
- lacking the ability to trust others
- feeling helpless to change one's feelings or behaviors

Stressors Reported by Females

Hamilton and Meston (2013) examined the effect chronic stressors may have on sexual arousal in females. Distraction was found to be a significant factor. Of note is that the distractions were naturally occurring, ongoing stressors in the females' lives and not those manipulated for the purpose of the study. According to Sathyanarayana et al. (2018), one study in the United States revealed over 40 percent of females experience some form of sexual dysfunction, with 22 percent of females experiencing low sexual desire. Sathyanarayana et al. (2018) investigated the effect of addictive disorders and chronic use of substances on sexuality. Individuals may turn to substance use to enhance sexual performance, though this may have the opposite effect (Sathyanarayana et al., 2018). The research found that therapy is best focused on the couple, the relationship, and the individual aspects of their sexual function (Sathyanarayana et al., 2018). Literature review by Galanakis et al. (2015) found that females' daily life stressors of fatigue, anxiety, and disease (such as diabetes or psoriatic arthritis) negatively affect relationship quality and, therefore, negatively affect sexual desire and sexual experience.

CULTURAL CONTEXT

Culture and Female Genital Mutilation (FGM)

Sexual dysfunctions in some females are related to cultural practices involving various forms of circumcision or genital cutting. Referred to as **female genital mutilation/circumcision (FGM/C)** by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), FGM/C is practiced in many countries in the Middle East and Africa. There are several types of FGM/C, mostly performed on five to fourteen-year-olds, that include *clitoridectomy*, in which all or part of the clitoris is removed; excision of the clitoris and the labia minora and majora; infibulation; and nicking or pricking. *Infibulation* is the most severe form of this procedure and involves removal of the external genitalia and stitching the vaginal opening to prevent penetration. The infibulated area must be forced open to allow for sexual intercourse and childbirth. These procedures are now considered child abuse by the WHO and the United Nations. These practices have great cultural meaning that revolves around femininity, premarital virginity, and marital fidelity (WHO, 2024a). Strong beliefs are related to the specific cultures that condone these practices, but there are signs of shifts occurring in specific countries where females are beginning to share their voices and fathers are joining in the efforts to end these practices (Mwendwa, 2020).

Read this article on FGM/C (https://openstax.org/r/77FGMarticle) by Costello. In this article, Costello identifies several cultures in which this practice is ongoing and identifies variations in the types of procedures that are done to

young girls. She also discusses the physical, emotional, and spiritual harm that these rituals can cause in young girls and how this affects them as they get older. The article concludes with specific suggestions for practitioners working with female clients who have experienced FGM, which begins with health-care professionals becoming familiar with the various types of FGM and communicating with sensitivity and cultural humility.

Many females who immigrate to the United States have undergone female circumcision or infibulation with subsequent complaints of vaginismus, orgasmic disorder, or vestibulodynia. Although these may not rise to the level of psychiatric diagnoses, they are aspects of sexual dysfunctions about which nurses must be aware and a sensitive area of client-centered care.

LINK TO LEARNING

The young woman in this video experienced FGM (https://openstax.org/r/77FemaleGenMuti) at age six as part of her culture in Somalia. At the age of twenty-nine, she discusses the trauma of the actual cutting, the lack of discussion about it within her family after the fact, and the lack of response from medical personnel in the years since that day.

Nurses' Potential Reactions to Clients with Sexual Dysfunction Issues

Nurses may encounter adults with sexual dysfunction issues in many different settings, ranging from general adult health clinics to postoperative in-hospital settings. They may also encounter such clients in psychiatric outpatient or inpatient settings. Regardless of the settings, nurses need self-awareness of their own attitudes about sexuality, knowledge about the vast variety of sexual issues related to health, and communication skills that enable them to assess and respond to clients with actual or potential problems. The less aware nurses are of their own sexuality, the less likely they are to respond in a sensitive, timely, and appropriate manner to the sexual concerns of their clients.

Nurses may fail to see potential or actual sexual concerns in their clients for several reasons. First, they may not think of their clients as sexual beings. They may lack confidence in their knowledge of human sexual development and behaviors and, similarly, they may lack experience in discussing aspects of human sexuality with other individuals. Their own culture and upbringing may create barriers as well (Williams & Addis, 2021).

In a descriptive study of nursing students in Pakistan, Jadoon et al. (2022) found that baccalaureate students had generally positive attitudes about addressing sexual health in their clients, but they felt uncomfortable or embarrassed in doing sexual assessments of people of the opposite gender. In another study of midwifery students in Turkey, researchers found that the students were restricted in asking questions about sexual health as part of their care plan; the students did not complete the sexuality component of their care plans (Serin et al., 2020). Many of these students felt the topic was private, and they were embarrassed to ask clients about sexual matters. Moreover, these students felt that their culture and religion established sexual taboos that restricted their ability to provide this aspect of client care.

Nursing education has a responsibility to include information about human sexuality in prelicensure programs as well as in graduate programs for advanced practice roles. Without exposure and opportunities to practice assessment, communication, and referral skills, nurses may feel confused and embarrassed when issues related to sexuality arise. Lack of adequate preparation leads to avoidance of this essential topic in health-care settings. Nurses need to be aware of the salience of sexuality and intimacy to overall health and well-being of persons in their care (Quinn & Happell, 2011; Quinn & Happell, 2013). Moreover, students should consider enrolling in electives in sociology, psychology, or human development on the topic of human sexuality.

Nurses may have encountered adverse childhood experiences that included sexual abuse or exploitation that stand as a barrier between them and providing sexual health care to clients. Some nurses in clinical settings experience sexual harassment by clients, visitors, and other hospital staff members. If nurses feel sexually unsafe in their work environment, this will present an enormous barrier to their ability to provide competent nursing care, particularly in areas that include sexual health matters.

Nursing Interventions and Management

Nursing interventions and management of individuals experiencing sexual dysfunctions are related to the nurse's self-confidence and competencies in dealing with sexual health issues in general. Nurses' responses to their clients are influenced by their own upbringing and sociocultural experiences throughout their lifetime. It is important to acknowledge that issues concerning sexual health may trigger earlier or ongoing sexual experiences of the nurse. This is a very critical area in which nurses, and nursing students, must be willing to do some serious self-reflection to determine their comfort with and ability to address the sexual issues of those persons entrusted to their care. If nurses have unresolved conflicts or trauma related to sexual experiences in their earlier lives or if they are currently experiencing their own issues related to sexuality or sexual relationships, they will not be able to provide the compassionate and knowledgeable care that is required of them in giving care to clients with actual sexual dysfunctions.

Basic human sexuality education is critical in preparing nurses to manage clients who have been diagnosed with sexual dysfunctions. Such education provides the student and the graduate nurse with a beginning vocabulary and understanding of the erotic and reproductive organs and processes within the human body. Utilizing cues from nursing assessment, which includes client collaboration, priority problems may be identified as:

- altered interest in others
- altered self-interest
- altered sexual activity
- altered sexual excitation
- altered sexual role
- altered sexual satisfaction
- decreased sexual desire
- perceived sexual limitation
- seeks confirmation of desirability
- undesired alteration in sexual function

Accompanying these priority problems are related factors, including clients having inaccurate information and inadequate knowledge about sexual function, lack of privacy, unaddressed abuse, value conflict, inadequate role models, and perceived vulnerability. Each of these factors constitutes an area in which nurses can begin a conversation with clients about sexual dysfunction.

PLISSIT Model

In 1976, Jack Annon developed and published the Permission Limited Information Specific Suggestions, and Intensive Therapy (PLISSIT) model to address behavioral problems related to human sexuality. This acronym has provided an easy-to-remember set of steps that nurses can follow in delivering sexual health care to clients. The four steps of the PLISSIT model are:

P = permission
LI = limited information
SS = specific suggestions
IT = intensive therapy

Each step in this model requires additional comfort, education, and experience before the practitioner can apply it, but having an awareness of the steps involved in managing the nursing approach to sexual dysfunction is a good place to start. Annon's original assumption was that most people who had sexual problems could solve these problems by following the steps of having permission to discuss them, and by receiving limited information, specific suggestions, or intensive therapy. Although nursing students and recent graduates may not have received adequate and detailed sexuality education to enable them to provide specific suggestions or intensive therapy, they can give clients permission to talk about sexuality and may also be able to provide limited information that would be helpful to the client. A recent study of nurse practitioners (NPs) revealed that even with advanced education, these NPs felt inadequately prepared to manage clients with dyspareunia, pelvic pain, or erectile dysfunction (Cappiello & Boardman, 2022).

LINK TO LEARNING

The PLISSIT model of sex communication (https://openstax.org/r/77PLISSIT) demonstrates the steps of giving permission, limited information, specific suggestions, and intensive therapy as a conceptual approach to working with clients experiencing sexual health issues.

In 2007, Taylor and Davis expanded the PLISSIT model, revising the name to be Extended PLISSIT or ExPLISSIT (explicit) model as it has come to be known. In their extension, Taylor and Davis reiterated that the very first step, permission (i.e., giving permission to a client to talk about their sexual health and concerns), should not be assumed or overlooked by rushing to more detailed steps. They underscored the importance of giving the client permission at any and all steps to talk about their sexual health needs and concerns. The Extended PLISSIT model outlines a process that begins with self-awareness, leads to reflection, then moves on to review, knowledge, and challenging assumptions. Each of the four steps includes permission, followed by reflection and review. Reflection and review apply to both client and nurse. The nurse needs to understand that just because the subject has been discussed on one occasion, it has not necessarily been resolved. Rather, it provides the opportunity for further permission-giving, reflection, and review.

LINK TO LEARNING

The video of the ExPLISSIT model of sex communication (https://openstax.org/r/77ExPLISSIT) demonstrates ways for clinicians to reflect and review the steps of giving permission, limited information, specific suggestions, and intensive therapy when working with clients experiencing sexual health issues.

Overall Health Benefits on Sexual Health

The World Health Organization (2024b) describes sexual health as similar to overall health, that is, not only the absence of disease, but also general well-being for every person. Cardiac health is essential for circulatory function, physical energy, and endurance—all of which can affect sexual activity and response. Individuals living with hypertension may have these concerns. The American Heart Association (AHA) (2023) recommends partnership with health-care providers to manage high blood pressure. The AHA further endorses heart-healthy measures to contribute to overall health, and to sexual health, consisting of balanced low sodium diet, maintenance of physical activity and healthy weight, low alcohol consumption, no tobacco use, and stress reduction (2023).

Kudesia et al. (2021) describe a plant-based dietary approach to women's health. Addressing topics of fertility, sexual disorders, and menopause, the authors assert a dietary connection, even phrasing this as a public health initiative. Kudesia et al. advocate a wellness focus for the U.S. health-care system, while acknowledging existing disparities within the system (2021).

Proposing an orientation away from risk and disease, Mitchell et al. (2021) call for a wellness public health focus concerning the concept of sexual well-being. Utilizing a biopsychosocial model, the authors address public health aspects that impact sexual well-being, such as human migration patterns and the COVID-19 pandemic.

Human sexuality is evident throughout the lifespan. As people age, they may experience changes in hormonal structure as well as changes in muscle tissue that create dysfunctions involving the pelvic floor. This can result in urinary incontinence in addition to a lack of interest and arousal for sexual activity (Buyuk et al., 2021). Learning to strengthen the pelvic floor may be important for clients who have experienced trauma to the external genitalia and may also enhance their ability to experience sexual arousal and satisfaction. Teaching clients how to do Kegel exercises may be part of the limited information or specific suggestions that nurses can share. Kegel exercises are also important following childbirth for the person who has given birth to strengthen the muscles of the pelvic floor.

LINK TO LEARNING

This video about Kegel exercises (https://openstax.org/r/77Kegelexercise) shows a detailed view of the musculature of the female perineum. In this video, a physical therapist with specialized training in sexual functioning provides guidance to female clients about how to know they are doing Kegel exercises correctly.

22.2 Paraphilias

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss terminology from the *DSM-5-TR* relative to paraphilias
- Describe stressors reported by clients due to paraphilias
- Identify nurses' potential reactions to clients with paraphilias
- Apply evidence-based nursing management of client/family distress as related to these conditions

A **paraphilia** is a sexual desire or behavior involving inanimate objects or nonconsenting other persons, or including subjugation. For example, some people are aroused and find sexual pleasure and gratification by fantasizing about or actually engaging with articles of clothing. Other people may be aroused and find sexual pleasure and experience orgasm by exhibiting their genitalia to nonconsenting individuals. Still others may find sexual pleasure dressing up differently than they typically would, such as dressing as a different gender. Most of these paraphilic fantasies and behaviors are more common in males than in females (APA, 2022); often, such thoughts and behaviors begin in childhood and may be exacerbated by adverse childhood experiences.

There is still debate as to whether some of these uncommon phenomena exist on a continuum of normal sexual arousal and behavior or whether they should be considered deviant (Castellini et al., 2018). Some of these paraphilic behaviors, such as pedophilia or sexual sadism, are illegal because they result in harm to other people. Others, such as fetishes (e.g., being sexually aroused by a person's shoes), do not necessarily harm other people, thus may be considered along a continuum of normalcy. Regardless of these classifications, there are situations in which the personal fantasies, thoughts, and behaviors associated with paraphilias rise to the level of psychiatric diagnoses, requiring psychiatric nursing and medical care.

DSM-5-TR Terminology Related to Paraphilias

A variety of uncommon sexual practices are considered paraphilias and may be diagnosable psychiatric disorders. To rise to the level of psychiatric diagnosis, a paraphilia must cause intense distress or impairment to oneself and/or to others (APA, 2022; Castellini et al., 2018). In the *DSM-5*, the eight specific paraphilic disorders identified are:

- fetishistic disorder
- transvestic disorder
- voyeuristic disorder
- exhibitionistic disorder
- frotteuristic disorder
- sexual masochism disorder
- sexual sadism disorder
- pedophilic disorder

Two other categories identified in the *DSM-5* are *other specific paraphilic disorder* and *unspecified paraphilic disorder* (APA, 2022). For all these disorders, the diagnostic criteria are that the sexual arousal experienced by the client is both intense and recurrent for a minimum of six months and that the feelings, urges, and behaviors create marked distress or impairment in the client's social functioning. "Other" and "unspecified" paraphilia means they do not meet all the diagnostic criteria for the other paraphilic disorders or that there is insufficient information to make a complete diagnosis (APA, 2022). The category of diagnosable psychiatric disorders known as paraphilias may refer to behaviors carried out by a person alone, in a consensual relationship with another person, or in a nonconsensual relationship that often carries legal consequences with it.

Solitary Behaviors

In the period after World War II, the so-called "sexual revolution" of the 1960s and 1970s led to changing attitudes about what sexual topics and behaviors were increasingly tolerated in American society (Crooks & Baur, 2017). With the increase in scientific study of sexual attitudes and behaviors (i.e., sexology), topics that had previously been taboo in society began to be understood in a more permissive light. For example, the sexology team of Masters, Johnson, and Kolodny (1988) clarified that masturbation, the process of providing sexual pleasure to oneself, was a solitary sexual behavior that provided comfort and gratification to adults and children alike. They confirmed that it was a phenomenon also seen in other members of the animal kingdom. They also debunked several previous myths about masturbation, including beliefs that it could be habit-forming, or unnatural. As the sexual revolution unfolded in America and sexologists began to publish the results of their research, much more is now known about the difference between sexual fantasies and behaviors as well as the difference between what sexual behaviors are "common" and healthy versus those that are unusual, offensive, and illegal. The human sexual repertoire is not a simple continuum from common to extreme, but there is much variation. Paraphilias in solitary behavior may involve a pattern of thoughts or actions specific to sexual arousal. Unless the thoughts or behaviors are distressful or harmful to the person, intervention is not required.

Fetishism

A **fetishistic disorder** refers to a paraphilia in which an individual has had intense and recurring sexual arousal from the use of nonliving objects, such as garments, or a highly specific focus on nongenital body parts. The individual with this disorder acts on fantasies, sexual urges, or behaviors that result in great distress or social impairment. When making the diagnosis, the disorder may be specified with a body part (typically not genitalia), with an inanimate object(s), or with combinations of these. For example, a person may have a foot fetish as well as a shoe fetish, deriving sexual arousal and gratification from both a specific part of the body and a related garment. Another person may have a fetish involving wearing female undergarments while engaging in foreplay with a female. If this person is not distressed by this behavior and the sexual partner views this as consensual, however, it would not meet the diagnostic criteria of a fetishistic disorder. A client with a diagnosable disorder may be aroused by more than one object or situation; some individuals acquire vast collections of the desired inanimate objects, such as shoes or leather boots.

Transvestism

A **transvestic disorder** refers to a paraphilia in which the person becomes sexually aroused or has urges and fantasies about becoming sexually aroused from cross-dressing (i.e., dressing in items usually worn by a different sex) and the person experiences great distress and social impairment from this situation. Some people enjoy dressing up as the opposite sex, but do not meet the diagnostic criteria of having this disorder because they lack the emotional distress and social impairment associated with the diagnostic category. This practice, and the mental disorder, may be more common in males than in females and often has its origin in childhood (Zucker et al., 2012). In some cases where cross-dressing is habitual in a male, it may also be accompanied by gender dysphoria (see Gender Dysphoria).

Behaviors Involving Others

Sexual fetishes are often experienced only as urges or fantasies. As such, they do not involve behaviors that are enacted with or toward another person. The behaviors that do involve others are, in general, enacted without the consent of the other. This lack of consent may lead to legal consequences. For example, pornographic depiction of children as sexual objects is illegal and can result in incarceration of the adult in possession of pictures, videos, etc. (Crooks & Baur, 2017). Examples of these behaviors are voyeurism, in which one is sexually aroused and satisfied from watching others, against their knowledge, as they undress or are in the nude; exhibitionism, in which one exposes their external genitalia to another, nonconsenting individual; frotteurism, in which one rubs against another person's body for sexual gratification; and pedophilia, in which one engages in sexual behavior with a child (who is unable to consent). Sadism also is a sexual behavior that involves another person and brings harm to them because the perpetrator inflicts physical or psychological suffering.

In a study of young adults attending six universities in Italy, Castellini et al. (2018) found that 68 percent of the sample admitted to having experienced paraphilic fantasies at some time during their lives. These researchers found that voyeurism was the most common paraphilia reported by males and females, whereas females tended to act on fetishism and masochism more often than males. These behaviors can be subject to criminal prosecution if

injury or death occurs, regardless of consent status of the participants.

Voyeurism

The term **voyeurism** means the experience of intense and recurring sexual arousal from observing another person, who is unsuspecting and nonconsenting, naked, undressing, or engaging in sexual activity. The person diagnosed with a voyeuristic disorder acts on the sexual urges involving a nonconsenting other person or in fantasies. Moreover, the person who engages in such behavior also experiences great distress or social impairment. This is one of the most common illicit paraphilias and is found more often among males than among females. A person must be at least eighteen years of age to receive this diagnosis to distinguish it from the natural curiosity associated with puberty. Although the exact cause of this disorder is unknown, there is evidence that it is associated with childhood sexual abuse, hypersexuality, and substance misuse; comorbid conditions may include attention-deficit hyperactivity disorder, depression, bipolar disorder, and anxiety (APA, 2022).

Voyeurism also has legal implications. With the advancement in technology has come a new form of voyeurism known as "video voyeurism." In this situation, the perpetrator may place a small camera in a public or private bathroom and record strangers' genitalia during urination. Or they may place the camera on the ceiling of a room and record sexual activity of others. In addition to their own sexual gratification, they may sell the videos to others. Currently, almost all states have laws to prohibit these activities, but the laws are difficult to enforce (Crooks & Baur, 2017).

Exhibitionism

Sexual arousal that comes from displaying one's external genitalia to another nonconsenting person is called **exhibitionism**. If the nonconsenting "other" is a child, then it is possible that the client also has a pedophilic disorder (APA, 2022). An individual diagnosed with exhibitionistic disorder has both intense and recurring sexual arousal from the exposure of their genitals to an unsuspecting and nonconsenting other person (child, adult, or both) for a period of at least six months and has acted on the urges or experiences great distress and social impairment as a result. A person could have an exhibitionistic sexual interest, but not act on the interest and, therefore, would not meet the criteria for the psychiatric diagnosis.

Although the diagnosis may be found in both males and females, it is far more common in males than in females. Among males, the interest in this behavior may arise in adolescence and eventually wane in older age. Antisocial behaviors or antisocial personality disorder may be a precursor or increase the risk for developing this disorder. Alcohol use and pedophilic disorder are also commonly associated with exhibitionistic disorder. High rates of comorbidity have been found in bipolar disorder, depression, anxiety, and substance use disorder as well (APA, 2022).

Frotteurism

The term **frotteurism** is the sexual arousal that comes from touching or rubbing against another nonconsenting person. As with other paraphilic disorders, to meet the *DSM-5* criteria for psychiatric diagnosis, the behavior must be exhibited at least three times over six months and the client must experience great distress (e.g., shame, guilt, anxiety) and social impairment (e.g., difficulty working). Most studies indicate that approximately 8 to 9 percent of males in North America may have this tendency (Savoie et al., 2021), but most do not meet the diagnostic criteria (APA, 2022). Frotteurism has been associated with various neurocognitive disorders, including schizophrenia, and substance intoxication. The condition may also be seen in individuals with conduct disorder and antisocial personality.

Sexual Masochism

The paraphilia **sexual masochism disorder** is where an individual has intense and recurring sexual arousal from being made to suffer from being beaten, bound, or humiliated. The sexual urges, behaviors, or fantasies lead to the individual feeling great distress or impairment in social or other important situations. This type of paraphilia may be specified as "with asphyxophilia" or "autoerotic asphyxia" when an individual achieves sexual arousal from restricted breathing (Crooks & Baur, 2017).

Sexual Sadism

Sexual sadism is sexual arousal that results from inflicting physical or psychological suffering on another person. The diagnosis in which an individual has intense sexual arousal from the suffering of another person and is

distressed and socially impaired by this arousal is called **sexual sadism**. Sadistic behaviors may include those that are gentle and playful, such as soft biting, but they may also be highly violent, such as the intense pain inflicted with violent rape or torture (Masters et al., 1988), which would have legal implications.

The term bondage-domination-sadism-masochism (BDSM) is broadly used to refer to a wide range of behaviors that individuals with sexual masochism and/or sexual sadism (as well as other individuals with similar sexual interests) engage in, such as restraints or restriction, discipline, spanking, slapping, sensory deprivation (e.g., using blindfolds), and dominance-submission role-play involving themes, such as master/enslaved person, owner/pet, or kidnapper/victim (APA, 2022).

Pedophilia

Pedophilia is the intense sexual arousal of an adult by a child or children. The paraphilia in which an individual, age sixteen years or older, is intensely attracted to a child or children and may engage in actual sexual behavior, including vaginal or rectal penetration is called **pedophilic disorder**. To reach the level of psychiatric diagnosis, the intense attraction, fantasies, urges, and/or actual behaviors must have continued for a period of at least six months, the child victim must be at least five years younger than the perpetrator, and the perpetrator must have been very distressed by this behavior, or the behavior must have resulted in great social problems (APA, 2022). Criminal law varies by state under statutory rape, child abuse, or sex offender categories. It is possible that an adult has a pedophilic sexual interest, which means that they are sexually aroused by children or engage in sexual fantasies involving children, but they do not overtly behave in a sexual way with children.

Pedophilia is considered a crime in the United States, so the individual with this psychiatric diagnosis requires particular attention. A condition known as emotional congruence with children is often an attribute found in persons who have either pedophilic sexual interest or pedophilic disorder. Emotional congruence in this sense means that the individual (adult) has feelings and thoughts that may be more like those of children than of adults. Moreover, this type of individual tends to prefer to spend more time with children than adults, including working in occupational or volunteer roles involving children in a variety of settings. Although it is uncommon in females, the prevalence in males is estimated to be about 3 percent. The intensity of the actual disorder may fluctuate throughout one's life, generally with onset in puberty. Many males may have been sexually abused as children themselves. Other attributes that may be found in the person with a paraphilic disorder include impulsivity, antisocial personality, substance intoxication, and a high degree of willingness to take risks. This disorder may occur with other paraphilic disorders, such as exhibitionistic disorder or may be diagnosed concurrently with obsessive-compulsive disorder, depression, anxiety, or bipolar disorder (APA, 2022).

Stressors Reported by Clients Associated with Paraphilias

As noted earlier, not all paraphilias are illegal or deviant. Rather, many individuals may experience erotic stimulation and arousal from any number of different inanimate objects. When the fantasy or urge to act on these feelings is translated into actual behavior that is harmful to oneself or others, paraphilias become problematic. As with all the paraphilias identified in the *DSM-5-TR*, two criteria must be met for the diagnosis. The first criterion is the recurrent nature of the behavior, urge, or fantasy over a period of six or more months, and the second criterion is that the urge, fantasy, or behavior "cause marked distress or interpersonal difficulty" (APA, 2022, p. 792). When behaviors cause harm or distress, they may become diagnosable psychiatric disorders. Some also have associated legal implications. The distress that one experiences with the diagnosis of a paraphiliac disorder may include anxiety, depression, guilt, shame, stigma, and loneliness. The stressors associated with paraphilic disorders may create psychological pain for which a client seeks relief through other behaviors, such as excessive gambling, eating, or drinking (Crooks & Baur, 2017).

Comorbid conditions that have been associated with paraphilias include dysthymia (a mood disorder), major depressive disorder, substance misuse, and childhood attention-deficit hyperactivity disorder (Pang, 2023). Clients with these disorders are often managed with selective serotonin reuptake inhibitor (SSRI) medications to reduce excessive fantasizing. Cognitive behavioral therapy may provide some assistance with the motivation to engage in associated compulsive behaviors (Pang, 2023).

Nurses' Potential Reactions to Clients with Paraphilias

Nurses may exhibit a wide range of responses to clients who have paraphilias or who may be diagnosed with

paraphilic disorders. Nurses' responses to clients with paraphilias may depend upon whether the paraphilia is illegal and/or if it reaches the level of a psychiatric disorder. A particularly salient aspect of paraphilias is the individual client's behavior. Many people may have urges or fantasies that involve a paraphilia, but they do not actually act out that urge or fantasy. Such thoughts and feelings are not illegal. Exhibitionism, pedophilia, and voyeurism, if enacted, however, are illegal (Yakeley & Wood, 2014).

Initially, nursing students may be curious and intrigued by the description of sexual arousal and other sexual behaviors that are different from or similar to their own. This is a normal response, and they should be encouraged to read and learn about differences in sexual interests and behaviors as much as any other area of human attributes that may be different from or similar to their own.

LINK TO LEARNING

Read this report of original research done with university students in Italy (https://openstax.org/r/77adversesexexp) to learn more about the relationship between paraphilias, hypersexuality, and adverse childhood sexual experiences.

Nurses are cautioned to be nonjudgmental in their attitudes about those whose behavior is drastically different from their own, and this applies also to clients who have been diagnosed with paraphilic disorders. What may add to confusion in this particular area of human behavior, however, is the lack of consensus about what is normal, abnormal, or how criminal penalties apply. Some of the paraphilic disorders (e.g., pedophilic disorder) are against the law, because of the harm they can do to children. The nursing student, faculty, and practitioner should know the laws of the state in which they work so that reporting suspected or actual criminal behaviors, especially when they pertain to children, can be done consistently and without reservation. It is also important to remember the difference between urges and fantasies versus actual behaviors. It is not criminal to experience urges or fantasies about sexual expression, but it may be criminal to enact such expressions.

Some nursing students and practicing nurses may find some of their own sexual arousal described in the paraphilias. This attests to the view that sexual arousal may exist along a continuum in many cases rather than a clearly dichotomized prevalence of normal versus deviant. Wherever one's arousal and preferences lie, it is essential that nursing students learn to be self-aware and self-reflective. When attitudes and beliefs lie outside one's consciousness, they have the potential to be misunderstood and create havoc in one's daily lives. If a student or practitioner discovers that their sexual behaviors are congruent with the diagnosable paraphilic disorders, it is imperative that they seek help from another health professional with specialized training in sexual dysfunction therapy, psychiatric advanced practice nursing, or other similar certifications (e.g., American Association of Sex Educators, Counselors, and Therapists [AASECT]).

Nursing Interventions and Management

Nurses who work in psychiatric or mental health settings may encounter clients with paraphilias; similarly, those who work in prisons or juvenile detention settings may also encounter clients who have enacted these behaviors and are now serving the criminal or sex offender punishments as a result. Nursing education at both entry level and graduate, advanced practice seeks to promote quality and safety through adherence to basic competencies. One of the most helpful of these competencies for nurses adjusting to rapid changes in sexuality content is to understand the concept of evidence-based practice (EBP).

The process to achieve EBP is a growing conversation. Bell (2020) reflects upon progress made. Themes identified by Bell (2020) through study of the literature include that nurses must:

- begin with a sense of inquiry and determine a clinical question
- locate research evidence to address the clinical question and think critically about application of the evidence
- implement practice change that incorporates nursing expertise and client preference with the evidence
- evaluate the outcome of the change
- work to share and sustain EBP

These themes are aspects of the nursing process and nurses' clinical judgment. EBP is a model for building nursing

expertise. To paraphrase anthropologist and scholar, Margaret Mead (1901–1978), who found that culture, not biology, determines gender, nurses should learn *how* to think, rather than *what* to think. Due to rapid developments in science and diversity awareness, nurses can no longer depend on tradition and routine for practice guidance.

Some topics of concern to nurses do not have published literature review or meta-analyses. With respect to the topic of paraphilias, the nursing literature does not provide much guidance, so one must venture into databases outside nursing to obtain evidence about this population and the health issues they experience. Nurses in clinical practice may develop a journal club in which they can find and evaluate current literature to enhance their basic understanding of human sexual functioning and behaviors.

LINK TO LEARNING

Johns Hopkins Hospital provides basic information about evidence-based nursing (https://openstax.org/r/77EBPJohnHopkin) practice. The site also includes a colorful diagram that shows one the process of working with an interprofessional team to solve problems in clinical practice.

22.3 Gender Dysphoria

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss terminology from the APA *DSM-5-TR* relative to gender identity
- Describe stressors reported by clients due to gender dysphoria
- Outline issues involved in planning nursing care for client with gender dysphoria
- Identify nurses' potential reactions to clients with gender dysphoria

Gender is a social construct and an individual experience (WHO, 2024b); people learn to act in accordance with the socially constructed expectations of their gender as they grow up. A person's sex is determined by a person's chromosomes, reproductive organs, and other characteristics; we typically determine sex by the genetic makeup of an individual as 46,XX (female) or 46,XY (male). The society in which an individual develops holds specific norms about roles, responsibilities, and behaviors to which individuals are expected to conform. These norms are based on the society's beliefs about what male and female roles, responsibilities, and behaviors "should" be. A person's gender identity is their deeply held internal perception of their gender. Generally, "cisgender" individuals are those whose gender identity and often their roles and behaviors are congruent with their sex. Other people may identify as both male and female or neither male nor female; some believe that they are not in the right body. Some terms in current use include *genderqueer* or *genderfluid*, which fall under the broader term of "nonbinary" (Clark et al., 2018). Transgender is a broad term that can be used to describe people whose gender identity is different from the gender they were thought to be when they were born. A transgender woman is a person who was assigned male at birth but who identifies and/or lives as a woman; a transgender man was assigned female at birth but lives as a man. Some, but not all, transgender or nonbinary people may experience **gender dysphoria**, a distress or unease that can occur when one's gender identity does not match their sex assigned at birth. The *DSM-5-TR* defines the term as "a marked incongruence between one's experienced/expressed gender and assigned gender" (APA, 2022, p. 511). More specifically, gender dysphoria is defined as a condition that must persist for at least six months and leads to significant dissatisfaction or discomfort.

In recent years, the subject of gender dysphoria has come to the forefront. There is greater awareness of children and early adolescents who persistently feel that they are in the "wrong body" (Testa et al., 2015). In a representative sample of high school students living in San Francisco, 3.4 percent reported either being sure they were Transgender or seriously questioning if they were (Johns et al., 2019). Many of these young people experience gender dysphoria and other mental health problems, including suicide attempts (Lowry et al., 2018).

Many parents of children who believe they were assigned the wrong sex at birth seek medical and psychological attention because of the extreme distress experienced by these children. Some children may express their disappointment and frustration associated with gender dysphoria at as young as four years of age; many display clinical depression and suicidal ideation and attempts (Olson et al., 2015). Medical response to this angst has resulted in the increased use of puberty blockers to help early adolescents and their families deal with these mental

health issues. Puberty blockers are drugs (usually gonadotropin-releasing hormone agonists [GnRHa]) that are prescribed for those children when they reach Tanner stage 2. The purpose of these drugs is to stop the process of puberty temporarily, giving the child and family more time to determine the authenticity and determination of the child's desire to transition to the other sex; this is one aspect of a phenomenon known as gender-affirming care (Edwards-Leeper et al., 2016).

The use of puberty blockers is part of the expert guidelines for children with gender dysphoria provided by the Endocrine Society in the United States (Hembree et al., 2017) and the World Professional Association for Transgender Health (Coleman et al., 2022). The use of these drugs is controversial because few longitudinal studies have been done to support the claim that they are reversible and cause no long-term consequences. These drugs have been shown to be safe in treating children with other endocrine disorders, such as precocious puberty (Lee et al., 2014). The limited studies completed to date provide some evidence that these hormones decrease lean body mass and height velocity; they are also credited, however, with providing hope and improved psychological functioning to gender-dysphoric youth (Rew et al., 2021).

The U.S. health-care system has been developed historically within the context of gender as a binary construct (Kilicaslan & Petrakis, 2019). That is, persons were assigned male at birth merely from the appearance of the external genitalia (penis and scrotum with or without descended testicles), or female from the appearance of the vulva and vaginal opening. These birth assignments have generally not been made from analysis of chromosomes that would confirm the male as 46,XY and the female as 46,XX. A **cisnormative** person has a gender identity that is congruent with their biological sex, or sex assigned at birth (Cicero & Wesp, 2017), whereas others may be identified as gender diverse (i.e., Transgender, Queer, Intersex, agender). Persons who do not identify as cisgender frequently experience health disparities related to stigma and discrimination related to their sexual identity and expression (Puckett et al., 2018).

Many persons who experience gender dysphoria engage in a process of transition from the sex assigned at birth to the sex they believe they are. These people may identify as Transgender or trans. Owing to a lack of understanding on the part of much of society, including those providing health-care services, they often experience a lack of appropriate services and, therefore, frequently avoid seeking routine health-care screenings and other services. The actual meaning of transition is highly individualized, meaning not all trans people take hormones or undergo cosmetic or gender-affirming surgery, especially when considering the cost of these services and lack of available providers.

REAL RN STORIES

Nurse: Calvin N., RN ADN
Years in Practice: 2+ years
Clinical Setting: Public family clinic
Geographic Location: Tampa, FL

I completed my associate degree nursing program in December 2021. My roommate for the last two semesters was Dex, and the two of us had spent every waking moment studying, being in class or clinical, or "socializing" with other students, which meant we were either studying for an exam or working on a group project.

The night of graduation, Dex went back to the apartment while I spent a few hours celebrating. When I got home, Dex had bags packed and was waiting to tell me goodbye. I asked what was going on—and I did say it wasn't necessary to explain because I could see Dex was preoccupied. I was surprised to learn that Dex had decided to put nursing on hold to pursue getting gender affirmation surgery.

After Dex left, I thought a lot about the situation and realized that I had only known Dex as a hard-working, stressed-out nursing student just like me. Thinking back, Dex was sort of a loner and seemed sad much of the time.

Since graduation, I have been working in a public family clinic and it has been great! There is a pediatrician on staff who has referred several adolescents to a multidisciplinary team for gender dysphoria and I am glad to see that these issues can be addressed early on.

It is expected that health-care providers will be responsive to the unique needs of Transgender individuals and develop gender-affirming care. WPATH, the World Professional Association for Transgender Health, "is an international, multidisciplinary professional association whose mission is to provide evidence-based care, education, research, public policy, and respect in transgender health" (Coleman, et al., 2022, p. S3). WPATH has published Standards of Care since 1979 to guide health-care professionals in providing safe care for gender-diverse individuals.

LIFE-STAGE CONTEXT

Age-Related Matters of Transgender Behaviors

The age at which a child begins to experience the incongruence between assigned gender and preferred gender varies widely. One study indicated the onset of symptoms of gender dysphoria in children as young as four years of age (Olson et al., 2015). Children and adolescents with gender dysphoria exhibit a variety of psychosocial problems that may include illicit drug use, binge drinking, symptoms of depression, and suicidal ideation (Zou et al., 2018). Some of their behavioral problems are responses to perceived parental and/or sibling rejection (Schmitz & Tyler, 2018). The early adolescent, assigned female at birth, with gender dysphoria may bind the breasts during puberty hoping to appear more masculine. Similarly, the young person who was assigned male at birth, may bind the scrotum to appear more feminine. These behaviors emphasize the extreme discomfort the child with gender dysphoria has for their own body.

Gender Identity

Gender identity is a category of social identity that differs from sex (APA, 2022). It is one's sense of self as being a male, female, or another gender, such as genderfluid or gender neutral. During childhood, children explore gender roles and may try on behaviors more commonly seen in the other sex. Feedback from parents, siblings, and peers helps to shape their sense of identity. In addition, the larger culture in terms of the location of their home, school, and religious affiliation provides enlarged areas in which to experience what it means to be male or female. During puberty, one's identity is of central importance as the adolescent is in the developmental stage of deciding who they are. This decision process is complex and involves reflection on earlier stages of life and ongoing stages of exploration and experimentation. In emerging adulthood, one ultimately integrates the many possible selves into an identity that strongly influences one's education, occupation, social relationships, and self as a mature sexual being (Harter, 2015).

It is important to make the distinction between sexual orientation and gender identity. The common acronym LGBTQIA+ refers to both sexual orientation and gender identity. The term *queer* may be used to describe either sexual orientation or gender identity; *Q* may also refer to *questioning* about one's orientation, identity, or sexual expression (Cicero & Wesp, 2017).

LINK TO LEARNING

This link presents a video of several Transgender youth who clarify terminology (https://openstax.org/r/77TransgenTerms) and indicate that Transgender connotes a wide variety of identities.

The word *dysphoria* means to feel dissatisfied or very unhappy. For individuals who experience gender dysphoria, they may feel this dissatisfaction and unhappiness in at least three general ways: physical, social, and mental. In terms of the physical domain, people with gender dysphoria are generally unhappy with the sexual parts of their body. For example, a person who was assigned the sex of male at birth may feel very unhappy to have the external genitalia of a penis and scrotum. Some children who were assigned male at birth (AMAB) have even announced that they wanted to or actually tried to cut off their own penis. In terms of the social domain, people with gender dysphoria are generally unhappy or dissatisfied with how they are expected to act or dress. For example, the person AMAB may state that they want to wear dresses and not pants; they may also want to change their name from John to Johanna, for instance. In terms of the mental domain, people with gender dysphoria are generally quite certain that they are inhabiting the wrong body and cannot believe that the sex assigned to them at birth is truly accurate

for who they really are.

Stressors Reported by Clients Owing to Gender Dysphoria

Children and adolescents who experience gender dysphoria may find schools to be hostile environments. Harassment, bullying, and discrimination are not uncommon, even in early childhood. As a result, many children, already feeling depressed and lonely because of their confusing gender identity, resort to using tobacco and alcohol. Most schools lack policies that would protect Transgender children and adolescents, which may lead to excessive absenteeism and victimization (Cicero & Wesp, 2017). It is important to note that gender diversity itself is not a psychiatric disorder or diagnosable illness. The child, adolescent, or adult who experiences gender dysphoria may also feel psychosocial distress that may manifest as symptoms of depression, anxiety, or eating disorders, however (Diemer et al., 2015).

The prevalence of gender dysphoria in the general population is relatively low, but the stress experienced by this underrepresented group is relatively enormous, sometimes even leading to and resulting in suicide. Suicidal ideation is particularly high in people of color who also experience discrimination related to their sexual orientation and gender identity (Sutter & Perrin, 2016). Insecurity, inferiority, irritability, shame, fear, loneliness, and hopelessness are among the stressful feelings associated with gender dysphoria (Testa et al., 2015).

Studies have shown that individuals who experience gender dysphoria not only experience heightened anxiety and suicidal ideation, but they experience ongoing concerns about gender-affirming health care (Edwards-Leeper et al., 2016; Reisner et al., 2015). For example, transmasculine individuals, those who are assigned female at birth, do not identify as female and may seek hormone therapy or gender-affirming surgery. In particular, those from racial and ethnic underrepresented populations face unique barriers to reproductive health-care services. They continue to be at high risk for STIs, HIV, and unplanned pregnancy (Agenor et al., 2022). Most health-care services that address gynecological care are provided under labels such as "women's health," but this term does not reflect the sensitivity needed to provide similar services to Transgender individuals who were assigned female at birth but identify as males. One participant in a qualitative study of transmasculine persons affirmed that just talking to the doctor ". . . about sexual health stuff always gave me violently bad dysphoria" (Agenor et al., 2022, p. 124).

In its Standards of Care, the World Professional Association for Transgender Health (WPATH) recommends that health-care professionals use the correct terms and language when interacting with gender-diverse individuals that reflect respect, uphold their dignity, and assure their safety. This international organization of multiple disciplines recognizes that persons who experience gender dysphoria or who are in transition from their natal sex (sex assigned at birth) to their expressed sex or gender experience stigma and discrimination, which often leads to health disparities. Many people who transition from their natal sex to their preferred gender do not receive adequate health care because they encounter numerous barriers, including discrimination (Puckett et al., 2018). As a result of such discrimination, many stop having regular health checkups, screening, and vaccinations.

LINK TO LEARNING

Watch this video about a trans male who explains gender dysphoria (https://openstax.org/r/77gendysphoria) and describes the differences between physical, social, and mental dysphoria.

Nursing Interventions and Management

Political rhetoric in the United States has drawn attention to the experiences of Transgender children and early adolescents. The nation's health objectives, known as *Healthy People 2030*, include an objective that is specific to improving "the health, safety, and well-being of lesbian, gay, bisexual, and transgender people" (U.S. Department of Human Services, n.d., para 1). As a result of these forces, researchers have begun to examine the preparation of nursing students in providing care to sexually and gender-diverse persons. To provide safe and culturally appropriate care for sexual minorities, nurses must first recognize and examine their own personal beliefs, biases, and assumptions about those who are different from themselves (Campinha-Bacote, 2007).

McCann and Sharek (2016) analyzed the findings from ten published papers and found that mental health services for Transgender individuals are often missing or inadequate. They recommended that "mental health nurses needed

relevant knowledge and skills to be able to deliver culturally competent care that encourages resilience and empowerment in transgender clients" (p. 284). Moreover, they noted that nurses may require additional training about the process of Transgender transition, use of hormones, HIV prevention and care, and other aspects of gender-affirming care.

The American Nurses Association opposes restrictions on Transgender health and calls for nursing advocacy (ANA, 2022). Throughout nursing education and services, nurses are encouraged to be knowledgeable about their clients' disease/illness processes and treatment. Nurses working with children and adolescents should listen to what they say about their gender, provide support, and refer to other health-care professionals who have more experience or comfort with this subject (Cicero & Wesp, 2017). Nurses should be knowledgeable about community resources that may be available for diverse clients and their families. Nurses should seek to learn from their peers who have different sexual orientations or gender identities from their own; such interactions provide essential social support to all nurses.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Teamwork and Collaboration to Address Gender Dysphoria

Although there is a paucity of nursing literature addressing gender dysphoria, nurses have the potential to contribute to greater knowledge and understanding of this important area of health care. One of the hallmarks of Quality and Safety Education for Nurses (QSEN) is that of teamwork and collaboration. Nurses who can reach out to other health professionals and seek answers to questions of how best to address the health-care issues of these clients will be making an important contribution to the overall health of society. Interprofessional education that includes social workers, pharmacists, physical therapists, occupational therapists, as well as physicians and nurses should address the unique needs of clients with gender dysphoria. In particular, there is a great need to understand how this phenomenon affects young children and young adolescents. The political climate in some conservative states, however, currently threatens the expansion of knowledge and understanding in this area. Nurses can advocate for citizens in these states to consider the evidence of how treatments, such as using puberty blockers for young adolescents who might otherwise be suicidal, is a good, not immoral, thing to do. Similarly, nurses can advocate for all members of society to learn to accept others who are different from themselves and to bring an end to "hate speech" and discriminatory behavior.

As in all areas of sexual health, the PLISSIT and ExPLISSIT models of sexual communication can be an important component of planning excellent nursing care. Many clients have developed fears related to their sexual health that stem from adverse childhood experiences or from learning from well-meaning adults in their lives that sex and sexual matters are not subjects to be approached in polite company. Nonetheless, communication is essential in developing sexual health. Just giving another permission to talk about a matter that has been long forbidden is often a life-changing first step in managing a sexual health issue.

It's also important to know one's own limitations concerning sexual health information. If you don't know the answer, be willing and ready to refer a client to someone who has more knowledge and experience in this important subject. If you are not certain about the information you are sharing with a client, do not give them misinformation. Be willing to explore professional literature in nursing, medicine, psychology, and sociology to find answers to your questions and those of your clients. Also be willing to start a conversation with a more experienced nurse, whom you trust, and who may have previous experience planning and providing care for persons with gender dysphoria.

Nurses' Potential Reactions to Clients with Gender Dysphoria

Some nurses may feel conflicted and uncomfortable when assigned to care for a person with gender dysphoria. Religious upbringing, strong beliefs about sexuality, and what is "right" or "wrong" may have resulted in the nurse holding unexamined biases and stereotypes of persons who are "different." When this is the case, it is important to share this discomfort with the person who has made the assignment so that the nurse can process the feelings and thoughts that come to the surface.

Some nurses may be going through a questioning process or may be in transition themselves. Awareness of one's own sense of gender identity will influence how the nurse thinks about clients who experience gender dysphoria.

Such awareness may enable the nurse to be an ally, offer support, and provide encouragement to the client. Having a safe and supportive group of friends and family will make such a journey healthy (Testa et al., 2015). When nurses are comfortable and secure in their own gender identity and feel confident that they can provide safe and sensitive care, they are then likely to treat the client experiencing gender dysphoria with respect and genuine caring.

LINK TO LEARNING

Franklin Covey created a self-assessment tool (https://openstax.org/r/77nursebias) to help explain what is meant by *bias* and how it may affect one's behavior as a professional nurse.

Summary

22.1 Categories of Sexual Dysfunction

Sexuality and sexual health are central to human well-being. Nurses in all health-care settings must keep in mind that their clients are sexual beings and that they may experience mild, moderate, or severe problems in different aspects of their sexual identity and/or behavior. Psychiatric care settings may provide the greatest opportunity for nurses to view and respond to the symptoms and distress of human sexual dysfunction; nurses and nursing students must first become aware of their own attitudes and beliefs about sexuality, however, before they can become skilled in this aspect of nursing care. Nursing students may need to enhance their educational preparation by taking a human sexuality elective in another department if their nursing curriculum does not provide sufficient information.

22.2 Paraphilias

The paraphilias are a type of sexual interest (i.e., urges, fantasies, behaviors) that are not limited to genital stimulation or fondling between mature, consenting human partners (APA, 2022). This classification of sexual interest is controversial as a psychiatric disorder, but when the urges or fantasies are enacted by an individual on another, nonconsenting individual, they may have dire legal consequences. Paraphilias may be limited to private thoughts and feelings, or they may involve acting out the urges and fantasies that involve other, nonconsenting individuals.

22.3 Gender Dysphoria

Gender dysphoria is characterized by unease or discomfort related to a person's strong belief or desire to be a gender other than one they were assigned at birth, with associated distress. This strong sense may manifest differently at a very young age than it does in adolescence or adulthood. The dysphoria often results in great distress for the child and the family. Children and adolescents may cope with their distress through many harmful behaviors, including illicit drug use, binge drinking, or exhibiting symptoms of depression. Moreover, they may also have suicidal ideation. The treatment of children and adolescents with gender dysphoria is somewhat controversial, especially in terms of the use of puberty blockers and gender affirmation surgery (usually reserved for adults). Health-care providers, however, are currently expanding what has become known as gender-affirming care to meet clients where they are and provide care as needed to clients who might otherwise avoid engaging in routine health checks.

Key Terms

cisnormative person who has a gender identity that is congruent with their biological sex, or sex assigned at birth
dyspareunia painful intercourse
ejaculation disorder pattern of ejaculation occurring either prematurely or delayed
erectile disorder difficulty in obtaining or maintaining a penile erection or experiencing a significant decrease in the rigidity of the erection during sexual activity
exhibitionism exposure of one's external genitalia to another person without their consent
female genital mutilation/circumcision (FGM/C) intentional removal of one or more parts of the external genitalia of young girls to protect their femininity and virginity in paternalistic cultures
fetishistic disorder paraphilia in which an individual has had intense and recurring sexual arousal from the use of nonliving objects, such as garments, or a highly specific focus on nongenital body parts
frotteurism person's tendency to become sexually aroused by rubbing oneself against another person without their consent
gender dysphoria personal, distressing disconnect between one's gender identity and their sex assigned at birth
gender identity one's sense of "self" as being a male, female, or some combination thereof
hypogonadism decreased activity of the ovaries or testes, which can cause endocrine disorders
myotonia increase in muscle tension (voluntary and involuntary muscles) throughout the body that occurs during sexual activity
orgasmic disorder disordered frequency or intensity of orgasm during sexual arousal and stimulation
paraphilia sexual desire or behavior involving inanimate objects or nonconsenting other persons, or including subjugation

pedophilic disorder paraphilia in which an individual, age sixteen years or older, is intensely attracted to a child or children and may engage in actual sexual behavior, including vaginal or rectal penetration
sexual dysfunction person's inability to respond sexually to mental or physical stimulation or to experience sexual pleasure
sexual interest/arousal disorder greatly reduced or lack of interest in or arousal by sexual stimulation
sexual masochism disorder paraphilia in which an individual has intense and recurring sexual arousal from being made to suffer from being beaten, bound, or humiliated
sexual response cycle pattern of physiological changes that occur in the human body during sexual arousal, stimulation, and engagement in sexual behavior
sexual sadism sexual arousal that results from inflicting physical or psychological suffering on another person
Transgender describes a person whose sex assigned at birth may differ from their gender identity
transvestic disorder paraphilia in which the person becomes sexually aroused or has urges and fantasies about becoming sexually aroused from cross-dressing
vaginismus very strong, involuntary contractions of muscles in the outer layers of the vagina, often associated with female sexual dysfunctions
vasocongestion increased presence of blood in spongy body tissues such as the penis and clitoris, labia, and nipples that occurs during sexual arousal and stimulation
vestibulodynia severe pain at the entrance of the vagina, often associated with female sexual dysfunctions
voyeurism being aroused by watching other people as they undress or engage in sexual activity, without their knowledge or consent

Assessments

Review Questions

1. To meet diagnostic criteria for sexual dysfunction as depicted in the *DSM-5-TR*, how long must a person have experienced the specific behavior?
    a. four weeks
    b. three months
    c. six months
    d. one year

2. What is a term used to describe painful intercourse?
    a. vaginismus
    b. dyspareunia
    c. anhedonia
    d. myotonia

3. What is a common surgical procedure that can potentially lead to erectile dysfunction in older males?
    a. prostate resection (TURP)
    b. hernia repair
    c. cystoscopy
    d. vasectomy

4. Orgasm is considered to be a phase in what cycle?
    a. sexual response
    b. sexual arousal
    c. sexual dysfunction
    d. sexual health

5. What classification of drugs is often responsible for adding stress in clients with sexual dysfunction?
    a. hormone replacements
    b. antihypertensives
    c. neuroleptics

d. antibiotics

6. What is the scientific or medical term used for feeling sexually aroused by rubbing one's body against another person against their will?
   a. exhibitionism
   b. frotteurism
   c. fetishism
   d. sexual masochism

7. A sexual behavior in which a person becomes aroused by a particular category of items (e.g., by lingerie) is known as what?
   a. sexual sadism
   b. pedophilia
   c. exhibitionism
   d. fetishism

8. What is the name of the act of feeling sexually aroused and fulfilled by giving another person physical or psychological pain?
   a. sexual sadism
   b. frotteurism
   c. sexual masochism
   d. voyeurism

9. An adolescent who experiences gender dysphoria is also likely to experience which of the following stressors? Select all that apply.
   a. isolation
   b. overcommitment
   c. stigma
   d. fatigue

10. When stressors associated with having gender dysphoria exceed the client's ability to cope effectively with their situation, what is the nurse's first step in responding?
    a. asking a more experienced nurse to meet with the client
    b. referring the family to a psychologist or psychiatrist
    c. giving permission to the client to talk about their feelings
    d. make specific suggestions to the client about other ways of coping with stress

Check Your Understanding Questions

1. What are the physiological changes that occur during the sexual response cycle?
2. What conflict might clients experience when medications affect an individual's sexual response and cause distress?
3. What is the main factor that distinguishes a paraphilia from a diagnosis of paraphilic disorder?
4. To meet diagnostic criteria found in the *DSM-5*, what two conditions must be met for a diagnosis of exhibitionistic disorder?
5. How can a nurse's intrapersonal experiences be related to the behavior of a client with a diagnosis of paraphilia?
6. What are two steps nurses could take when applying evidence-based nursing management of the client or family in distress related to a family member's paraphilic disorder?
7. Identify at least three stressors often reported by clients who experience gender dysphoria.

8. What is one of the first things a nurse should consider when planning care for a client with gender dysphoria?
9. Identify two conflicting feelings that nurses may have when interacting with a client who has gender dysphoria.
10. Nurses may feel confused when asked by a family member if puberty blocker medications are safe for their child. What is the name of an international organization that could offer scientific information to help this family?

Reflection Questions

1. How should the nurse respond to a question from a client who is concerned about whether a new medication will affect them sexually?
2. What experiences have you had within your family or community that have influenced the way you think about sexuality and sexual health?
3. What additional knowledge might you need to feel comfortable in discussing sexual health issues with your nursing clients?
4. What do you believe is the role nurses should play within the health-care team as it relates to providing safe and sensitive sexual health care?
5. Clients who experience sexual dysfunction and associated distress may benefit from the nurse who provides what kind of response?
6. Describe stressors reported by clients due to paraphilias.
7. Some clients may seek relief from psychological pain associated with paraphilic disorders. Identify two types of behavior that may exacerbate the client's distress.
8. In providing care for an adult with gender dysphoria, what are some things you could do to plan gender-affirming care?
9. If family members are reluctant to consider medical treatments (e.g., puberty blocking hormones) for a prepubertal child with serious gender dysphoria, how would you prepare yourself to provide care to this family?

What Should the Nurse Do?

Paul, a forty-two-year-old male, arrives at the urology clinic with concerns related to sexual dysfunction. He reports symptoms of erectile dysfunction, including difficulty achieving and maintaining an erection, leading to increased stress and strain in his relationship. Paul's medical history reveals a diagnosis of hypertension for which he is prescribed antihypertensive medication. His vital signs indicate a blood pressure of 140/90 mmHg, heart rate of 78 beats per minute, respiratory rate of 18 breaths per minute, and temperature of 98.5°F. During the assessment, Paul discloses stressors associated with his sexual dysfunction, citing work-related pressures and a recent family loss.

1. How might Paul's recent family loss and work-related pressures contribute to his experience of sexual dysfunction, and what implications does this analysis have for developing a holistic care plan?
2. As a nursing student, what solutions can be generated to address both the physiological and emotional aspects of Paul's sexual dysfunction, and how might these be integrated into his care plan?

Nick, a thirty-five-year-old male, seeks support at the mental health clinic for distress related to paraphilias. He reports symptoms of recurrent, intense sexual fantasies and urges involving nonconsenting partners, leading to significant personal distress. Nick's symptoms include persistent, intrusive thoughts about these fantasies that interfere with his daily functioning and interpersonal relationships. His anxiety and depression, managed with medication, have intensified with the distress caused by these symptoms. Vital signs are stable, with a blood pressure of 120/80 mmHg, heart rate of 76 beats per minute, respiratory rate of 16 breaths per minute, and temperature of 98.7°F.

3. Given Nick's history of anxiety and depression, what hypothesis should be prioritized in understanding the relationship between his mental health history and the exacerbation of paraphilic symptoms, and how does

this guide the selection of interventions?

4. How will a nursing student determine the effectiveness of interventions in alleviating Nick's distress and improving his overall well-being, and what adjustments might be necessary based on ongoing assessment?

Alex, a twenty-five-year-old Transgender individual, presents to the LGBTQIA+ health clinic seeking support for gender dysphoria. Alex reports experiencing significant distress due to a misalignment between assigned gender at birth and gender identity. Vital signs are stable, with a blood pressure of 118/76 mmHg, heart rate of 80 beats per minute, respiratory rate of 18 breaths per minute, and temperature of 98.6°F. Alex has a history of anxiety and depression, managed with therapy.

5. How might societal discrimination and challenges in social relationships contribute to Alex's experience of gender dysphoria, and what implications does this analysis have for planning nursing care?
6. Given Alex's history of anxiety and depression, what hypothesis should be prioritized regarding the impact of mental health on gender dysphoria, and how does this guide the selection of interventions?
7. What gender-affirming interventions and counseling support can you generate to address Alex's distress, and how might these be integrated into the nursing care plan?

Competency-Based Assessments

1. In a clinical setting, identify three common stressors reported by clients experiencing sexual dysfunction and explain how these stressors can impact both the physiological and psychological aspects of the condition.
2. As a clinical nurse, what potential reactions might you experience when caring for a client with sexual dysfunction issues, and how can self-awareness and empathy contribute to providing effective care?
3. As a nursing student, explain how evidence-based nursing management can be applied to address client and family distress related to sexual dysfunction, providing at least two evidence-based interventions.
4. What potential reactions might you experience when providing care to a client with paraphilias, and how can self-awareness and education help mitigate these reactions?
5. Why is it important for nurses to discuss terminology from the APA *DSM-5-TR* when providing care to clients with gender dysphoria, and how can this knowledge enhance communication and foster a supportive environment?
6. Discuss the potential reactions you might experience when providing care to a client with gender dysphoria, and explain how cultural competence and self-awareness can help manage these reactions.

References

Agenor, M., Zubizarreta, D., Geffen, S., Ramanayake, N., Giraldo, S., McGuirk, A., Caballero, M., & Bond, K. (2022). "Making a way out of no way:" Understanding the sexual and reproductive health care experiences of transmasculine young adults of color in the United States. *Qualitative Health Research, 32*(1), 121–134. https://doi.org/10.1177/10497323211050051

American Heart Association. (2023). *How high blood pressure can affect your sex life*. https://www.heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure/how-high-blood-pressure-can-affect-your-sex-life

American Nurses Association. (2022, October 26). *American Nurses Association opposes restrictions on Transgender healthcare and criminalizing gender-affirming care*. https://www.nursingworld.org/news/news-releases/2022-news-releases/american-nurses-association-opposes-restrictions-on-transgender-healthcare-and-criminalizing-gender-affirming-care/

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed.) [Text Revision]. American Psychiatric Association Publishing.

Annon, J. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioural treatment of sexual problems. *Journal of Sex Education and Therapy, 2*(1), 1–15.

Bell, S. (2020). Evidence-based practice competencies for RNs and APNs: How are we doing? *Neonatal Network, 39*(5), 299–302. https://doi.org/10.1891/0730-0832.39.5.299.

Busby, D. M., Leonhardt, N. D., Leavitt, C. E., & Hanna-Walker, V. (2020). Challenging the standard model of sexual response: Evidence of a variable male sexual response cycle. *The Journal of Sex Research, 57*(7), 848–859. https://doi.org/10.1080/00224499.2019.1705960

Buyuk, A., Cetin, S. Y., & Sakinci, M. (2021). The effects of pelvic floor muscle training and behavioral training on sexual dysfunction, incontinency, physical activity level and quality of life in the elderly. *Sexuality and Disability, 39*, 555–568. https://doi.org/10.1007/s11195-021-09684-1

Campinha-Bacote, J. (2007). Becoming culturally competent in ethnic psychopharmacology. *Journal of Psychosocial Nursing and Mental Health Services, 45*(9), 26–33. https://doi.org/10.3928/02793695-20070901-09

Campinha-Bacote, J. (2011). Coming to know cultural competence: An evolutionary process. *International Journal for Human Caring, 15*(3), 42–48.

Cappiello, J. D., & Boardman, M. B. (2022). Did I learn enough to practice? Reflections of new nurse practitioner graduates in providing sexual and reproductive health care. *Journal of the American Association of Nurse Practitioners, 34*(1), 109–118. https://doi.org/10.1097/JXX.0000000000000552

Castellini, G., Rellini, A., Appignanesi, C., Pinucci, I., Fattorini, M., Grano, E., Fisher, A. D., Cassioli, E., Lelli, L., Maggi, M., & Ricca, V. (2018). Deviancy or normalcy? The relationship among paraphilic thoughts and behaviors, hypersexuality, and psychopathology in a sample of university students. *The Journal of Sexual Medicine, 15*, 1322–1335. https://doi.org/10.1016/j.jsxm.2018.07.015

Cicero, E. C., & Wesp, L. M. (2017). Supporting the health and well-being of Transgender students. *The Journal of School Nursing, 33*(2), 95–108. https://doi.org/10.1177/1059840516689705

Cicero, E. C., Reisner, S. L., Merwin, E., Humphreys, J. C., & Silva, S. G. (2020). The health status of Transgender and gender nonbinary adults in the United States. *PLOS One, 15*(2), e0228765. https://doi.org/10.1371/journal.pone.0228765

Clark, B. A., Veale, J. F., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2018). Non-binary youth: Access to gender-affirming primary health care. *International Journal of Transgenderism, 19*(2), 158–169. https://doi.org/10.1080/15532739.2017.1394954

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., . . . Arcelus, J. (2022). Standards of care for the health of Transgender and gender diverse people, version 8. *World Professional Association for Transgender Health, 23*(S1), S1–S258. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

Crooks, R. L., & Baur, K. (2017). *Our sexuality* (13th ed.). Cengage Learning.

Diemer, E. W., Grant, J. D., Munn-Chernoff, M. A., Patterson, D. A., & Duncan, A. E. (2015). Gender identity, sexual orientation, and eating-related pathology in a national sample of college students. *Journal of Adolescent Health, 57*, 144–149. http://dx.doi.org/10.1016/j.jadohealth.2015.03.003

Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with Transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity, 3,* 165–172. http://dx.doi.org/10.1037/sgd0000167

Feng, T., Heulitt, G., Lee, L. J., Liao, M., Li, H.-F., Porter, J. R. (2020). Randomised comparison of techniques for control of the dorsal venous complex during robot-assisted laparoscopic radical prostatectomy. *BJU International, 126*(5), 586–594. https://doi.org/10.1111/bju.15133

Friedman, S. (2019). Assessing and treating sexual dysfunctions in Orthodox Jewish couples: A summary of 41 consecutive cases. *Mental Health, Religion & Culture, 22*(9), 930–942. https://doi.org/10.1080/13674676.2019.1688269

Galanakis, M., Kallianta, M., Katsira, C., Liakopoulou, D., Chrousos, P., & Darviri, C. (2015). The association between stress and sexual dysfunctionality in men and women: A systematic review. *Psychology, 6*, 1888–1892. https://dx.doi.org/10.4236/psych.2015.614186

Gerritse, K., Hartman, L., Antonides, M. F., Wensing-Kruger, A., de Vries, A. L. C., & Molewijk, B. C. (2018). Moral challenges in Transgender care: A thematic analysis based on focused ethnography. *Archives of Sexual Behavior, 47*, 2319–2333. https://doi.org/10.1007/s10508-018-1287-3

Gerritse, K., Martens, C., Bremmer, M. A., Kreukels, B. P. C., DeBoer, F., & Molewijk, B. C. (2022). Sharing decisions and uncertainties: A qualitative interview study of healthcare professionals' ethical challenges and norms regarding decision-making in gender-affirming medical care. *BMC Medical Ethics, 23*, 139. https://doi.org/10.1186/s12910-022-00880-y

Gewirtz-Meydan, A., & Ofir-Lavee, S. (2021). Addressing sexual dysfunction after childhood sexual abuse: A clinical approach from an attachment perspective. *Journal of Sex & Marital Therapy, 47*(1), 43–59. https://doi.org/10.1080/0092623X.2020.1801543

Ghadigaonkar, D. S., & Murthy, P. (2019). Sexual dysfunction in persons with substance use disorders. *Journal of Psychosexual Health, 1*(2), 117–121. https://doi.org/10.1177/2631831819849365

Hamilton, L. D., & Meston, C. M. (2013). Chronic stress and sexual function in women. *Journal of Sexual Medicine, 10*(10), 2443–2454. https://doi.org/10.1111/jsm.12249

Harter, S. (2015). *The construction of the self: Developmental and sociocultural foundations*. The Guilford Press.

Hembree, W. C., Cohen-Kettenis, P., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society* Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism, 102,* 3869–3903, https://doi.org/10.1210/jc.2017-01658

Hortal-Mas, R., Moreno-Poyato, A. R., Granel-Giménez, N., Roviralta-Vilella, M., Watson-Badia, C., Goméz-Ibáñez, R., Aguayo-González, M. P., Giménez-Diez, D., Bernabeu-Tamayo, M. D., & Leyva-Moral, J. M. (2020). Sexuality in people living with a serious mental illness: A meta-synthesis of qualitative evidence. *Journal of Psychiatric Mental Health Nursing, 29*, 130–146. https://doi.org/10.1111/jpm.12700

Jadoon, S. B., Nasir, S., Victor, G., & Pienaar, A. J. (2022). Knowledge, attitudes and readiness of nursing students in assessing peoples' sexual health problems. *Nurse Education Today, 113*, 105371. https://doi.org/10.1016/j.nedt.2022.105371

Johns, M. A., Lowry, R., Andrzejewski, J., Barrios, L. D., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students—19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Reports, 68*, 67–71. https://www.cdc.gov/mmwr/volumes/68/wr/mm6803a3.htm

Kaplan-Marans, E., Sandozi, A., Martinez, M., Lee, J., Schulman, A., & Khurgin, J. (2022). Medications most commonly associated with erectile dysfunction: Evaluation of the Food and Drug Administration National Pharmacovigilance Database. *Sexual Medicine, 10*(5), 100543. https://doi.org/10.1016/j.esxm.2022.100543

Kilchevsky, A., Vardi, Y., Lowenstein, L., & Gruenwald, I. (2012). Is the female G-spot truly a distinct anatomic entity? *Journal of Sex Medicine, 9*, 719–726. https://doi.org/10.1111/j.1743-6109.2011.02623.x

Kilicaslan, J., & Pitrakis, M. (2019). Heteronormative models of health-care delivery: Investigating staff knowledge and confidence to meet the needs of LGBTIQ+ people. *Social Work in Health Care, 58,* 612–632. https://doi.org/10.1080/00981389.2019.1601651

Kudesia, R., Alexander, M., Gulati, M., Kennard, A., & Tollefson, M. (2021, May 8). Dietary approaches to women's sexual and reproductive health. *American Journal of Lifestyle Medicine, 15*(4), 414–424. https://doi.org/10.1177/15598276211007113

Leavitt, C. E., Leonhardt, N. D., & Busby, D. M. (2019). Different ways to get there: Evidence of a variable female sexual response cycle. *The Journal of Sex Research, 56*(7), 899–912. https://doi.org/10.1080/00224499.2019.1616278

Lee, J. W., Kim, H. J., Choe, Y. M., Kang, H. S., Kim, S. I., Jun, Y. H., & Lee, J. E. (2014). Significant adverse reactions

to long-acting gonadotropin-releasing hormone agonists for the treatment of central precocious puberty and early onset puberty. *Annual Pediatric Endocrinology and Metabolism, 19*, 135–140. https://doi.org/10.6065/apem.2014.19.3.135

Lowry, R., Johns, M. M., Gordon, A. R., Austin, B., Robin, L. E., & Kann, L. K. (2018). Nonconforming gender expression and associated mental distress and substance use among high school students. *JAMA Pediatrics, 172*, 1020–1028. https://doi.org/10.1001/jamapediatrics.2018.2140

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response.* Little, Brown and Company.

Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1988). *Masters and Johnson on sex and human loving.* Little, Brown and Company.

McCabe, M. P., & Connaughton, C. (2017). Sexual dysfunction and relationship stress: How does this association vary for men and women? *Current Opinion in Psychology, 13*, 81–84. http://dx.doi.org/10.1016/j.copsyc.2016.05.007

McCann, E., & Sharek, D. (2016). Mental health needs of people who identify as Transgender: A review of the literature. *Archives of Psychiatric Nursing, 30*, 280–285. http://dx.doi.org/10.1016/j.apnu.2015.07.003

Mitchell, K. R., Lewis, R., O'Sullivan, L. F., & Fortenberry, J. D. (2021). What is sexual wellbeing and why does it matter for public health? *The Lancet Viewpoint, 6*(8), E608–E613. https://doi.org/10.1016/S2468-2667(21)00099-2

Morin, M., Dumoulin, C., Bergeron, S., Mayrand, M-H., Khalifé, S., Waddell, G., Dubois, M-F., & PVD Study Group. (2021). Multimodal physical therapy versus topical lidocaine for provoked vestibulodynia: A multicenter, randomized trial. *American Journal of Obstetricians and Gynecologists, 224*(2), 189. E1-189.e12. https://doi.org/10.1016/j.ajog.2020.08.038

Mwendwa, P., Mutea, N., Kaimuri, M. J., De Brún, A., Kroll, T. (2020). "Promote locally led initiatives to fight female genital mutilation/cutting (FGM/C)" lessons from anti-FGM/C advocates in rural Kenya. *Reproductive Health, 17*(1), 30. https://doi.org/10.1186/s12978-020-0884-5

Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline physiologic and psychosocial characteristics of Transgender youth seeking care for gender dysphoria. *Journal of Adolescent Health, 57*, 374–380. http://dx.doi.org/10.1016/j.jadohealth.2015.04.027

Pang, N. T. P., Masiran, R., & Alimuddin, A. S. (2023). Paraphilia without symptoms of primary psychiatric disorder: A case report. *Journal of Medical Case Reports, 17*, 46. https://doi.org/10.1186/s13256-023-03774-8

Puckett, J. A., Cleary, P., Rossman, K., Mustanski, B., & Newcomb, M. E. (2018). Barriers to gender-affirming care for Transgender and gender nonconforming individuals. *Sex Research and Social Policy, 15,* 48–59. https://doi.org/10.1007/s13178-017-0295-8

Quinn, C., & Happell, B. (2011). Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care. *International Journal of Mental Health Nursing, 21*, 154–162. https://doi.org/10.1111/j.1447-0349.2011.00783.x

Quinn, C., & Happell, B. (2013). Talking about sexuality with consumers of mental health services. *Perspectives in Psychiatric Care, 49*, 13–20. https://doi.org/10.1111/j.1744-6163.2012.00334.x

Reichmann, G., Parlier-Ahmad, A. B., Beck, L., Thakkar, B., Alappattu, M., Boissoneault, J., & Martin, C. E. (2022). Chronic pelvic pain and sexual dysfunction among females and males receiving treatment for opioid use disorder. *Frontiers in Pain Research, 2*, 787559. https://doi.org/10.3389/fpain.2021.787559

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of Transgender youth in care at an adolescent community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56,* 274–279. https://dx.doi.org/10.1016/j.jadohealth.2014.10.264

Rew, L., Young, C., Monge, M., & Bogucka, R. (2021). Puberty blockers for Transgender and gender diverse youth: A critical review of the literature. *Child & Adolescent Mental Health, 26(1*), 3–14. https://dx.doi.org/10.1111/

camh.12437

Sathyanarayana Rao, T. S., Maheshwari, S., George, M., Chandran, S., Manohar, S., & Rao, S. S. (2018, February). Psychosocial interventions for sexual dysfunction in addictive disorders. *Indian Journal of Psychiatry, 60*(Suppl 4), S506–S509. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_37_18

Savoie, V., Quayle, E., & Flynn, E. (2021). Prevalence and correlates of individuals with sexual interest in children: A systematic review. *Child Abuse and Neglect, 115*, 105005. https://doi.org/10.1016/j.chiabu.2021.105005

Schmitz, R. M., & Tyler, K. A. (2018). The complexity of family reactions to identity among homeless and college lesbian, gay, bisexual, Transgender, and queer young adults. *Archives of Sex Behavior,* 47, 1195–1207. https://doi.org/10.1007/s10508-017-1014-5

Serin, E. K., Dal, N. A., & Öner, Ö. I. (2020). The communication skills and empathic tendencies of nursing and midwifery students to reproductive pattern section of the care plan. *Sexuality and Disability, 38*, 161–171. https://doi.org/10.1007/s11195-019-09587-2

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology, 63*(1), 98–105. https://dx.doi.org/10.1037/cou0000

Taylor, B., & Davis, S. (2007). The extended PLISSIT model for addressing the sexual wellbeing of individuals with an acquired disability or chronic illness. *Sex and Disability, 25*, 135–139. https://doi.org/10.1007/s11195-007-9044-x

Testa, R. J., Coolhart, D., & Peta, J. (2015). *Gender quest workbook: A guide for teens & young adults exploring gender identity.* New Harbinger Publications, Inc.

U.S. Department of Health and Human Services. (n.d.) *LGBT*. https://health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt

Vieira-Baptista, P., Lima-Silva, J., Preti, M., Xavier, J., Vendeira, P., & Stockdale, C. K. (2021). G-spot: Fact or fiction?: A systematic review. *Sexual Medicine, 9*, 100435. https://doi.org/10.1016/j.esxm.2021.100435

Williams, M., & Addis, G. (2021). Addressing patient sexuality issues in cancer and palliative care. *British Journal of Nursing, 30*(10, Oncology Supplement), S24–328.

Wincze, J. P., & Weisberg, R. B. (2015). *Sexual dysfunction: A guide for assessment and treatment* (3rd ed.). Guilford.

World Association for Sexual Health. (2021). *WAS statement concerning actions to support gender diversity worldwide.* https://worldsexualhealth.net/wp-content/uploads/2022/03/august10_2021.pdf

World Health Organization. (2024a). *Female genital mutilation.* https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

World Health Organization. (2024b). *Gender and health*. https://www.who.int/health-topics/gender#tab=tab_1

World Health Organization. (2024c). *Sexual health*. https://www.who.int/health-topics/sexual-health#tab=tab_3

Yakeley, J., & Wood, H. (2014). Paraphilias and paraphilic disorders: Diagnosis, assessment and management. *Advances in Psychiatric Treatment, 20*, 202–213. https://doi.org/10.1192/apt.bp.113.011197

Zou, Y., Szczesniak, R., Teeters, A., Conard, L. A. E., & Grosssoehme, D. H. (2018). Documenting an epidemic of suffering: Low health-related quality of life among Transgender youth. *Quality of Life Research, 27*, 2107–2115. https://doi.org/10.1007/s11136-018-1839-y

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38*, 151–189. https://doi.org/10.1080/0092623X.2011.611219

CHAPTER 23
Children and Adolescents

FIGURE 23.1 Understanding the psychiatric-mental health issues that can affect young people and older adults is important for a nurse to care for clients across the life span. (credit: "Ada's feet" by Christian Haugen/flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION Nurses should be aware of the ways that neurodevelopmental and neurocognitive disorders affect the brain and neurological systems function (Environmental Protection Agency [EPA], 2023). These disorders most often begin during a person's developmental stages, such as in toddlers, children, and adolescents, but they persist into adulthood (Blain, 2022). Neurodevelopmental disorders have a genetic component, but can also be associated with environmental factors, such as lead exposure (EPA, 2023). Nurses have a role in educating clients about environmental factors that have the potential to cause or exacerbate these conditions. A child with a neurodevelopmental disorder can have "difficulties with language and speech, motor skills, behavior, memory, learning, or other neurological functions" (EPA, 2023, About the Neurodevelopmental Disorders Indicators section, para. 2). Nurses also have a role in performing and staying attuned to continued research on new treatments, medications, and preventive strategies for neurodevelopmental disorders.

23.1 Intellectual Disabilities

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the issues involved in diagnosing intellectual disabilities
- Recall the major forms of intellectual disability
- Outline approaches used in the treatment of intellectual disability

According to the American Psychiatric Association (2021b), intellectual disabilities affect 1 percent of the population. Most cases are found in males and, of all cases, about 85 percent of them are considered mild intellectual disability. The onset must be during the person's developmental period, which is before they turn twenty-two (American Association on Intellectual and Developmental Disabilities, 2023). There are two areas of functioning involved in intellectual disabilities: **intellectual functioning**, the way a person learns and problem-solves; and **adaptive functioning**, a person's ability to conduct their activities of daily living through communication and independent living.

Defining and Diagnosis of Intellectual Developmental Disorder

The preferred term for intellectual functioning that falls below an IQ of 70 and starts before age eighteen is **intellectual developmental disorder**, previously known as "mental retardation" (EPA, 2015). These disabilities can affect speech, thought, language, socialization, motor skills, and behavior (Empower Behavioral Health, 2023). Categories range from mild to severe. Classification is generally dependent upon the person's IQ level in combination with their functioning. Levels and manifestations of intellectual disability vary greatly in children. Children with an intellectual disability might have a hard time communicating their needs, and an intellectual disability can cause them to develop more slowly than other children of the same age.

Causes of intellectual disabilities include genetic disorders (Down syndrome, Fragile X syndrome, Prader-Willi syndrome); maternal infections and exposure to alcohol during pregnancy; traumatic injuries during the birth process; and exposure to measles, whooping cough, or meningitis (EPA, 2015; Special Olympics, 2023). In 30 to 50 percent of cases, the cause is unknown; researchers suspect that in milder forms of intellectual disabilities with an unknown cause, environmental factors, such as lead, mercury, and polychlorinated biphenyls (PCB) exposure, may be determining factors (EPA, 2015). Intellectual disability can be caused by a problem that starts any time before birth to when a child turns eighteen years old.

Life expectancy for individuals with intellectual disability may be that of the general population, according to the Association on Aging with Developmental Disabilities (2024). Loved ones of those with intellectual disabilities are advised to plan for their support in later life, including care providers, housing, and possibly estate planning or assets held in trust (Helpers Community, 2022).

Diagnosis of intellectual developmental disorders typically occurs when a parent or medical provider notices that a child is not meeting age-appropriate developmental guidelines for speech, language, socialization, motor skills, and behavior (Empower Behavioral Health, 2023). The nurse or medical provider can assess the child's development and then refer them for additional testing that might include a standardized IQ test (American Psychiatric Association, 2021a). The *DSM-5* diagnostic criteria focus on three domains: conceptual, social, and practical. Diagnosis is no longer based solely on IQ test scores, but instead connects the severity of the impact the disability has on a child's functioning to how they scored on an IQ test (American Psychiatric Association, 2013a). Therapies available include medication for specific symptoms, speech and behavior therapy, and counseling. Early intervention is important because it can improve the outcomes for the individual and their family.

The more severe the degree of intellectual disability, the earlier the signs can be noticed during developmental monitoring, such as the following (Centers for Disease Control and Prevention [CDC], 2021a):

- sitting up, crawling, or walking later than other children
- talking later than other children or having trouble speaking
- difficulty remembering things
- difficulty understanding social rules
- difficulty seeing the results of their actions
- difficulty solving problems

Refer children who are suspected to have an intellectual disability based on developmental screening to developmental pediatricians or other specialists for treatment. In children with a mild intellectual disability, there may not be an identification of deficit until after the child enters school, when they begin to show difficulties with learning (Committee to evaluate the supplemental security income disability program for children with mental disorders, 2015).

LINK TO LEARNING

Visit this website to understand the Classifications of Intellectual Disability Severity (https://openstax.org/r/77disabilitysev) published by the National Academy of Sciences.

Conceptual Domain

The **conceptual domain** of adaptive functioning includes a person's abilities in language, reading, writing, math, reasoning, knowledge, and memory (American Psychiatric Association, 2013a). Symptoms in this domain include slower learning; slower reading speed; difficulties with problem-solving, planning, and logical thinking; being easily distracted; and lacking focus (Cleveland Clinic, 2023a).

Social Domain

The **social domain** of adaptive functioning considers the individual's ability to make friends and have relationships with others. It encompasses communication skills, empathy, and social judgment (American Psychiatric Association, 2013a). Symptoms in this area include the inability to understand social boundaries, difficulty understanding relationships with others—friendships, romantic relationships—and appropriate social interactions (Cleveland Clinic, 2023a).

Practical Domain

The **practical domain** of adaptive functioning considers the individual's ability to act independently in their personal care, job role, school and work tasks, and money management (American Psychiatric Association, 2013a). Symptoms in this domain include having a slower ability to learn self-care activities, such as toileting, bathing, and dressing; inability to understand concepts, such as time or money management; and difficulty learning to complete chores (Cleveland Clinic, 2023a).

Types of Intellectual Disability

The types of intellectual disability are based on their causes, if known. Genetic mutations cause Down syndrome, fetal alcohol syndrome, Fragile X syndrome, and birth defects (Special Olympics, 2023). Cerebral palsy can be caused by trauma during delivery or infections during the pregnancy, such as toxoplasmosis or rubella, that interrupt fetal development (Cleveland Clinic, 2023a). Exposure to alcohol, tobacco, illicit drugs, medications, and radiation also interrupt fetal development. Certain medical conditions, such as hypothyroidism in the mother, can also affect the developing fetus and the intellectual abilities of the child once born. Head trauma to a baby or child can cause intellectual disabilities.

CULTURAL CONTEXT

Cultural Stigma toward Those with Intellectual and Developmental Disabilities (IDDs)

Individuals with IDD experience stigma. And stigma may vary by culture. Nurses should be aware of specific cultural stigmas that may be applied to this population of people in order to provide individualized treatment that aligns with personal/family beliefs. Some Asian and African cultures believe in interdependence and harmony, so they would be more apt to appreciate family interventions in which the person with IDD can feel accepted. In Thailand, for instance, it is important for families to be involved in cultural activities as a way of inclusion. Some Bangladeshi families want their family members who have IDD to be active participants in life, thus decreasing stigma. On the other hand, some Arab and Chinese families need more privacy because their cultures are more concerned with protecting the family from shame. These examples show the need for health-care providers to be cognizant that the interventions they provide must be culturally relevant in order to help decrease stigma while providing support to

individuals and their families.

(Jansen-van Vuuren & Aldersey, 2020).

Down Syndrome

When a baby is born with an extra chromosome 21, they are diagnosed with **Down syndrome**. The medical term for having an extra chromosome is trisomy; therefore, the medical name for Down syndrome is Trisomy 21 (CDC, 2023a). Down syndrome is the most commonly diagnosed chromosomal disease in the United States and occurs in about one out of seven hundred babies born each year (CDC, 2023a).

According to the CDC (2023a), distinguishing physical factors for Down syndrome include:

- a flattened face, especially the bridge of the nose
- almond-shaped eyes that slant up
- a short neck
- small ears
- a tongue that tends to stick out of the mouth
- tiny white spots on the iris (colored part) of the eye
- small hands and feet
- a single line across the palm of the hand (palmar crease)
- small pinky fingers that sometimes curve toward the thumb
- poor muscle tone or loose joints
- shorter in height as children and adults

Diagnosis typically happens during routine prenatal testing. There are two types of testing: screening tests, such as a blood test or ultrasound, and diagnostic tests, such as amniocentesis, that look at a sample of amniotic fluid. Screening tests are less invasive and considered safer for both the pregnant person and the fetus.

People with Down syndrome often have comorbidities, such as hearing loss, heart defects, and eye diseases. Medical treatments and surgery may be used to treat these conditions. Other services to help the person live a better life include speech, occupational, and physical therapy (CDC, 2023a). These services address the person's functioning in the conceptual, social, and practical domains.

Fragile X Syndrome

Fragile X syndrome is a genetic disorder that involves the Fragile X Messenger Ribonucleoprotein 1 (FMR1) gene responsible for producing a protein that helps brain development. When a person has Fragile X, they do not have this protein, and that causes developmental delays—such as an inability to sit up, walk, or talk by developmental guidelines—learning disabilities, and behavioral problems—such as not making eye contact, hand flapping, or an inability to sit still (CDC, 2022a). If it is suspected that the child is not reaching developmental milestones due to this disorder, providers can perform genetic testing by collecting blood to test the person's DNA (CDC, 2022a).

Physical features seen in a person with Fragile X include a long, narrow face, a large forehead and jaw, large ears and lazy eyes, soft skin, flat feet, decreased muscle tone, a high arch to the palate, and enlarged testicles in males (Cleveland Clinic, 2021). This disorder has no cure, but treatments include therapy to help a person learn to walk and talk. Medications may be used to help control behavior issues.

Early intervention services provided to children from birth to three years old help to increase the child's development. Parents can access information about services that are available in their state by going to the Center for Parent Information and Resources website (https://openstax.org/r/77parentresourc) and clicking on the tab for their state.

Fetal Alcohol Syndrome

Fetal alcohol spectrum disorders (FASDs) can occur when a fetus is exposed to alcohol during the prenatal period (CDC, 2022b). The symptoms that individuals experience can range from mild to severe and affect physical, behavioral, and cognitive functioning. The most serious of the FASDs is **fetal alcohol syndrome (FAS)**. Signs and symptoms of FAS include problems with the central nervous system, facial features (such as small eye opening, thin upper lip, low nasal bridge), and growth (such as a small head); learning disabilities; vision or hearing problems; and

difficulty in school. While there are no specific tests to diagnose FAS, medical assessment includes the alcohol intake history during the pregnancy, the baby's birth weight, facial features, and any problems with coordination or small head size. Although an exact number of cases is difficult to determine, the CDC has based an estimate on reviewing medical records and determined that in some areas of the United States one in one thousand live births is born with FAS (CDC, 2023b). According to the CDC (2022), there is no cure for FAS and treatment consists of medication management for some symptoms along with behavior therapy and parent training.

Prader-Willi Syndrome

Prader-Willi syndrome affects approximately one in 20,000 to 30,000 people in the United States (Fermin Gutierrez & Mendez, 2023). It entails an abnormality in the fifteenth chromosome that results in a genetic disorder affecting metabolism, behavior, and development. A hallmark symptom is a chronic feeling of not being full after eating (hyperphagia) combined with low metabolism that can lead to obesity (Cleveland Clinic, 2023b). Symptoms in infancy include a weak cry, weak muscle tone, lethargy, and inability to feed well. As the child grows, other physical symptoms may become more obvious. These include "almond shaped eyes, a long, narrow head, a triangular mouth, small hands and feet, short height, and underdeveloped genitals" (Cleveland Clinic, 2023b, para. 8). Behavioral and developmental symptoms, such as temper tantrums, intellectual disability, sleep problems, skin picking, and hyperphagia, also become more apparent. There is no cure for this syndrome and treatment is based on managing symptoms. Medications to increase certain hormones are given based on gender assigned at birth. Supportive therapies, such as physical, speech, and special education, can increase both physical and cognitive function in these children. Complications from the obesity related to overeating in Prader-Willi syndrome may include diabetes, heart disease and hypertension, respiratory problems, and sleep apnea (Cleveland Clinic, 2023b).

Treatment of Intellectual Disability

Treatment of intellectual disability is based on three categories: treatments or mitigation related to underlying causes, treatments of comorbid physical and mental disorders, and early behavioral and cognitive interventions (Committee to evaluate the supplemental security income disability program for children with mental disorders, 2015). All treatment should be person-centered and tailored to the individual.

LINK TO LEARNING

The American Nurses Association's position statement relating to people with intellectual and developmental disabilities (https://openstax.org/r/77nurseposition) asserts that individuals with these disabilities experience health-care disparities, require support across their life spans, and should receive person-centered care that includes advocacy and strengths identification.

Mitigation of Underlying Causes of Intellectual Disability

Research has shown that the causes of these disorders can be genetic, biological, psychological, and/or environmental (Committee to evaluate the supplemental security income disability program for children with mental disorders, 2015). While some of the causes occurring prenatally are related to genetics, and cannot be mitigated as easily, pregnant clients can have genetic testing and avoid other causes. Encourage clients to talk to their medical provider about genetic counseling prior to becoming pregnant if there is any family history of any genetic condition that can cause an intellectual disability. Educate pregnant clients to avoid things like drinking alcohol, smoking, and changing litter boxes (exposure to toxoplasmosis) during pregnancy. Keeping up with maternal vaccines that prevent illnesses prior to becoming pregnant, such as those for rubella, whooping cough, and meningitis, reduces the risk of fetal exposure. Accessing proper prenatal care and screenings can decrease the chances of premature birth. Although close observation by an obstetrician during the birth process can decrease brain injury that might occur during birth, there may still be birth complications that cause the baby not to get enough oxygen, resulting in an intellectual disability. After birth, parents can protect their children through proper use of car seats to prevent head trauma, by following the recommended vaccination and well-child appointments, eating a healthy diet, and limiting exposure to toxic metals, such as lead and mercury (Cleveland Clinic, 2023a).

CLINICAL JUDGMENT MEASUREMENT MODEL

Take Action: Interventions to Prevent Cognitive Disabilities

A first-time mother is at her obstetrician's office for her first prenatal visit. As part of the visit, the nurse goes into the exam room to provide education to the client. The nurse explains the importance of keeping up with her prenatal appointments and screenings. She also double-checks the client's vaccination history to determine if any important vaccines are missing, explaining to the client that diseases, such as rubella, can cause future cognitive disabilities for her baby. The nurse confirms that the client has a cat at home and asks the client if there is someone else in the house who can clean the litter box because possible exposure to the toxoplasma parasite in the cat's stool is harmful to the growing fetus (CDC, 2022c). As the client progresses through her prenatal visits, the nurse will continue to provide interventions to help ensure that the client is aware of prevention techniques to keep the baby safe from environmental factors that could cause cognitive disorders.

(Hooper, 2021; CDC, 2023b)

Treatment of Comorbid Physical and Mental Disorders

As many as 25 percent of people with intellectual disabilities have a psychiatric comorbidity. The most common of these are schizophrenia, depression, and attention-deficit hyperactivity disorder (Committee to evaluate the supplemental security income disability program for children with mental disorders, 2015). Medication and psychological support are the standard treatments. Genetically caused intellectual disabilities also may have associated physical disorders. Each of these is treated according to their severity—with medication or supportive therapies.

Early Behavioral and Cognitive Interventions

Under the Individuals with Disabilities Education Act (1990), early intervention services must be available to identify and help infants and toddlers (up to age three) who have disabilities (Center for Parent Information & Resources, 2017). Generally, early intervention programs, special education, vocational programs, day programs for adults, residential options, and case management (American Psychiatric Association, 2021a) may be available. The U.S. Department of Education and the Individuals with Disabilities Education Act (IDEA) offer special education programs for educational support once a child enters school. As a person ages, vocational training helps them learn how to work. An example of this is having a work partner to assist the high school individual in a work environment, such as a grocery store. Day programs provide the individual with an opportunity to get out of the house and be involved in activities with other people. There are residential options, such as group homes, for people whose intellectual disabilities are so severe that they are unable to care for themselves in their own home. Community agencies, such as local mental health centers, may also provide case management to assist clients with tasks, such as getting to medical appointments, managing medications, and grocery shopping.

More specifically, early intervention is a process that involves the child, the parent, and the intervention team meeting with the goal of providing problem-solving resources to the parent and child (Guralnick, 2017). The team develops an individualized education program (IEP) to address the child's educational needs (Center for Parent Information & Resources, 2017). Another resource is services under Section 504 for accommodations in school, including extracurricular programs (PACER Center, 2018). Parents can find a list of early intervention programs, by state, on the Centers for Disease Control and Prevention website (https://openstax.org/r/77earlyinterven). These services can increase the child's success in school by helping them overcome challenges they may have related to learning new skills (CDC, 2023c).

23.2 Communication Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline the different types of communication disorders
- Describe the principles used to treat communication disorders

Approximately one in ten American children have a communication disorder, one of a group of neurodevelopmental disorders that affect speech and language development (Psychology Today, 2022). While there is not one specific

etiology for communication disorders, some risk factors include medical problems, motor skill problems, and genetics (Law et al., 2017). Early intervention is the best way to treat communication disorders. Children with language disorders may feel frustrated when they cannot understand others or make themselves understood and, as a result, may act out, act helpless, or withdraw. Language or speech disorders may also be present with other disorders, such as ADHD, anxiety, or autism (CDC, 2021b). Table 23.1 lists some key signs of speech, language, and hearing disorders by age.

Age	Presentation
Birth to 3 months	No smiling or playing with others
4 to 7 months	No babbling
7 to 12 months	Minimal vocalization; no gestures
7 months to 2 years	No understanding of spoken words
12 to 18 months	Saying only a few words
1½ to 2 years	Not putting two words together
2 years	Saying fewer than 50 words
2½ to 3 years	Struggles with early reading and writing; shows no interest in books or drawing
2 to 3 years	Struggles with playing and talking with other children

TABLE 23.1 **Early Signs of a Speech, Hearing, or Language Disorder** (American Speech-Language-Hearing Association, 2023)

Defining Communication Disorders

Persistent difficulty with language and/or speech is considered a **communication disorder**. There are set developmental milestones that mark a healthy progression on the speech-language trajectory, and individuals with communication disorders may not meet them. Problems with articulation, quality, pitch, loudness, and repetition of speech sounds (stuttering) may characterize issues with speech. Overall causes of communication disorders include "hearing loss, neurological disorders, brain injury, vocal cord injury, autism, intellectual disability, drug abuse, physical impairments, emotional or psychiatric disorders, and developmental disorders" (Psychology Today, 2022, para. 15). There is an increased risk for communication disorders if there is a family history of these disorders. Communication disorders are more common in boys aged three to seventeen than their female counterparts (NIH, 2016).

Early intervention is the best treatment. Nurses should recommend that parents follow pediatric developmental milestones and can refer to the CDC website (https://openstax.org/r/77commhelp) (CDC, 2023d). The nurse can also recommend that the parents talk to the pediatrician when concerns arise regarding their child not reaching speech-language age-related milestones, such as making squealing sounds by age six months or saying mama or dada by age twelve months. Each age group listed on the CDC website has specific things that a child should be able to do or say by that age. Treatment may involve seeing a speech-language pathologist.

LIFE-STAGE CONTEXT

Stages of Communication Development in Childhood

During the first five years of a child's life, they are developing critical skills that assist them with learning verbal and reasoning skills, how to socialize with others, and growing their independence. Developmental milestones help both

parents and health-care professionals to recognize any deficits a child has that may indicate a communication disorder. Nurses working with pediatric clients can ask the parent questions about family history, when a child's symptoms were first noticed, and provide support to the parents.

(Psychology Today, 2023)

The *DSM-5* breaks communication disorders into five categories: language disorder, speech sound disorder, childhood-onset fluency disorder (stuttering), social communication disorder, and unspecified communication disorder, which can be caused by a medical or neurological condition and will not meet the *DSM-5* criteria.

Language Disorder

A **language disorder** is when an individual has difficulty learning and using spoken, written, or signed language. They can physically make the sounds but cannot use language correctly. Their language ability is below what is expected for their age. A person with language disorder is unable to adequately express and receive communication (Psychology Today, 2022). Expressive communication involves making the verbal or nonverbal signal and receptive communication is understanding the language that is taken in from another person.

Language disorders caused by a medical or neurological condition are not diagnosed with *DSM-5* criteria. These may include brain injury, a problem that occurred during pregnancy—such as maternal stress, folic acid and vitamin D insufficiency, and smoking and alcohol use (D'Souza et al., 2019)—a birth defect, or have an unknown cause. Other language disorders have a strong genetic factor; many children who develop them have a familial history. Treatment for language disorders is primarily through speech-language therapy. There may also be the need for psychotherapy in cases where the individual has behavioral issues.

Speech Sound Disorder

A **speech sound disorder** is the inability to articulate words or sounds in order to communicate with others. While this disorder may be the result of a physical complication, such as cleft palate, it may be related to a hearing impairment, a genetic component, or can be related to a neurodevelopmental problem in which the brain fails to correctly deliver impulses to muscles involved in making the sounds (Psychology Today, 2022).

Symptoms observed in children with a speech sound disorder include stuttering, lisping, using shorter words and syllables past the age of seven, having a nasal quality to their voice, and running out of air when talking. Referral to a speech-language pathologist for assessment and diagnosis is a common beginning of treatment. Treatment will involve speech and language therapy to identify and correct articulation problems. Speech therapy helps 75 percent of children resolve their speech sound disorder by the time they turn six (Psychology Today, 2022).

Child-Onset Fluency Disorder

Children between the ages of two and five can sometimes stutter, but this is just part of learning to speak. It usually goes away on its own, but there are some individuals who have chronic stuttering that persists into adulthood (Mayo Clinic, 2021), which is considered **child-onset fluency disorder**. Symptoms that may occur include repeating a word or a sound, difficulty beginning to say a word, adding extra words like "um," facial tightness or tension in the face and upper body, anxiety when talking, and decreased ability to communicate. Interestingly, people who stutter usually do not stutter when talking to themselves or while singing a song (Mayo Clinic, 2021). Treatment by a speech-language pathologist might be needed if the stuttering lasts more than six months, gets worse with anxiety, and is affecting school, work, or social situations.

PSYCHOSOCIAL CONSIDERATIONS

Effects of Stuttering on Social Anxiety in Children

Stuttering can cause children to have social anxiety because of the bullying and negativity they receive from peers. The *DSM-5* describes social anxiety disorder as the fear of performance-based social interactions. In the case of a child or adolescent who stutters, the school environment is a prime target for this type of anxiety. When a child stutters, they often avoid social situations due to their embarrassment. This avoidance can lead to decreased social development, low self-esteem, and inability to create healthy relationships with peers.

One potential treatment for stuttering is psychodrama. This therapy provides a safe environment in which a child can role-play certain situations in order to learn how to resolve conflicts. Psychodrama has been shown to be effective in decreasing stuttering and social anxiety and improving self-esteem. Psychodrama gives the child the chance to see what they could do during a certain situation to help them cope better and envision their strengths (López-González et al., 2021).

(Younis et al., 2021)

Social Communication Disorder

A person with **social communication disorder** has difficulty using verbal and nonverbal communication within a social situation. This may cause problems with making and maintaining friends. The individual might not understand how to effectively carry on a conversation or understand nonliteral language meanings or grasp the rules of conversation. The exact cause of social communication disorder is unknown, and it is often connected to another condition, such as intellectual disability or a traumatic brain injury (American Speech-Language-Hearing Association, 2023). A speech-language pathologist is the primary treatment provider and is responsible for screening, assessment, and diagnosis. It is within the scope of practice of the speech-language pathologist to provide "clinical services, education, advocacy, research, and administration" (American Speech-Language-Hearing Association, 2023, Roles & Responsibilities section, para. 1). The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires that children and adolescents with social communication disorders be provided speech-language services in schools.

Unspecified Communication Disorder

When a child exhibits some symptoms of communication disorders, but the symptoms do not fall into a pattern according to the *DSM-5*, then they are described as having unspecified communication disorder. There is no particular cause noted in the *DSM-5* for this disorder. The age of onset is typically early childhood (Porter, 2023). There are no specific treatments specified by the *DSM-5* for this disorder, but speech-language therapy may be helpful.

Treatment of Communication Disorders

Treatment for communication disorders generally begins with a parent telling their child's health-care provider about concerns for their child's language development. The provider then may make a referral to a speech-language pathologist for assessment, diagnosis, and treatment. Early intervention, some of which may be free or low-cost, is considered to have the best outcomes.

The speech-language pathologist (SLP) follows four basic principles for the provision of services: "(1) Family centered and culturally and linguistically responsive; (2) developmentally supportive promoting children's participation in their natural environments; (3) comprehensive, coordinated, and team based; and (4) based on the highest quality evidence available" (Paul & Roth, 2011, p. 320). These four principles are used to focus on the individual needs of each child and their family.

There are three main goals of treatment for communication disorders. The first is helping children work on and improve their communication. The second is to teach children coping skills and alternative ways to communicate when they are having difficulty with communication. The third is encouraging children to use and practice their communication skills at home, at school, and with friends (MentalHelp.net, 2023).

Nursing Implications

With those goals in mind, treatment of communication disorders is collaborative, meaning that different professionals and caregivers work together to assist the child in learning how to communicate better. These roles can be shared by the speech-language pathologist, school nurse, peers, parents, and classroom teachers (American Speech-Language-Hearing Association, 2023). A treatment plan is agreed upon with different parts of that plan being implemented by identified members of the team. School nurses can work individually with clients or in group settings (e.g., special education).

Nurses need to remember that just because a client cannot communicate in the same way as the nurse, it is important to include them in the care that is being provided. This quote from a nurse who was part of a focus group in Mimmo et al. (2022) highlights the importance of treating the client with respect and dignity: *"talking to the*

patients whether or not they can talk back to me . . . treating them as though they can listen so talk to them . . . just say, hi, . . . treat them with dignity" ("Know the Child" section).

Types of Interventions Used to Treat Communication Disorders

The types of intervention recommended to treat a communication disorder is based on the child's age, the severity of the disorder, and whether or not it is connected to another disorder. Interventions are intended to assist the child in developing their language skills and remove barriers to social participation (Law et al., 2017). Direct interventions are those that focus on the child as an individual or in a group. Indirect interventions are those that involve the parents interacting with their children as a way of modeling speech and language behavior. Indirect interventions are used less as the child ages. Rewards, such as stickers, are often used as reinforcement for the child following the directions of the therapy by repeating sounds, vocabulary, and sentence structures (Law et al., 2017). As children get older, the therapy focuses on teaching skills that encourage the use of judgment to determine the correct phonics and grammar to use in the moment. Considerations for therapy focus on who is going to deliver the therapy, where it will take place, the frequency/intensity/duration of the therapy, and the expected outcomes.

23.3 Autism Spectrum Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define autism spectrum disorder
- Understand the different types of family support available to children with autism spectrum disorder
- Identify resources for information and support

Autism spectrum disorder (ASD) can be found four times more often in males than in females. It is seen in all racial, ethnic, and socioeconomic groups (CDC, 2022d). The prevalence of ASD was 50 percent higher in White children than among Black or Hispanic children in years prior to 2016, but between 2016 and 2018, it evened out (Maenner et al., 2023). This developmental disorder has multiple causes that result in brain differences that affect a person's interaction with others, communication, and learning. According to the CDC (2022d), in 2020, approximately one in thirty-six children were identified as having ASD.

Definition of Autism Spectrum Disorder

The developmental disorder of the brain that causes impairment in behavior, communication, interaction with others, and learning is called **autism spectrum disorder (ASD).** The signs and symptoms of ASD usually begin before a child turns three years old. These symptoms continue through the life span, but can change or improve over time. ASD is characterized by the following: (1) difficulty with communication and interaction with other people, (2) restricted interests and repetitive behaviors, and (3) symptoms that hurt the person's ability to function properly in school, work, and other areas of life. Autism is known as a "spectrum" disorder because there is wide variation in the type and severity of symptoms experienced by individuals. Although ASD is a lifelong disorder, treatments and services can improve a person's symptoms and ability to function (National Institute of Mental Health, 2022).

Since the publication of the *DSM-5*, several disorders have been classified as falling under ASD rather than as separate from it or have been removed from the classification. For example, **pervasive developmental disorder not otherwise specified (PDD-NOS)** has been reclassified as under ASD and was formerly used when the child did not meet all the criteria for autism. **Asperger syndrome** is a disorder that has been reclassified as under ASD and has no requirement for onset by age three or language delay, and no criteria for communication or cognitive deficit (Gehret, 2022). Another disorder reclassified as falling under ASD is **childhood disintegrative disorder (CDD)** is rare, affecting only 1.7 in 100,000 children (Gehret, 2022), and is defined as a severe form of autism with a late onset, usually around the age of four years.

One disorder removed from the *DSM-5* list of autism disorders is **Rett syndrome**, which affects mostly girls and often displays symptoms that are similar to autism. Less than 1 percent of cases are inherited; instead, they come from a gene mutation (Gehret, 2022). Due to genetic etiology, this disorder is a distinct category and, therefore, removed from *DSM-5* diagnostic criteria.

Screening and Diagnosis

Because there is no specific test to diagnose this disorder, parents and health providers look at how the child is

developing and meeting age benchmarks. It is important to diagnose a child as early as possible so that they can begin to receive services that will support their development over time. Health-care providers can sometimes diagnose ASD as early as eighteen months of age (CDC, 2022e), with most children being diagnosed before thirty months of age.

The American Academy of Pediatrics (2023) recommends screening children during their regular pediatric appointments at ages eighteen months and twenty-four months. This screening helps to identify developmental and behavioral challenges. The parent is given the M-CHAT-R/F screening tool, a twenty-three-question standardized form to complete. Examples of the yes/no questions include "Does your child like climbing on things, such as stairs?" and "Does your child look you in the eye for more than a second or two?" This form is used in combination with health history, family history, and observation of the child's development, especially if behavior is delayed or different than expected. Additional referrals for psychological evaluation and support can follow analysis of the M-CHAT-R/F.

There are also tests that check for other medical conditions that can cause ASD-like symptoms (Healthychildren.org, 2023) and tests to check for symptoms that often accompany ASD. For instance, lead screening involves a blood test to check for serum blood levels of lead in children who live in a high-risk environment. Moreover, providers may recommend genetic testing, because 42 percent of children will have a genetic component. Some risk factors include a family that already has one child with ASD, having chromosomal conditions like Fragile X syndrome, birth complications, and being born to older parents (CDC, 2022e). They may also recommend a test to check for an iron or vitamin deficiency because most children with ASD are picky eaters.

LINK TO LEARNING

Watch this American Academy of Pediatrics informational video (https://openstax.org/r/77autism) to help parents understand the CDC's 2023 statistics about the prevalence of autism spectrum disorder. It can be useful when educating families receiving a diagnosis of ASD in their child.

Areas of Concern

A parent or guardian may become concerned when they notice that their child is not meeting published developmental guidelines. The CDC (2023) checklists help parents document milestones that their child is or is not meeting. Parents can take the completed checklist for the primary care provider to review at scheduled well-child appointments. This form includes social/emotional, language/communication, cognitive, and movement/physical developmental milestones for specific age groups along the developmental trajectory. If the provider suspects ASD, then they may refer the child to speech, behavioral, or occupational therapies (Healthychildren.org, 2023).

A parent may also notice that their child is having a problem with **emotional dysregulation**, where an individual is unable to control their feelings and emotions. This is common in people who have ASD (Cleveland Clinic, 2023c). Most children will experience temper tantrums at some point, but they usually grow out of them. A person with emotional dysregulation is not able to control their emotions and that can result in mood swings, angry outbursts, and losing their temper.

Another sign that parents may observe in their child is the presence of unusual **repetitive and stereotyped behaviors**, such as hand flapping, body rocking, repeating words, or placing toys in the same order all the time (CDC, 2022e). Other areas of concern include difficulty in social interactions, communication, and relationships.

Social Interactions

People with ASD have difficulty with social communication and interaction, experience restricted interests, and exhibit repetitive behaviors. Here are some examples of behaviors in these categories (National Institute of Mental Health, 2022):

- making little or inconsistent eye contact
- not looking at or listening to people
- rarely sharing enjoyment of objects or activities by pointing or showing things to others
- being slow to respond (or failing to respond) to someone calling their name

- having difficulties with the back-and-forth nature of a conversation
- talking at length about a favorite subject without noticing that others are not interested or without giving others a chance to respond
- exhibiting facial expressions, movements, and gestures that do not match what is being said
- using a tone of voice that may sound flat and robotlike
- having trouble understanding another person's point of view or being unable to understand other people's actions
- repeating certain behaviors or exhibiting unusual behaviors
- echolalia, which means the involuntary repetition, or echo, of words, phrases, or vocalizations
- having a lasting, intense interest in certain topics, such as numbers, details, or facts
- having overly focused interests, such as with moving objects or parts of objects
- getting upset by slight changes in a routine
- being more or less sensitive than other people to sensory input, such as light, noise, clothing, or temperature; this sensitivity can present as physical touch, like a hug, actually being experienced as painful; items, such as seams on pants, can be overwhelming and extremely agitating

Although people with ASD experience many challenges, they also often have many strengths, including these strengths (National Institute of Mental Health, 2022):

- being able to learn things in detail and remember information for long periods of time
- being strong visual and auditory learners
- excelling in math, science, music, or art

Communication

Communication skills are different for each person with ASD. According to Posar et al. (2022), approximately 25 to 30 percent of children with this illness do not develop language skills at all or remain minimally verbal Some people with ASD use single words or repeat the words they hear others say. Others have great vocabularies and can talk about specific topics at length (NIH, 2020). It all depends on their level of autism and its effect on their intellectual and social development.

Relationships

Due to being unable to pick up on cues from others or an inability to initiate conversations or interactions, relationship building can be difficult. Their repetitive behaviors, such as pacing and hand flapping, may be distracting or uncomfortable for others (Autism Speaks, n.d.).

Family Support

Families must adapt to the needs of the child with ASD. Sensory considerations, such as modifying the environment, creating routines, or using other strategies can help manage discomfort in a child with ASD (Autism Speaks, n.d.). Siblings may feel added stress as their responsibilities within the household increase. Lack of insurance coverage for therapies may increase parental stress. Having family outings can be difficult due to the decreased social skills of the child with ASD.

Nurses can support families through careful assessment of their needs. Nurses must consider the severity of the ASD of the child and how much the parents understand about ASD. Nurses can assist parents in finding community resources and services that support the care of the child with ASD. These services must be culturally relevant and affordable for the family. Parents must be included in the planning process, just as clients are included when nurses create individual care plans.

Levels of Support by Severity

In order for a child to be diagnosed with ASD, they must meet certain criteria set forth by *DSM-5* (CDC, 2022d). The child must have deficits in the three areas of social communication and interaction, as well as exhibit two to four restricted/repetitive behaviors. There are three levels of support that are based on severity of need; three is the highest level of support (Table 23.2).

Level	Supports
1	Needs some support Can communicate with others but with difficulty May not understand social cues and body language of others
2	Needs substantial support Has difficulty communicating or socializing with others Performs repetitive behavior, called stimming, that helps them self-regulate
3	Needs very substantial support Has extreme difficulty with self-expression Has difficulty completing activities of daily living (ADLs) Is prone to neglect, abuse, and discrimination

TABLE 23.2 **Levels of Support for Children with Autism Spectrum Disorder** (Rudy, 2023)

Interdisciplinary Team

Current treatments for ASD seek to reduce symptoms that interfere with daily functioning and quality of life. ASD affects each person differently, meaning that people with ASD have unique strengths and challenges and thus different treatment needs. Treatment plans typically involve multiple professionals with interventions customized to the individual (National Institute of Mental Health, 2022). As individuals with ASD exit high school and grow into adulthood, additional services can help improve their health and daily functioning and facilitate social engagement. Supports may help complete job training, find employment, and secure housing and transportation (National Institute of Mental Health, 2022).

There are many categories of treatments available, and some treatments involve more than one approach. Treatment categories include (National Institute of Mental Health, 2022):

- behavioral
- developmental
- educational
- social-relational
- pharmacological
- psychological
- complementary and alternative

LINK TO LEARNING

This article provides another viewpoint regarding use of applied behavior analysis (https://openstax.org/r/77appbehanalysi) (ABA).

Developmental Approaches

Developmental approaches focus on improving specific developmental skills, such as language skills or physical skills. Developmental approaches are often combined with behavioral approaches. The most common developmental therapy for people with ASD is speech and language therapy. Speech and language therapy helps improve the person's understanding and use of speech and language. Some people with ASD communicate verbally. Others with severe symptoms of ASD may communicate using signs, gestures, pictures, or an electronic communication device (National Institute of Mental Health, 2022). Occupational therapy teaches skills to help the person live as independently as possible. Skills may include dressing, eating, bathing, and relating to other people. Occupational therapy can also include sensory integration therapy to help improve responses to sensory input that may be restrictive or overwhelming (National Institute of Mental Health, 2022). Physical therapy may help improve physical skills, such as fine movements of the fingers or larger movements of the trunk and body (National Institute of Mental Health, 2022).

Educational Approaches

Educational treatments take place in a classroom setting. One type of educational approach is the Treatment and Education of Autistic and Related Communication-Handicapped Children (TEACCH) approach. TEACCH is based on the idea that people with autism thrive on consistency and visual learning. It provides teachers with ways to adjust the classroom structure to improve academic and other outcomes. For example, teachers can write daily routines and place them in clear sight, set boundaries around learning stations, and accompany verbal instructions with visual instructions or physical demonstrations (National Institute of Mental Health, 2022).

Behavioral Approaches

Behavioral approaches focus on changing an individual's behaviors by promoting understanding of what happens before and after the behavior. A notable behavioral treatment for people with ASD is called applied behavior analysis (ABA). Applied behavior analysis encourages desired behaviors and discourages undesired behaviors to improve a variety of skills, and progress is tracked and measured (National Institute of Mental Health, 2022).

Social-Relational Approaches

Social-relational treatments focus on improving social skills and building emotional bonds. For example, "social stories" provide simple descriptions of what to expect in a social situation. "Social skills groups" provide opportunities for people with ASD to practice social skills in a structured environment.

Pharmacological Approaches

There are no medications used to treat ASD, but medications may be used to treat symptoms and improve functioning. For example, medication may be used to manage high energy levels, improve focus, or limit self-harming behavior, such as head banging or hand biting. Medication may also treat concurrent psychological and medical conditions, such as anxiety, depression, seizures, or sleep problems (National Institute of Mental Health, 2022).

Psychological and Behavioral Approaches

Psychological and behavioral approaches can help people with ASD cope with anxiety, depression, and other mental health issues. For example, CBT helps individuals focus on the connections between their thoughts, feelings, and behaviors. During CBT, a therapist and the individual work together to identify goals and change how the person thinks about a situation to change how they react to the situation (National Institute of Mental Health, 2022).

Complementary and Alternative Treatments

Some individuals with autism use special diets, herbal supplements, chiropractic care, animal therapy, art therapy, mindfulness, or relaxation therapies (National Institute of Mental Health, 2022). Treatment is most effective when tailored to the individual, and additional enriching therapies can help individuals with ASD to thrive.

Nurse's Role

The nurse's role is primarily education-based. Nurses can educate themselves on new treatment techniques, community resources, and how to support the family of their clients who have ASD. Nurses can work with families to develop the interventions that will work best for the individual client. If the client needs help with communication, the nurse can assist the family with getting communication devices, such as picture boards (Lesser & Ebert, 2020). School nurses can review the use of these tools with their students to build rapport in the school setting.

CLINICAL JUDGMENT MEASUREMENT MODEL

Take Action: The Nurse Performs an Intervention

Care of a client with ASD requires interventions that fit the abilities of the individual and are based on the specific level of support required by that individual. Depending upon where that individual falls on the autism spectrum, the nurse can choose from a wide variety of interventions. For instance, if a nurse is caring for several clients who need Level 1 support, a good intervention would be to facilitate a social cues group to teach them about understanding social cues and what they mean.

(Ignatavicius & Silvestri, 2023)

Community Services and Information Resources

There are several levels of intervention services available depending on when ASD is suspected and diagnosed (Healthychildren.org, 2023). The first is early intervention programs available through the state if the child is under the age of three when ASD is first suspected. Once the child is between ages three and five, the parent can contact the local school district to find out if the child is eligible to attend a developmental preschool program.

The Autism Speaks website (https://openstax.org/r/77autismspeaks) contains a variety of useful information about available resources. This website has filters for state, life stage, and level of support that the user can click to get the information that best fits the individual they are hoping to support. The National Autism Association (https://openstax.org/r/77autismassoc) is another useful site to explore resources; education for individuals, families, first responders, and teachers; and ways to advocate for those with autism.

23.4 Attention-Deficit/Hyperactivity Disorder

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline diagnosis and presentation of attention-deficit hyperactivity disorder
- Define the nurse's role in creating a family plan for child with attention-deficit hyperactivity disorder
- Identify resources for information and support

One of the most common neurodevelopmental disorders is **attention-deficit hyperactivity disorder (ADHD)**, which involves difficulty paying attention, difficulty controlling impulsive behaviors, or excessive activity (CDC, 2023e). It is usually first diagnosed in childhood and often lasts into adulthood. Not everyone living with attention deficit shows hyperactivity; **attention-deficit disorder (ADD)** involves distractibility and difficulties with mental focus and working memory. ADHD can negatively affect a person's academics, social functioning, and relationships with peers. It can also have a negative effect on their family life. While ADHD and ADD have typically been associated with childhood, both can be diagnosed during adulthood; childhood ADHD and ADD can also persist into adulthood.

LINK TO LEARNING

This website provides information on ADD and ADHD (https://openstax.org/r/77ADDADHDinfo) and includes a comparison of ADD to ADHD, self-tests for children and adults, and many credible resources and references.

Diagnosis and Presentations of Attention-Deficit Hyperactivity Disorder

ADHD affects approximately 9.8 percent of American children aged thirteen to seventeen (CDC, 2022f). The global prevalence of ADHD in children and adolescents who are younger than nineteen is estimated to be 5 percent (Wüstner et al., 2019). It is normal for children to exhibit challenging behaviors and have trouble focusing at certain times. Children with ADHD, however, often have more severe symptoms that cause difficulties at school, at home, or with friends (CDC, 2021c), including:

- daydreaming
- forgetting or losing things
- squirming or fidgeting
- talking too much
- making careless mistakes or taking unnecessary risks
- difficulty resisting temptation
- difficulty getting along with others

Diagnosing a child with ADHD is a process requiring several steps by a mental health professional or pediatrician. There is no single test to diagnose ADHD, and many other problems, such as anxiety, depression, sleep problems, and learning disorders can have similar symptoms as ADHD. The diagnostic process includes a medical exam; hearing and vision tests; and a checklist rating ADHD symptoms completed by parents, teachers, and the child (CDC, 2021c). ADHD lasts into adulthood for at least one-third of children with ADHD. Treatments for adults can include medication, psychotherapy, or a combination of treatments (CDC, 2021c). There are three types of ADHD,

depending on which types of symptoms are strongest in the individual: inattentive, hyperactive-impulsive, and combined (CDC, 2021c).

Inattentive

A person who is **inattentive** finds it difficult for the individual to organize or finish a task, to pay attention to details, or to follow instructions or conversations. The person is easily distracted or forgets details of daily routines. The presentation of these symptoms can be missed or misinterpreted by others as "laziness" or "not paying attention."

LIFE-STAGE CONTEXT

ADHD Is Not Just for Kids

According to an article published by the Harvard Medical School (Collier, 2020), older adults who may not have ever been diagnosed with ADHD often seek the advice of their primary care provider when they begin to notice problems with their memory or completion of tasks. It is often not recognized until the older person realizes that other people in their family are being diagnosed with ADHD. This disease is one of the "most inherited disorders in medicine" (para. 4) so providers will look at family history when addressing memory concerns in older adults.

(Collier, 2020)

Hyperactive-Impulsive

The person fidgets and talks a lot. It is hard for them to sit still for a length of time (such as during a meal or while doing homework). Young children may run, jump, or climb constantly. The individual feels restless and has trouble with impulsiveness. Someone who is **impulsive** may interrupt others, grab things from other people, or speak at inappropriate times. It is hard for the person to wait their turn or listen to directions. A person with impulsiveness may also have more accidents and injuries than others.

Combined Type

Mixed symptoms of the above two types are equally present in the person with the combined type. It is important to remember that a person's symptoms of ADHD can change over time, and their predominant presentation may change.

Nurse's Role in Supporting Families with Children with ADHD

A nurse can support parents of children with ADHD by educating them on some interventions they can use with their children. The CDC (2023) suggests that families:

- Create a routine to help the child to stay focused.
- Organize things like shoes, toys, school bags, and keep them in the same place.
- Provide a quiet environment for completing homework. Limit distractions, such as background noise from TVs.
- Do not give the child a lot of choices because that can be overwhelming for them. It is better to give them just two options to choose from when they need to make a choice.
- Be clear with directions that you give your child. Be sure to include praise for when the child meets goals that have been set. The use of a sticker chart is a visual reminder of the work they are accomplishing.
- Help the child try different things like sports or after-school activities to see which ones they really like and are good at because this helps to create positive experiences for them.
- Provide healthy lifestyle options—good food, time for exercise, and plenty of sleep.

Nurses should be aware of the different community resources available and refer parents to those entities. Nurses also need to be aware of cultural beliefs, financial concerns, and support systems in place for the family/child and provide the nursing care accordingly. Patient-centered care is outlined in the QSEN Institute Competencies (2022).

CLINICAL SAFETY AND PROCEDURES (QSEN)

Client/Family-Centered Care for the Client with ADHD

When caring for a client with ADHD, nurse will:

- Recognize the client's inability to focus as a potential barrier to participation in the plan of care.
- Promote and facilitate the client's involvement in extracurricular activities as a means to promote healthy lifestyle, socialization and well-being.
- Allow the client time to make decisions in order to show the nurse's respect for the client's unique abilities.

Promoting Overall Wellness

Many children with ADHD also have other disorders. These can include learning disabilities, conduct problems, anxiety, and depression, so it is important for nurses to screen children with ADHD for additional disorders (CDC, 2023e). The main symptoms of ADHD, being impulsive and inattentive, can cause these children to have a higher risk for injuries. They may ride a bicycle and not pay attention to traffic, be reckless when driving a car, act aggressively (in children who also have conduct disorder), and not remember to make healthy food choices or participate in regular physical activity. Parents and health-care providers can work together to remind children about safety and to monitor their well-being.

Medications

Nurses may play a role in medication management. Medication may help children aged six and older manage their ADHD symptoms and control behaviors that cause difficulties with family, with friends, and at school (CDC, 2021c). A comprehensive medical exam, including height, weight, blood pressure, heart rate, and cardiovascular history, should precede medication. Providers should establish a pretreatment baseline to measure common side effects, such as appetite and sleep changes, headaches, and abdominal pain. Adolescent clients should also be assessed for substance use (Krull, 2022).

The choice of medication by the prescriber depends on many factors, such as the following (Krull, 2022):

- duration of coverage (e.g., desired coverage for school day plus completion of homework)
- the desire to avoid medication administration at school
- the ability of the child to swallow pills or capsules
- coexisting emotional or behavioral conditions
- history of substance misuse in the client or a household member (i.e., stimulants with less abuse potential are prescribed)
- expense
- preferences of the child and their caregivers

Stimulants, such as methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and dextroamphetamine-amphetamine (Adderall), are considered first-line treatment because of rapid onset of action and a long record of safety and efficacy. Stimulants are available in short-, intermediate-, and long-acting formulations. The exact mechanism of action of stimulants in ADHD is unknown, but they are known to affect the dopaminergic and noradrenergic systems, causing a release of catecholamines. Stimulants have been found to improve caregiver-child interactions, aggressive behavior, and academic productivity (Krull, 2022).

Stimulants are controlled substances and require a Schedule II prescription. There is a black box warning for CNS stimulants, including methylphenidate and amphetamine-like substances, because they have a high potential for abuse and dependence. In fact, up to 29 percent of school- and college-aged students with stimulant prescriptions have been asked to give, sell, or trade their medication (Krull, 2022). Assess the risk of abuse by the client or their family members before prescribing stimulants, and evaluate for signs of abuse and dependence while the client is receiving therapy (Food and Drug Administration, 2023).

Stimulants may cause minor side effects that resolve with lower dosage levels or a different prescription. The most common side effects include the following (National Institute of Mental Health, 2016; U.S. National Library of Medicine, n.d.): difficulty falling asleep or staying asleep, loss of appetite and weight loss, stomach pain, and/or

headache. Less common side effects include motor or verbal tics (sudden, repetitive movements or sounds) or personality changes, such as appearing "flat" or without emotion (National Institute of Mental Health, 2016). Neurobiology and Pharmacological Standards provides more information on pharmacology.

SNRIs, such as atomoxetine (Strattera), are an alternative to stimulants for clients who experience side effects. They may also be helpful in treating concurrent depressive or anxiety disorders. SNRIs are not controlled substances, so they may be prescribed for adolescents (or their family members) with substance use disorders. The dosage depends on the child's weight, and the duration of action is ten to twelve hours. Atomoxetine has a black box warning about increased risk of suicidal ideation in children and adolescents (Krull, 2022).

Alpha-2 adrenergic agonists, such as clonidine, may be utilized in combination with stimulants to reduce hyperactivity and sleep difficulties. These medications may also be used when children respond poorly to stimulants or SNRIs, have unacceptable side effects, or have significant coexisting conditions. Neuchat et al. (2023) assert that further research is indicated into the safe and effective long-term use of Alpha-2 agonists.

CLINICAL JUDGMENT MEASUREMENT MODEL

Analyze Cues: The Use of Graphic Organizers to Develop Clinical Judgment Related to the Use of Medication to Treat ADHD

Nursing students today are being encouraged to use some type of graphic organizer to assist them with organizing the vast amount of information they are learning. Being able to analyze cues from assessment date is a priority nursing action. Concept maps are a tool that can be used to identify how data points are connected. To understand the side effects of certain medications, such as medications used to treat ADHD, a student could be asked to create a concept map. This would clearly connect certain side effects to certain medications and help the student to understand the importance of asking their clients if they are having any significant side effects since beginning a medication.

(Ignatavicius & Silvestri, 2023)

Behavioral Therapies

Behavioral therapies are aimed at helping the child with ADHD decrease their disruptive behaviors and increase their positive behaviors (CDC, 2023e). Parent training in managing their children's behavior is the go-to first therapy for children younger than six years old. Training parents helps them be better equipped for their young children. For children older than six years, a combination of medication and behavior therapy is recommended, along with parent training and school involvement in which teachers educate children on the behavior that is expected within the classroom and help them to create focus plans. Behavioral therapies include parent training in "behavior management, behavior therapy with the child, and behavior management in the classroom" (CDC, 2023e, para. 6).

Community Services and Information Resources

Parents can be referred to the National Resource Center on ADHD (https://openstax.org/r/77NatADHDresour), funded through the National Center on Birth Defects and Developmental Disabilities (NCBDDD) and the CDC (Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], 2023). This program provides resources, an ADHD Helpline, digital media, weekly newsletters, education, and advocacy for those with ADHD and their families. Another great resource is the ADHD Resources Center (https://openstax.org/r/77AACAPwebsite) on the American Academy of Child & Adolescent Psychiatry website. Parents can find educational resources, locate treatment resources, watch video clips, and learn about clinical resources. To find local resources, parents can speak with their child's pediatrician, teacher, or go to the SAMHSA website (https://openstax.org/r/77SAMHSAwebsite) to find a local provider.

23.5 Specific Learning Disorders and Motor Disorders

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the various forms of specific learning disorders
- Outline approaches used to treat specific learning disorders
- Define and categorize motor disorders

Globally, learning disabilities occur in nearly 5 percent of all school-aged children. Learning disorders are caused by genetic and environmental factors (Dominguez & Carugno, 2023). Risk factors for developing learning disabilities include genetics, poverty, premature birth, alcohol exposure in utero, and traumatic brain injuries (Dominguez & Carugno, 2023). Typically, children will be evaluated for learning disorders after they begin experiencing difficulties in school. Children with learning disorders may feel frustrated when they cannot learn a topic or skill and may act out, act helpless, or withdraw. Learning disorders may also be present with other disorders, such as ADHD or anxiety, making it hard for a child to succeed in school. Children with learning disorders often require specialized instruction to meet their needs (CDC, 2021d). Moreover, motor disorders occur in two ways: increased movement and decreased movement. The most common motor disorder in children are tic disorders (Ueda & Black, 2021).

Defining Specific Learning Disorders

A **learning disorder** occurs when a person has a difficult time in an area of learning, but it is not related to motivation or IQ level, emotional problems, cultural differences, or level of disadvantage. There are four commonly recognized learning disorders: dyslexia, dyscalculia, dysgraphia, and nonverbal learning disability (Dominguez & Carugno, 2023).

Dyslexia

The most common learning difference is **dyslexia**, which affects a person's ability to read because it causes problems with phonological processing (Dominguez & Carugno, 2023). Dyslexia occurs in 7 to 10 percent of the population (University of Michigan, 2023a) and is the result of brain differences in the regions that process language (Mayo Clinic, 2022). Symptoms are often missed until the child begins school and, at that time, the teacher may be the person to notice that the child is having a problem with word recognition. Some indications of dyslexia are being a late talker; reversing sounds in words; difficulty naming colors, letters, and numbers; difficulty spelling; taking a long time to complete reading and writing assignments; and avoiding reading. Early intervention is the best treatment. Nurses should encourage parents to talk to their child's health-care provider if they notice their child is having difficulty with reading and comprehension.

Because dyslexia affects a person's reading and comprehension, it is understandable that it would affect their academic performance. Every subject in school requires some type of reading or writing. Students with dyslexia might overcompensate by memorizing material and using their verbal processing skills (University of Michigan, 2023b). These students may be gifted in other learning areas, such as "thinking outside of the box, creativity, hands-on learning, and sports" (para. 3). Teachers can use a variety of approaches in the classroom that incorporate verbal, visual, and hands-on applications to address these students' learning needs. Accommodations (such as having more time to take a test), an IEP (individualized education program), or a 504 (a less detailed plan often related to accommodations) are interventions that help to support the student who has dyslexia.

Dyscalculia

Difficulty with calculation and completion of arithmetic problems is called **dyscalculia**. In this disorder, the child may have difficulty completing math problems, learning basic math, using math symbols, and understanding the way numbers relate to one another (Mayo Clinic, 2023a). Early intervention can help the child better understand basic math by offering extra support to teach them ways to get their schoolwork completed. The child may also benefit from an individualized education program (IEP), which sets individual learning goals to meet the child's needs.

Dysgraphia

Distorted writing, even with instruction and intact motor ability, is called **dysgraphia**. This disorder causes the child to have trouble remembering how to form letters, trouble with spelling, grammar, and punctuation, and difficulty putting thoughts into words (Mayo Clinic, 2023a). Tutoring, getting extra time to complete assignments, or

occupational therapy may help the child have an easier time with the task of writing.

Nonverbal Learning Disability

Nonverbal learning disorders are often undiagnosed until the third grade when children begin to have difficulty with reading comprehension. This disability causes difficulty with "problem-solving, recognizing social cues and body language, and visual-spatial tasks" (Dominguez & Carugno, 2023, para. 9). Children with these disorders often have good language skills. They can also be good at memorizing words. Examples of symptoms seen in this disability are difficulty understanding abstract concepts, not being able to read other's expressions, poor physical coordination, problems with fine motor skills, such as writing, and difficulty paying attention (Mayo Clinic, 2023a).

Approaches to Treating Specific Learning Disorders

Parents can ask the school to assess their child for learning disorders. A general physical exam may start the process to be sure that there are no problems with vision, hearing, or another medical condition that could be hindering learning. There may be a team of professionals to evaluate the child. This team can consist of a school psychologist, a special education teacher, an occupational therapist, a social worker or nurse, and a speech-language pathologist (Mayo Clinic, 2023a). The team gathers information through tests, feedback from teachers, feedback from parents, and a review of the child's academic history. Based on all of this information, the team will determine whether the child has a learning disorder and plan for the best way to help that child reach age-appropriate learning goals.

The treatment plan is different for each child. It may include interventions, such as tutoring, an IEP, classroom accommodations, occupational or speech-language therapy, and possibly medication to address depression, anxiety, or behavioral issues (Mayo Clinic, 2023a).

LINK TO LEARNING

This video provides information on the skills and qualities of a learning disability nurse (https://openstax.org/r/77disabltynurse) that can improve success with clients.

Criteria for Defining Motor Disorder

The Virginia Commission on Youth (2021) describes **motor disorders** as a group of disorders that begin in the developmental years and contribute to delays in children reaching motor milestones. Symptoms include difficulty climbing stairs and tying shoes, making repetitive movements, and possibly having physical or verbal tics.

The three most common categories of motor disorders are developmental coordination disorder, stereotypic movement disorder, and tic disorders (Virginia Commission on Youth, 2021). Developmental coordination disorder presents as a child not meeting motor milestones. Often, these discrepancies are not diagnosed until the child enters school. Stereotypic movement disorder presents early in childhood. In this disorder, individuals are unable to control repetitive movements other than by restricting themselves by wrapping their arms in their clothes or sitting on their hands. Tic disorders include vocal, motor, simple, and complex tics. The *DSM-5* describes three primary tic disorders: Tourette disorder, persistent (chronic) motor or vocal tic disorder, and provisional tic disorder (CDC, 2023f). The nurse is a member of the treatment team and acts as an educator and support person. See 23.6 Tic Disorder and Tourette Syndrome for focused information on diagnosis, medical treatment, and nursing care.

REAL RN STORIES

Nurse: Irene S., MSN RN
Years in Practice: More than 45
Clinical Setting: Children's residential treatment center
Geographic Location: GA, NC, and TN

Years ago, I worked at a children's residential treatment center that included a special education school. I

collaborated with the school nurse, as part of the treatment team for Dani, nine years old.

Dani had been born prematurely to a teen mother and was raised mostly in foster care before coming to our facility. Dani's problem list included speech-language difficulty that impaired communication. The school's treatment team had recommended picture boards to help with communication, but on the first day of using them, Dani had thrown them on the floor and run out of the classroom.

At first, we worked to develop a plan to make the picture board more appealing to Dani, using different colors and images, but the child was still resistive. One day, as we walked on the grounds, I asked Dani to tell me about the picture boards. Struggling to explain, Dani relayed a scenario of "my Mom aways drawing 'cos she could never read." Using the picture boards in the classroom made it seem that Dani could not read and this was not how Dani wanted to be seen by the other students.

In a treatment team meeting, Dani told us that if the teacher could give a longer time frame to answer questions, verbal answers would be better than the pictures on the board.

It was reinforced to me that Dani's self-determination was clearly a component of advocacy, as well as a strategy, for supported decision-making in nursing care for this client.

23.6 Tic Disorder and Tourette Syndrome

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe diagnosis of tic disorder and Tourette syndrome
- Understand treatment options and the nurse's role in treatment of children with tic disorder and Tourette syndrome
- Identify resources for information and support

Tourette syndrome (TS) and other tic disorders affect approximately 1 percent of school-aged children in the United States (Tourette Association of America, n.d.). Tics are sudden twitches, movements, or sounds that occur repeatedly in a person who is unable to stop their body from doing these actions. There are two types of tics: motor and vocal. Motor tics are movements of the body, such as blinking, shrugging the shoulders, or jerking an arm. Vocal tics are sounds that a person makes with their voice, such as grunting, humming, clearing the throat, or yelling out a word or phrase. Although the media often portray people with TS as involuntarily shouting out swear words (i.e., coprolalia) or constantly repeating the words of other people (i.e., echolalia), these symptoms are rare (CDC, 2021e).

Diagnostic Criteria for Tic Disorder and Tourette Syndrome

A **tic disorder** causes a person to uncontrollably twitch, move, or make sounds. The first symptoms are often motor tics that occur in the head and neck area. Tics are often worse during times that are stressful or exciting and tend to improve when a person is calm or focused on an activity (CDC, 2021e). Tourette syndrome (TS) tics typically begin when a child is five to ten years old. According to the CDC (2023g), diagnosis of **Tourette syndrome** occurs when a person has two or more motor tics and at least one vocal tic that have lasted at least a year and began prior to the age of eighteen years old. The symptoms must not be related to any other medical condition.

In most cases, tics decrease during adolescence and early adulthood and sometimes disappear entirely. But many people with TS experience tics into adulthood and, in some cases, tics can become worse during adulthood (CDC, 2021e). Tics are typically mild and do not require treatment, but it is essential to educate the individual and others about TS and provide appropriate support across all settings (e.g., school, work, and home). Behavioral treatment or medication may become necessary when tics become problematic or interfere with daily functioning (Tourette Association of America, n.d.). The *DSM-5* includes three types of tic disorders: Tourette syndrome, persistent motor or vocal tic disorder, and provisional tic disorder (CDC, 2023f).

Movements

All three types of tic disorders can have motor tics present (CDC, 2023f). In persistent motor or vocal tic disorder, the individual has either motor or vocal tics (but not both) for at least one year (CDC, 2023f). In provisional tic disorder, the individual has one or the other or both but symptoms must be less than a year. Tourette syndrome

must have two or more motor tics and a vocal tic for at least a year. Movements include blinking, shrugging, and twitching.

Vocalizations

Vocalizations always occur in Tourette syndrome and may occur in persistent motor and vocal tic disorder and provisional tic disorder. Vocalizations include clearing the throat, humming, and/or yelling a phrase or word, sometimes an obscenity (CDC, 2023f). Despite its portrayal in media, coprolalia (using inappropriate language) only occurs in one in ten people who have Tourette (CDC, 2023g).

Treatment

There is no known cure for tic disorders, but there are medications and therapies available to reduce the tics. Parents should be made aware that, for some children taking stimulant medication for ADHD, tics are a possible side effect (Nam et al., 2022). Nurses can educate parents on support systems that are available in the community to help them feel less alone and able to provide comfort and support to their children.

PSYCHOSOCIAL CONSIDERATIONS

Teens with Tourette Syndrome

When an adolescent enters middle school and then high school, their peer group becomes their focus. A young person with Tourette syndrome may experience bullying, stigma, and misunderstanding (Tourette Association of America, 2023). Educating others about this disorder is an important part of the school community's role to decrease judgmental behavior toward the student with Tourette. All students want to feel supported and able to make friends. This is especially important during their adolescent/teen years.

(Tourette Association of America, 2023)

Medications and Comprehensive Behavioral Intervention for Tics

Both medications and behavioral interventions for tics have been found to be helpful in reducing tics. Therapies available include Comprehensive Behavioral Intervention Therapy (CBIT); psychotherapy to help with accompanying disorders, such as anxiety, depression, and ADHD; and deep brain stimulation (DBS). CBIT entails creating awareness of the tics and tic triggers, choosing a different behavior to replace the tics, and figuring out environments and stressors that increase tics and altering them. This form of therapy includes education, relaxation training, and behavioral rewards to the person with tics. CBIT has been shown to improve tics and offers long-term progress (Frey & Malaty, 2022). When a person has severe tics that are not responding to any other type of treatment, DBS is an option in which a battery-operated device is implanted into the person's brain. This device gives electrical stimulation to the targeted area of the brain that controls movement (Mayo Clinic, 2018).

Some of the medications used to treat tics include antipsychotics, such as haloperidol (Haldol), risperidone (Risperdal), pimozide (Orap), and aripiprazole (Abilify). The potential side effects of weight gain and involuntary movements (Mayo Clinic, 2018) vary. Botox (botulinum) injections administered to an affected muscle can reduce a motor or vocal tic. Stimulant medications used for ADHD, such as methylphenidate (Ritalin and Metadate CD), can be used to increase concentration (but in some people with Tourette syndrome, this will also increase their tics). Antidepressants, such as fluoxetine (Prozac), assist with feelings of sadness or anxiety. And, it has been recently found that topiramate (Topamax), an anti-seizure medication, helps some people with Tourette syndrome (Mayo Clinic, 2018).

Clonidine and guanfacine may be used to stimulate alpha2 adrenergic receptors in the brain, though these medications may be sedating. Also, used outside the United States, benzamides are dopamine receptor blocking agents with fewer side effects. These include tiapride, sulpiride, and amisulpride (Frey & Malaty, 2022).

LINK TO LEARNING

View this website for valuable information on tics and Tourette syndrome (https://openstax.org/r/77tourette) from

Cincinnati Children's Hospital.

Nurse's Role

Nurses support clients and their families through diagnosis, treatment, and management of tic disorders. Nurses can educate parents on psychosocial development in their children and the way their focus changes from family to school to their social circles once they become teenagers (Lee, 2022). Nurses can also teach parents ways to educate their children on tic management for long-term care. Learning how to cope with the effects of tics, physically, educationally, and emotionally are other areas in which a nurse can assist the family (Lee, 2022). The school nurse can be a source of support to the student by giving them a safe space to display their tics, educating staff about Tourette syndrome, and being aware of the medications that the student is taking.

Community Services/Information Resources

The Tourette Association of America offers resources to train teens to advocate for those with Tourette and tic disorders, while educating the public about these conditions (CDC, 2023g). The teen can download a guide to the disorder (https://openstax.org/r/77touretteguide) to access more information about the illness, navigating school and social situations, and becoming an ambassador to others. The website also contains a page dedicated to resources listed in A–Z format (https://openstax.org/r/77helptourette) for individuals, parents, and professionals.

Schools can work with faculty and parents to set up an individualized education program (IEP) to support the child's academic needs while also educating them on how to cope with this illness. The IEP might include items such as using worksheets that require minimal writing or allowing the student to leave the classroom two to three minutes early when moving to another class, in order to avoid crowded hallways (PACER Center, 2018).

23.7 Conduct Disorder, Oppositional Defiant Disorder, and Disruptive Mood Dysregulation

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe disruptive, impulse control disorders, such as conduct disorder, oppositional defiant disorder, and disruptive mood dysregulation disorder
- Understand multisystemic treatment for a child with conduct disorders
- Identify resources for information and support

Disruptive, impulse control disorders may arise in childhood or in adolescence. This category includes behavioral problems demonstrating lack of regard for others' feelings or rights. In 40 percent of adolescents with conduct disorder, this disorder may develop into antisocial personality disorder in adulthood (American Psychiatric Association, 2021b). Oppositional defiant disorder (ODD) is a lesser version of conduct disorder, but 30 percent of children diagnosed with it will go on to be diagnosed with conduct disorder. Disruptive mood dysregulation disorder (DMDD) is defined by a child's angry outbursts.

Definitions of Disruptive Disorders

These disorders may be a combination of genetic and environmental factors, but the exact cause is unknown (Cleveland Clinic, 2022a).

Conduct Disorder

When a child shows An ongoing pattern of aggression toward others with serious violations of rules and social norms at home, at school, and with peers is called **conduct disorder (CD)**. These rule violations may involve breaking the law and result in arrest (CDC, 2021f). Adults with antisocial conduct disorder typically show symptoms of CD before age fifteen (Mayo Clinic, 2023b). Examples of CD behaviors are as follows (CDC, 2021f):

- breaking serious rules, such as running away, staying out all night, or skipping school
- being aggressive in a way that causes harm, such as bullying, fighting, or being cruel to animals
- lying, stealing, or purposefully damaging other people's property

Children who exhibit these serious behaviors should receive a comprehensive evaluation and treatment by a mental health professional. Some signs of behavior problems, such as not following rules in school, can be related to

learning disorders that require additional assessment and interventions. Without treatment, many children with conduct disorder are likely to have ongoing problems resulting in the inability to adapt to the demands of adulthood (American Academy of Child & Adolescent Psychiatry, 2018).

Conduct disorder may have onset in childhood or adolescence. Symptoms can begin as early as preschool, but usually more serious symptoms appear when a child reaches middle school to age eighteen (American Psychiatric Association, 2021b). It is more common in males than in females. Conduct disorder occurs in 2 to 10 percent of children in the United States (Cleveland Clinic, 2022a). Conduct disorder is not diagnosed after age eighteen, so an adult who has the symptoms of conduct disorder may be diagnosed with antisocial personality disorder.

The exact cause of conduct disorder is unknown. It is believed to be a combination of genetic and environmental factors (Cleveland Clinic, 2022a). Genetic and biological factors include traumatic brain injury and seizures, higher than normal levels of testosterone, and inheriting the traits of conduct disorder. Environmental factors include lack of structure in the home environment, exposure to domestic violence, low socioeconomic status, drugs and crime in the child's neighborhood, and parents who have substance use problems or conduct disorder behaviors.

Diagnosis is made after a child or adolescent is fully assessed by a mental health professional after the individual exhibits three or more of the following symptoms in the past twelve months and at least one symptom in the past six months: "seriously violating their parents' rules, lying or stealing, destruction of property, and aggression toward people and/or animals" (Cleveland Clinic, 2022a, "How is conduct order diagnosed?" section).

Oppositional Defiant Disorder

A behavioral condition in which the child has symptoms of being uncooperative, defiant, and may be hostile toward people in authority is called **oppositional defiant disorder (ODD)** (Cleveland Clinic, 2022b). Most children will display this type of behavior at some point in their early years, but if this behavior lasts longer than six months, then the child may be diagnosed with ODD. About 30 percent of children with ODD go on to develop the more serious behavioral symptoms of conduct disorder. This disorder can be treated with CBT, family therapy, and peer group therapy (Cleveland Clinic, 2022b). Although medications are not typically used, there have been studies conducted showing that medications, such as guanfacine, may have some benefit at decreasing symptoms (Newcorn et al., 2020).

Disruptive Mood Dysregulation Disorder

Another behavioral disorder seen in children is **disruptive mood dysregulation disorder (DMDD)** in which children experience chronic, intense, angry outbursts. This disorder may be a comorbidity with autism and other neurodevelopmental disorders. To diagnose DMDD, symptoms need to be present before the child turns ten years old and must disrupt their daily lives (Cleveland Clinic, 2022c). Psychotherapy is a first-line treatment for this disorder tried prior to considering the use of any medications. There is not specific FDA-approved medication for DMDD, but medications may be prescribed to manage certain symptoms—stimulants to decrease irritability, antidepressants for mood, and atypical antipsychotic medications to treat aggression (Cleveland Clinic, 2022c).

LINK TO LEARNING

Learn more about the signs and symptoms of conduct disorder (https://openstax.org/r/77conductdisord) by watching this short video from Dr. Ben Michaelis.

Multisystemic Treatment (MST)

Multisystemic treatment (MST) is an intensive therapy that takes place over a three- to five-month period and uses a family-based approach (AnnaFreud.org, 2023). This type of therapy provides support for both the child/adolescent and their parents. It can occur in the home, school, or other chosen area within the individual's local community. The goal is to interrupt the cycles leading to disruptive behaviors. The MST therapist works closely with the family to provide twenty-four-hour support and education on ways to avoid antisocial behaviors. Benefits of this treatment include reduced incarceration, reduced delinquent behavior, improved mental health, and improved family functioning (County Health Rankings, 2023).

Medications

Medication is not a first-line treatment for conduct disorder. If the child/adolescent is experiencing explosive anger, then the health-care provider may suggest that the individual take risperidone (Risperdal). Risperidone is an antipsychotic medication that has been FDA-approved to help children with autism spectrum disorder. It may be used off-label for short periods of time in children/adolescents with conduct disorder (Miller, 2023).

Treatment Settings, Family Therapy

Starting treatment early for CD is important. For younger children, research indicates the most effective treatment is behavior therapy training for parents where a therapist helps the parent learn effective ways to strengthen the parent-child relationship and respond to the child's behavior. For school-age children and teens, a combination of behavior therapy training that includes the child, the family, and the school is most effective (American Academy of Child & Adolescent Psychiatry, 2018).

Behavioral interventions for the classroom help children and adolescents succeed academically. Behavioral classroom management is a teacher-led approach that encourages a student's positive behaviors in the classroom through a reward system or a daily report card and discourages their negative behaviors. Organizational training teaches children and adolescents time management, planning skills, and ways to keep school materials organized to optimize student learning and reduce distractions (CDC, 2021f).

Behavioral interventions reward desired behaviors and reduce maladaptive coping behaviors. Most child and adolescent treatment settings use structured programs to motivate and reward age-appropriate behaviors. For example, the point or star system may be used where the child receives points or stars for desired behaviors, and then specific privileges are awarded based on the points or stars earned each day.

The basis of family therapy is to decrease negative interactional patterns between family members. The parents of children with conduct disorders often place blame on their children for everything else that is not going well in the family environment (Helimaki et al., 2020). Developing a working relationship with the different family members can be a challenge for the therapist as the layers of relationships all influence family dynamics. One point that Helimaki et al. (2020) make is that it is important to be sure that if the child is present in sessions with the parents that the child is not left out of the conversation or just a passive participant who is listening to what is being said about them.

PSYCHOSOCIAL CONSIDERATIONS

Family Empowerment

Families that have a child with conduct disorder can feel overwhelmed by the behaviors present in this disorder. Nurses and other mental health professionals are in a position in which they can help to empower these families. Family therapy offers a safe space for family members to share their feelings of guilt, fear, shame, and vulnerability (Helimaki et al., 2020). Therapists and nurses can teach the family how to build better communication between family members while dealing with their child's difficult behaviors.

(Helimaki et al., 2020)

Nurse's Role

There are several evidence-based strategies that nurses can teach parents and caregivers to help manage behaviors of children and adolescents with conduct disorder, such as time-out and special time (Hilt & Nussbaum, 2016). As part of parent management training (PMT), the intervention of time-out may be effective for emotional regulation when used consistently in a therapeutic manner (Roach et al., 2022). Such consistency increases the child's feeling of security as opposed to dysfunctional forms of discipline. Roach et al. (2022) acknowledge the need for further research in this area. Time-out is a strategy for shaping a child's behavior through selective and temporary removal of the child's access to desired attention, activities, or other reinforcements following a behavioral transgression. This strategy works for children who experience regular positive praise and attention from their parents or caregivers because they feel motivated to maintain that positive regard. The length of time should be about one minute for each year of age, but adjustments need to be made based on the child's developmental level. For example, children with developmental delays should have shorter durations (Hilt & Nussbaum, 2016). Tips for caregivers implementing time-outs include the following (Hilt & Nussbaum, 2016):

- Set consistent limits to avoid confusion.
- Focus on changing priority misbehaviors rather than everything at once.
- After setting a time-out, decline further verbal engagement until a "time-in."
- Ensure time-outs occur immediately after misbehavior rather than being delayed.
- Follow through if using warnings (e.g., "I'm going to count to three . . . ").
- State when the time-out is over. Setting a timer can be helpful.
- When the time-out finishes, congratulate the child on regaining personal control and then look for the next positive behavior to praise.
- Give far more positive attention than negative attention.

Special time is a strategy for a caregiver and a young child to establish the enjoyment of each other's company. It is also referred to as "child-directed play" because it emphasizes that caregivers follow the child's lead. Tips for caregivers implementing special time include the following (Hilt & Nussbaum, 2016):

- Commit to setting aside a regular time for "special time." Daily is best, but two to three times a week consistently also works.
- Select the time of day and label it as "our special time." Choose a time short enough that it can happen reliably, usually 15 to 30 minutes. Ensure that this time happens no matter how good or bad the day's behaviors were.
- Allow the child to select the activity, which must be something you do not actively dislike or does not involve spending money or completing a chore.
- Follow the child's lead during play, resisting the urge to tell them what to do.
- End on time; a timer may be helpful. Remind the child when the next special time will be.
- If the child refuses at first, explain you will just sit with them during the "special time."
- Expect greater success if you set your own special times for yourself, too.

Strengths and Protective Factors Identification

Children and adolescents pull their strengths from several areas. Nurses recognize that these strengths then become the children's protective factors. When children can engage in activities with others and gain a sense of enjoyment and well-being from that activity, they build their own sense of self-esteem and social support systems (Go et al., 2017). Children growing up in a home environment with positive parental influence have a higher likelihood of more positive outcomes versus children who are exposed to intimate partner violence and sexual abuse. School involvement is also a protective factor that supports children and adolescents by encouraging engagement and minimizing the number of conduct issues (Go et al., 2017).

Functional Analysis

Functional analysis is a strategy for preventing a recurring problematic behavior by first identifying why a behavior keeps recurring and then devising a plan to prevent recurrences. For example, a parent reports their young child "throws temper tantrums every time we go to the store." As the mental health professional, the nurse helps the parent analyze the behavior, the parent realizes they have been giving the child candy to halt the tantrums, which actually functions to reward the behavior and encourages it to happen again. If the parent were to stop delivering this unintentional reward, the tantrums would theoretically decrease. Alternatively, the parent may focus on avoiding reexposing the child to a recognized trigger for the behavior (Hilt & Nussbaum, 2016).

Community Services and Information Resources

The American Academy of Child & Adolescent Psychiatry website has a Conduct Disorder (https://openstax.org/r/77conductresour) Resource Center (2019) page that provides parents with answers to frequently asked questions, a list of helpful article and books, and a link to finding a child/adolescent psychiatrist. The National Federation of Families (2023) provides an interactive map of the United States (https://openstax.org/r/77USMap). The viewer can click on a particular state to find out the contact names of resources within their state.

Summary

23.1 Intellectual Disabilities

Intellectual disabilities are diagnosed in the developmental years but continue to affect individuals across the life span. Intellectual disabilities affect about 1 percent of the world's population. There are many categories of intellectual disabilities that range from mild to severe. There are three areas of functioning affected by intellectual disabilities: conceptual, social, and practical. Causes can be related to genetics, maternal exposure to toxins while pregnant, and environmental factors. Treatments are based on the type of intellectual disability that has been diagnosed and any comorbidities that exist. Early intervention is a key component of all treatments.

23.2 Communication Disorders

Approximately one in ten American children have a communication disorder, one of a group of neurodevelopmental disorders that affect speech and language development (Psychology Today, 2022). The *DSM-5* breaks communication disorders into five categories: language disorder, speech sound disorder, childhood-onset fluency disorder (stuttering), social communication disorder, and unspecified communication disorder (those that do not meet the *DSM-5* criteria).

The type of intervention used to treat a communication disorder is based on the child's age, the severity of the disorder and whether it is connected to another disorder. Interventions are intended to assist the child in developing their language skills and remove barriers to social participation (Law et al., 2017). Early intervention is considered to have the best outcomes and low-cost or free services may be available.

23.3 Autism Spectrum Disorder

According to the CDC, in 2020, approximately one in thirty-six children were identified as having autism spectrum disorder (ASD). ASD is a developmental disorder of the brain that causes impairment in behavior, communication, interaction with others, and learning. The American Academy of Pediatrics (2023) recommends screening children during their well-child visits at ages eighteen months and twenty-four months. This screening helps to identify developmental and behavioral challenges.

The nurse's role is primarily education-based. Nurses can assist parents in finding community resources and services that support the care of the child with ASD. Current treatments for ASD seek to reduce symptoms that interfere with daily functioning and quality of life. ASD affects each person differently, meaning that people with ASD have unique strengths and challenges and thus different treatment needs. Treatment plans typically involve multiple professionals with interventions customized to the individual.

23.4 Attention-Deficit/Hyperactivity Disorder

Attention-deficit hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders of childhood. It is usually diagnosed in childhood but often lasts into adulthood. ADHD affects approximately 9.8 percent of children aged thirteen to seventeen (CDC, 2022f). There is no single test to diagnose ADHD, and many other problems, such as anxiety, depression, sleep problems, and learning disorders, can have similar symptoms as ADHD. There are three types of ADHD, depending on which types of symptoms are strongest in the individual: inattentive, hyperactive-impulsive, and combined (CDC, 2021c). The main symptoms in ADHD, being impulsive and inattentive, can cause these children to have a higher risk for injuries.

Nurses should be aware of the different community resources available and refer parents to those entities; they should understand the medications prescribed to those with ADHD and therapies that have proven effective. Stimulants such as methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and dextroamphetamine-amphetamine (Adderall) are considered first-line treatment because of rapid onset of action and a long record of safety and efficacy. Behavioral therapies are aimed at helping the child with ADHD decrease their disruptive behaviors and increase their positive behaviors (CDC, 2023e).

23.5 Specific Learning Disorders and Motor Disorders

Globally, learning disabilities occur in nearly 5 percent of all school-aged children. Learning disorders are caused by genetic and environmental factors (Dominguez & Carugno, 2023). Risk factors for developing learning disabilities

include genetics, poverty, premature birth, alcohol exposure in utero, and traumatic brain injuries (Dominguez & Carugno, 2023). There are four commonly recognized learning disorders: dyslexia, dyscalculia, dysgraphia, and nonverbal learning disability (Dominguez & Carugno, 2023). The treatment plan is different for each child. It may include interventions, such as tutoring, an IEP, classroom accommodations, occupational or speech-language therapy, and possibly medication to address depression, anxiety, or behavioral issues (Mayo Clinic, 2023a). Motor disorders are a group of disorders that begin in the developmental years and cause delays in children reaching motor milestones. Symptoms include difficulty climbing stairs and tying shoes, making repetitive movements, or having physical or verbal tics.

23.6 Tic Disorder and Tourette Syndrome

Tourette syndrome (TS) and other tic disorders affect approximately 1 percent of school-aged children in the United States (Tourette Association of America, n.d.). Tics are sudden twitches, movements, or sounds that people do repeatedly with the inability to stop their body from doing these actions. In most cases, tics decrease during adolescence and early adulthood, and sometimes disappear entirely. The *DSM-5* includes three types of tic disorders: Tourette syndrome, persistent motor or vocal tic disorder, and provisional tic disorder (CDC, 2023f).

There is no known cure for tic disorders, but there are medications and therapies available to reduce the tics. Some of the medications used to treat tics include antipsychotics, such as haloperidol (Haldol), risperidone (Risperdal), pimozide (Orap), and aripiprazole (Abilify). Botox (botulinum) injections administered to an affected muscle can reduce a motor or vocal tic. Comprehensive behavioral intervention for tics (CBIT) includes education, relaxation training, and behavioral rewards to the person with tics. CBIT has been shown to improve tics over the long-term (Frey & Malaty, 2022).

23.7 Conduct Disorder, Oppositional Defiant Disorder, and Disruptive Mood Dysregulation

Conduct disorder (CD) is diagnosed when a child shows an ongoing pattern of aggression toward others with serious violations of rules and social norms at home, at school, and with peers. Conduct disorder symptoms can begin as early as preschool but usually worsen when a child reaches middle school to age eighteen (American Psychiatric Association, 2021b). It is more common in males than females. Conduct disorder occurs in 2 to 10 percent of children in the United States (Cleveland Clinic, 2022a). The exact cause of conduct disorder is unknown. Multisystemic treatment (MST) is therapy that takes place over a three- to five-month period and uses a family-based approach (AnnaFreud.org, 2023). This type of therapy provides support for both the child/adolescent and their parents. Medication is not a first-line treatment for conduct disorder. Research indicates the most effective treatment is behavior therapy training for parents where a therapist helps the parent learn effective ways to strengthen the parent-child relationship and respond to the child's behavior. For school-age children and teens, a combination of behavior therapy training that includes the child, the family, and the school is most effective (American Academy of Child & Adolescent Psychiatry, 2018).

Key Terms

adaptive functioning person's ability to conduct their activities of daily living through communication and independent living

Asperger syndrome disorder that has been reclassified as under ASD and has no requirement for onset by age three or language delay, and no criteria for communication or cognitive deficit

attention-deficit disorder (ADD) disorder involving distractibility and difficulties with mental focus and working memory

attention-deficit hyperactivity disorder (ADHD) disorder commonly diagnosed in childhood that involves difficulty paying attention, difficulty controlling impulsive behaviors, or excessive activity

autism spectrum disorder (ASD) developmental disorder of the brain that causes impairment in behavior, communication, interaction with others, and learning

child-onset fluency disorder chronic stuttering that persists into adulthood

childhood disintegrative disorder (CDD) rare, severe form of autism with a late onset

communication disorder persistent difficulty with language and/or speech

conceptual domain includes a person's abilities in language, reading, writing, math, reasoning, knowledge, and memory

conduct disorder (CD) diagnosed when a child shows an ongoing pattern of aggression toward others with serious

violations of rules and social norms at home, at school, and with peers

disruptive mood dysregulation disorder (DMDD) disorder in which children experience chronic, intense angry outbursts

Down syndrome intellectual disability where a baby is born with an extra chromosome 21

dyscalculia difficulty with calculation and completion of arithmetic problems

dysgraphia having distorted writing even with instruction and intact motor ability

dyslexia most common learning disability, affects a person's ability to read as it causes problems with phonological processing

emotional dysregulation inability to control emotions, can result in mood swings, angry outbursts, and losing temper

fetal alcohol syndrome most serious of the fetal alcohol spectrum disorders, and often features problems with the central nervous system, facial features, growth, learning disabilities, vision or hearing problems, and difficulty in school

Fragile X syndrome genetic disorder that involves the Fragile X Messenger Ribonucleoprotein 1 (FMR1) gene responsible for producing a protein that helps brain development

impulsive describes the behavior associated with ADHD that involves interrupting others, grabbing things from other people, or speaking at inappropriate times

inattentive describes the behavior associated with ADHD that involves difficulty for individual to organize or finish a task, pay attention to details, or follow instructions or conversations

intellectual developmental disorder child is not meeting age-appropriate developmental guidelines for speech, language, socialization, motor skills, and behavior

intellectual disability preferred term for intellectual functioning that falls below an IQ of 70 and starts before age eighteen

intellectual functioning way a person learns and problem-solves

language disorder difficulty learning spoken, written, or signed language

learning disorder occurs when a person has a difficult time in an area of learning, but it is not related to motivation or IQ level, emotional problems, cultural differences, or level of disadvantage

motor disorders group of disorders that begin in the developmental years and cause delays in children reaching motor milestones

oppositional defiant disorder (ODD) behavioral condition in which the child has symptoms of being uncooperative, defiant, and may be hostile toward people in authority

pervasive developmental disorder not otherwise specified (PDD-NOS) disorder reclassified as under ASD and was formerly used when the child did not meet all the criteria for autism

practical domain considers the individual's ability to act independently in their personal care, job role, school and work tasks, and money management

Prader-Willi syndrome abnormality in the fifteenth chromosome that results in a neurobiological disorder that affects metabolism and behavior

repetitive and stereotyped behaviors unusual behaviors, such as hand flapping, body rocking, repeating words, and placing toys in the same order

Rett syndrome disorder that affects mostly girls and often displays symptoms that are similar to autism

social communication disorder disorder in which a person has difficulty using verbal and nonverbal communication within a social situation

social domain considers the individual's ability to make friends and have relationships with others

speech sound disorder inability to articulate words or sounds in order to communicate with others

tic disorder disorder that causes a person to uncontrollably twitch, move, or make sounds

Tourette syndrome disorder that is diagnosed with the presence of two or more motor tics and at least one vocal tic that have lasted for at least a year, began before age eighteen, and are not due to another medical condition

Assessments

Review Questions

1. As a nurse working in obstetrics, what is one way to mitigate possible causes of intellectual disability?
    a. Explain to the parent the treatment options available.

b. Explain to the parent environmental risks to avoid during pregnancy.
c. Explain to the parent that genetics have a role in this disability.
d. Explain to the parent that learning disabilities often go unnoticed until the child enters school.

2. Which of the major types of learning disabilities has an avoidable cause?
a. Fragile X
b. Down syndrome
c. fetal alcohol syndrome
d. Prader Willi syndrome

3. Bobby is a seven-year-old who attends second grade in a public school. His teacher notices that Bobby doesn't volunteer to answer questions or talk with the other children. When he does talk, he sometimes stutters, especially if he gets nervous or thinks the other children are looking at him. What is one type of treatment that might make Bobby feel more comfortable talking in class?
a. scheduling a conference with his mother
b. psychodrama
c. singing
d. having a hearing assessment

4. A student nurse is trying to remember the five different types of communication disorders. They know that unspecified means that it does not fit into a specific *DSM-5* diagnosis classification but cannot remember the possible causes. How can the instructor explain it?
a. This type of disorder is often caused by genetics.
b. This type of disorder is often caused by a traumatic brain injury.
c. This type of disorder has no known cause.
d. This type of disorder has a combination of genetic, environmental, and physical causes.

5. Nurse Stefan is caring for a ten-year-old client who has ASD. The client's mother is concerned that her child is not getting all his homework completed and she does not want him to get behind in school. Nurse Stefan educates the client's mother by offering several suggestions. What is the nurse's most appropriate response?
a. "You should encourage your son to get all his work done in one sitting."
b. "Creating a quiet study corner in your home will help him to focus."
c. "Allow him to have the TV on in the background as this sometimes helps."
d. "Make him sit down and complete homework as soon as he gets home."

6. A student nurse is learning about ASD. What statement to the clinical instructor demonstrates that the student understands the definition of this disorder?
a. "The signs and symptoms of this disorder go away once the child turns eighteen."
b. "The signs and symptoms of this disorder usually begin before age three."
c. "The disorder is mainly based on physical symptoms."
d. "This is a developmental disorder."

7. A parent of a three-year-old child with ASD has called the local school district to inquire about resources available to support her child. The child's pediatrician referred the mother to the school district. What information can the school nurse share about the primary source of support at this age?
a. "You will need to check with the state for an early intervention program."
b. "Your child may be eligible to attend a developmental preschool program."
c. "Your child will not be eligible for services until she begins kindergarten."
d. "I don't know why your pediatrician referred you to us as there is nothing we can do to help."

8. Nurse John is an elementary school nurse teaching a group of parents about ADHD. What is one tip he could share that can be effectively used by the parents?
a. using a strict discipline program to correct the student's behavior

b. giving plenty of options for the child to choose from when doing an activity
c. using a sticker chart to document the child's accomplishments
d. creating a lively environment to make learning exciting

9. Jane is a nursing student living with ADHD. She knows from her own experience that this neurodevelopmental disorder affects being able to pay attention and being overly active. What is one other statement that is true about ADHD?
a. ADHD is one of the most common neurodevelopmental disorders.
b. ADHD rarely occurs in adults.
c. ADHD is commonly treated with medication in children under age six.
d. ADHD lowers the risk for childhood injuries.

10. A parent of a child who is newly diagnosed with ADHD wants to know where to find resources to help her better understand this condition. You are the school nurse where the child is enrolled. What could you suggest to the mother?
a. Google ADHD on the computer to see what she finds.
b. Check the ADHD Resource Center for more information.
c. Wait to see how the child adjusts to school before looking for more resources.
d. Go to the local health department to find out what they have available.

11. Martha is a school nurse who is assessing an only child who had an outburst in class. It has been noted by the child's teacher that he is having difficulty focusing in class. When he gets frustrated, he sometimes loses his temper and the teacher is afraid he might hurt himself or someone else. What might some of the child's symptoms indicate?
a. an undiagnosed learning disability
b. undiagnosed ADHD
c. a normal developmental phase that the child is working through
d. an only child who is used to getting things his way

12. A distraught mother brings her ten-year-old-son to the pediatrician and explains that no matter how much she tries to encourage her son to read books, he shows no interest and gets really upset when she pushes him to have reading time. In school, he gets average grades and explains that he gets frustrated because the schoolwork makes no sense. What diagnosis would the nurse suspect?
a. dysphagia
b. dyscalculia
c. dysgraphia
d. dyslexia

13. A nurse is talking to a parent about the steps taken to treat learning disorders. What does the nurse explain as the first priority?
a. a full physical exam to determine if there are any vision, hearing, or medical causes
b. a referral to a speech-language pathologist
c. developing an individualized education program to support the child academically
d. a "wait-and-see" approach since it may be part of normal development

14. A school nurse is meeting with a group of elementary school teachers to talk about motor disorders. One of the teachers raises their hand and says, "I have a student in my class who cannot stop moving her arms unless she sits on her hands. Could this be a movement disorder?" What diagnosis would the nurse suggest as a possibility for this student?
a. a tic disorder
b. a stereotypic movement disorder
c. a developmental coordination disorder
d. normal development for the student's age

15. A nursing instructor is asking a student to explain the care given for tic disorders and Tourette syndrome. What statement demonstrates that the student understands the concept?
    a. "One effective type of behavioral therapy used for tics is CBIT."
    b. "There is no current treatment for Tourette syndrome."
    c. "Most people with tic disorders will have them for their entire lives."
    d. "Tourette syndrome usually begins after age eighteen years old."

16. Johnny is twelve-year-old boy who has had an increase in aggressive behaviors, picking fights with other students at his school. Johnny's mother calls his doctor's office to ask if there is medication to help decrease these behaviors. After gathering more information about the recent increase in Johnny's outbursts, what is the best response from the nurse?
    a. "Allow more freedom at home as that may be adding to his outbursts."
    b. "Medication may not be indicated right away; there are other options."
    c. "Tell Johnny that his behavior is unacceptable."
    d. "Allow Johnny to skip school if he is having a difficult time being there."

17. A parent is worried about their adolescent who has been having angry outbursts for three weeks. The parent reaches out to the pediatrician's office asking about multisystemic treatment. How can the nurse explain it?
    a. "immediate assessment for oppositional defiant disorder"
    b. "very upsetting, but just typical for teenagers"
    c. "a combination of behavior therapy training that includes the child, the family, and the school"
    d. "a course of prescription medication"

Check Your Understanding Questions

1. Describe five of the physical characteristics that you might see in a baby who has Down syndrome.
2. Outline the interventions that might be taken to provide treatment to a person with a communication disorder.

The family of a six-year-old with severe autism has just moved to a new town. The parents go to the elementary school to enroll their child and to inquire about services available to their child. Their child is nonverbal, has repetitive behaviors, especially when feeling stressed, and has a high sensitivity to light and noise. At this school, the teachers and school nurse work closely with the special education department and are well-versed on the services that are available in this school district.

3. Based on what you have learned in this section what are some services you would expect to be offered to this child?
4. What help might the family get from the school nurse?
5. What is one resource listed in this module that the parents could access for more information about autism?
6. Describe ways you can assist a parent to better understand the diagnosis of ADHD and the resources available to them.
7. What information would you need in order to develop a family care plan for a child with ADHD?
8. Describe the steps taken to provide treatment to someone with a learning disorder.
9. Describe five interventions that a nurse can teach a parent to use when implementing time-outs for a child or adolescent who needs help managing their behavior.

Reflection Questions

1. What challenges may arise in accurately diagnosing intellectual disabilities, and how can a nurse contribute to overcoming these challenges?
2. What information might you need to determine if a child has a child-onset fluency disorder?
3. Discuss the potential impact of tic disorders and Tourette syndrome on a child's psychosocial development. How can nursing interventions contribute to mitigating these impacts and fostering resilience in the child?

4. As a nurse working in a pediatric office, what information would you initially need from the parent who is worried about their child's behavior?

What Should the Nurse Do?

Maria, a six-year-old female, has been brought to the pediatric clinic by her parents. Maria's parents express concerns about her social interactions and repetitive behaviors. Maria presents with limited eye contact, challenges in verbal communication, and resistance to changes in routine. Her medical history indicates that Maria was born full-term without complications. Vital signs are heart rate of 90 beats per minute, respiratory rate of 24 breaths per minute, blood pressure of 90/60 mmHg, and oral temperature of 98.6°F (37°C). Maria's parents report that they have been feeling overwhelmed and are seeking guidance on how to best support their daughter.

1. What behavioral cues or observations in Maria's interactions and routines might indicate potential challenges related to autism spectrum disorder?
2. What specific steps should a nurse take to collaborate with Maria's family in addressing their concerns and providing support for Maria's potential diagnosis of autism spectrum disorder?

Aaron, an eight-year-old male, is brought to the pediatric clinic by his parents. They express concerns about his behavior, noting that he struggles to stay focused in school, is easily distracted, and has difficulty completing tasks. Aaron's teacher has also reported impulsive behavior and challenges with peer interactions. His medical history reveals no significant issues, and vital signs are within normal limits (heart rate of 90 bpm, respiratory rate of 20 breaths per minute, blood pressure of 110/70 mmHg, and temperature of 98.6°F).

3. How should a nurse distinguish between ADHD-related symptoms and potential underlying issues, such as anxiety or learning disabilities, during the analysis of 'Aaron's cues?
4. What steps should a nurse take to collaborate with Aaron's parents and teachers to implement the family plan, and how would a nurse ensure its integration into both home and school settings?

Layla, a ten-year-old female, is brought to the pediatric clinic by her parents for her annual checkup. They express concerns about Layla's academic performance, noting persistent difficulties in reading and writing. Layla exhibits frustration and avoidance behaviors when confronted with school-related tasks. Her medical history indicates no significant health issues, and vital signs are within normal limits at the visit: heart rate of 85 bpm, respiratory rate of 18 breaths per minute, blood pressure of 110/70 mmHg, and temperature of 98.7°F.

5. What specific behaviors and expressions of frustration exhibited by Layla may be indicative of a potential specific learning disorder, and how do these cues differ from age-appropriate academic challenges?
6. Considering Layla's symptoms, what are the primary hypotheses for her academic challenges, and how would you prioritize them to guide further assessment and intervention?

Andrew is an eight-year-old male whose parents contacted the pediatrician to express concern about his unusual behaviors. The primary symptoms that Andrew is experiencing are repetitive, sudden, involuntary movements and sounds. These symptoms have been happening for about a year. There is no family history of any neuropsychiatric conditions. Andrew is an only child who does well in school. Recently, the tics have begun to affect his concentration and classroom participation.

7. What additional information would the pediatrician need to know in order to confirm a diagnosis?
8. What might Andrew's teacher suggest to implement at school to support his education?
9. What information could a nurse provide to Andrew's parents to help them manage Andrew's condition?

Competency-Based Assessments

1. As a clinical nurse, how might you differentiate between adaptive behaviors related to intellectual disability and those influenced by cultural factors?

2. Make a chart of the five types of communication disorders. Include a column for each diagnosis, a column for symptoms, and a column for treatment.

3. Think about the information you might need to develop a family care plan for a child with ASD. Write out aspects of a personalized plan.

4. As a clinical nurse, why is it essential for you to consider the unique strengths and challenges of the child when developing a family plan for ADHD?

5. What are the potential benefits of involving teachers and school personnel in the creation and implementation of the family plan for a child with ADHD?
6. How might the recognition of dyslexia in a school-aged child influence a nursing care plan, and what interdisciplinary collaborations could enhance the effectiveness of the plan?
7. How might you incorporate family-centered care principles when working with a child diagnosed with a motor coordination disorder, and what benefits could this approach bring to the child and family?
8. As a nursing student, make a plan to advocate for a child with Tourette syndrome within an educational setting. What considerations should be taken into account to create a supportive environment for the child?

References

American Academy of Child & Adolescent Psychiatry. (2018, June). *Conduct disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/conduct-disorder-033.aspx

American Academy of Child and Adolescent Psychiatry. (2019). *Conduct disorder resource center.* https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/Home.aspx

American Association on Intellectual and Developmental Disabilities. (2023). *Historical context*. https://www.aaidd.org/intellectual-disability/historical-context

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). APA Publishing.

American Psychiatric Association. (2013b). *Intellectual disability. Fact sheet*. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Intellectual-Disability.pdf

American Psychiatric Association. (2021a). *What are disruptive, impulse control and conduct disorders?* https://www.psychiatry.org/patients-families/disruptive-impulse-control-and-conduct-disorders/what-are-disruptive-impulse-control-and-conduct

American Psychiatric Association. (2021b). *What is intellectual disability?* https://www.psychiatry.org/patients-families/intellectual-disability/what-is-intellectual-disability

American Speech-Language-Hearing Association. (2023). *Social communication disorder*. Retrieved July 31, 2023, from https://www.asha.org/practice-portal/clinical-topics/social-communication-disorder/#collapse_3

Anna Freud.org. (2023). *Understanding treatment options*. https://www.annafreud.org/resources/children-and-young-peoples-wellbeing/understanding-treatment-options/

Association on Aging with Developmental Disabilities (2024). *About us*. https://www.agingwithdd.org/about/

Autism Speaks. (2023). *Resource guide*. https://www.autismspeaks.org/resource-guide

Autism Speaks. (n.d.). *Sensory issues*. https://www.autismspeaks.org/sensory-issues

Blain, T. (2022, March 31). *What are neurodevelopmental disorders?* Retrieved July 28, 2023, from https://www.verywellmind.com/neurodevelopmental-disorders-definition-symptoms-traits-causes-treatment-5221231

Center for Parent Information & Resources. (2017). *Intellectual disability*. https://www.parentcenterhub.org/intellectual/#diagnosis

Centers for Disease Control and Prevention. (2021a). *Facts about intellectual disabilities in children*. https://www.cdc.gov/ncbddd/childdevelopment/facts-about-intellectual-disability.html

Centers for Disease Control and Prevention. (2021b, February 22). *Language and speech disorders in children*. https://www.cdc.gov/ncbddd/childdevelopment/language-disorders.html

Centers for Disease Control and Prevention. (2021c, September 23). *What is ADHD?* https://www.cdc.gov/ncbddd/adhd/facts.html

Centers for Disease Control and Prevention. (2021d, February 22). *Learning disorders in children.* https://www.cdc.gov/ncbddd/childdevelopment/learning-disorder.html

Centers for Disease Control and Prevention. (2021e, April 20). *What is Tourette syndrome?* https://www.cdc.gov/ncbddd/tourette/facts.html

Centers for Disease Control and Prevention. (2021f, March 22). *Behavior or conduct problems in children.* https://www.cdc.gov/childrensmentalhealth/behavior.html#conduct

Centers for Disease Control and Prevention. (2022a, June 3). *What is Fragile X syndrome?* Retrieved July 28, 2023, from https://www.cdc.gov/ncbddd/fxs/facts.html

Centers for Disease Control and Prevention. (2022b, November 4). *Basics about FASDs.* Retrieved July 28, 2023, from https://www.cdc.gov/ncbddd/fasd/facts.html

Centers for Disease Control and Prevention. (2022c, December 13). *Parasites – Toxoplasmosis (Toxoplasma infection)*. https://www.cdc.gov/parasites/toxoplasmosis/gen_info/pregnant.html

Centers for Disease Control and Prevention. (2022d, November 2). *Autism spectrum disorder (ASD).* https://www.cdc.gov/ncbddd/autism/hcp-dsm.html

Centers for Disease Control and Prevention. (2022e, December 9). *What is autism spectrum disorder?* https://www.cdc.gov/ncbddd/autism/facts.html

Centers for Disease Control and Prevention. (2022f, February 24). *Data and statistics on children's mental health.* https://www.cdc.gov/childrensmentalhealth/data.html

Centers for Disease Control and Prevention. (2022g, March 28). *Signs and symptoms of autism spectrum disorder.* https://www.cdc.gov/ncbddd/autism/signs.html

Centers for Disease Control and Prevention. (2023a, June 28). *Facts about Down syndrome*. Retrieved July 28, 2023, from https://www.cdc.gov/ncbddd/birthdefects/downsyndrome.html

Centers for Disease Control and Prevention. (2023b, October 10). *Fetal alcohol spectrum disorders (FASDs).* https://www.cdc.gov/ncbddd/fasd/data.html#Prevalence-of-FASDs

Centers for Disease Control and Prevention. (2023c, June 6). *What is "Early intervention"?* https://www.cdc.gov/ncbddd/actearly/parents/states.html

Centers for Disease Control and Prevention. (2023d, June 6). *CDC's developmental milestones.* https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Centers for Disease Control and Prevention. (2023e, September 27). *Treatment of ADHD*. https://www.cdc.gov/ncbddd/adhd/treatment.html

Centers for Disease Control and Prevention. (2023f, May 31). *Diagnosing tic disorders*. https://www.cdc.gov/ncbddd/tourette/diagnosis.html

Centers for Disease Control and Prevention. (2023g, May 3). *Five things you may not know about Tourette syndrome*. https://www.cdc.gov/ncbddd/tourette/features/tourette-five-things.html

Centers for Disease Control and Prevention. (2023h, May 31). *Tourette syndrome (TS).* https://www.cdc.gov/ncbddd/tourette/diagnosis.html

Centers for Disease Control and Prevention. (2023i, May 4). *Tourette syndrome treatments*. https://www.cdc.gov/ncbddd/tourette/treatments.html

Cherewick, M., Daniel, C., Shrestha, C. C., Giri, P., Dukpa, C., Cruz, C. M., Rai, R. P., & Matergia, M. (2023). Psychosocial interventions for autistic children and adolescents delivered by non-specialists in low- and middle-income countries: A scoping review. *Frontiers in Psychology*, *14*, 1181976. https://doi.org/10.3389/fpsyg.2023.1181976

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). (2023). *About the national resource*

center. https://chadd.org/about/about-nrc/

Cleveland Clinic. (2021, May 18). *Fragile X syndrome*. https://my.clevelandclinic.org/health/diseases/5476-fragile-x-syndrome

Cleveland Clinic. (2022a, August 4). *Conduct disorder*. https://my.clevelandclinic.org/health/diseases/23924-conduct-disorder

Cleveland Clinic. (2022b, May 16). *Oppositional defiant disorder (ODD).* https://my.clevelandclinic.org/health/diseases/9905-oppositional-defiant-disorder

Cleveland Clinic. (2022c, October 31). *Disruptive mood dysregulation disorder (DMDD).* https://my.clevelandclinic.org/health/diseases/24394-disruptive-mood-dysregulation-disorder-dmdd

Cleveland Clinic. (2023a). *Intellectual disability*. https://my.clevelandclinic.org/health/diseases/25015-intellectual-disability-id

Cleveland Clinic. (2023b). *Prader-Willi syndrome*. https://my.clevelandclinic.org/health/diseases/21016-prader-willi-syndrome

Cleveland Clinic. (2023c). *Emotional dysregulation.* Retrieved October 11, 2023, https://my.clevelandclinic.org/health/symptoms/25065-emotional-dysregulation

Collier, S. (2020, April 21). *Struggling with attention and organization as you age? It could be ADHD, not dementia*. Harvard Health Publishing/Harvard Medical School. https://www.health.harvard.edu/blog/struggling-with-attention-and-organization-as-you-age-it-could-be-adhd-not-dementia-2020042119514

Committee to evaluate the supplemental security income disability program for children with mental disorders. (2015). *Clinical characteristics of intellectual disabilities- mental disorders and disabilities among low-income children*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK332877/

County Health Rankings. (2023). *Multisystemic therapy (MST) for juvenile offenders*. https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/multisystemic-therapy-mst-for-juvenile-offenders

D'Souza, S., Crawford, C.N., Buckley, J., Underwood, L., Peterson, E. R., Bird, A., Morton, S. M.B., & Waldie, K. E. (2019). Antenatal determinants of early childhood talking delay and behavioral difficulties. *Science Direct*, 57, https://doi.org/10.1016/j.infbeh.2019.101388

Dominguez, O., & Carugno, P. [Updated 2023 Mar 19]. In Learning Disability.: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554371/

Empower Behavioral Health. (2023, February 12). *What are neurodevelopmental disorders?* Retrieved July 28, 2023, from https://www.empowerbh.com/blog/what-are-neurodevelopmental-disorders/

Environmental Protection Agency. (2023). *America's children and environment (ACE)*. https://www.epa.gov/americaschildrenenvironment/health-neurodevelopmental-disorders.

Fermin Gutierrez, M. A., & Mendez, M. D. (2023, January 31). *Prader-Willi syndrome*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK553161/

Food and Drug Administration. (2023). FDA updating warnings to improve safe use of prescription stimulants used to treat ADHD and other conditions. https://www.fda.gov/drugs/drug-safety-and-availability/fda-updating-warnings-improve-safe-use-prescription-stimulants-used-treat-adhd-and-other-conditions

Frey, J., & Malaty, I. A. (2022). Tourette syndrome treatment updates: A review and discussion of the current and upcoming literature. *Current Neurology and Neuroscience Reports*, *22*(2), 123–142. https://doi.org/10.1007/s11910-022-01177-8

Gehret, M. (2022, August 10). *What are the 5 different types of autism?* Spectrum of Hope. Retrieved October 10, 2023, https://spectrumofhope.com/blog/5-different-types-of-autism/

Go, M., Chu, C. M., Barlas, J., & Chng, G. S. (2017). The role of strengths in anger and conduct problems in

maltreated adolescents. *Child Abuse & Neglect, 67*, 22–31. https://doi.org/10.1016/j.chiabu.2017.01.028.

Guralnick, M. J. (2017). Early intervention for children with intellectual disabilities: An update. *Journal of Applied Research in Intellectual Disabilities, 30*, 211–229. https://depts.washington.edu/chdd/guralnick/pdfs/2017-Guralnick-Early%20Intervention%20_for_Children-Update.pdf

Healthychildren.org. (2023, March 23). *If autism is suspected, what's next?* https://www.healthychildren.org/English/health-issues/conditions/Autism/Pages/If-Autism-is-Suspected-Whats-Next.aspx

Helimäki, M., Laitila, A., & Kumpulainen, K. (2020). Why am I the only one you're talking to, talk to them, they haven't said a word? *The American Journal of Family Therapy, 50*(2), 113–130. https://doi.org/10.1080/01926187.2020.1870582

Helpers Community. (2022). *What happens to disabled adults with no family?* https://helperssf.org/what-happens-to-disabled-adults-with-no-family

Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. https://doi.org/10.1176/appi.books.9781615370511

Hooper, M. (2021). *Nursing care of children with impaired cognitive function*. Frontier ER https://frontlineer.com/nursing-care-of-children-with-impaired-cognitive-function/

Ignatavicius, D., & Silvestri, L. (2023). *Using graphic organizers to develop clinical judgment in prelicensure nursing students.* Elsevier Education. https://evolve.elsevier.com/education/expertise/active-learning/using-graphic-organizers-clinical-judgment/#article-anchor-bottom

Jansen-van Vuuren, J., & Aldersey, H. M. (2020). Stigma, acceptance and belonging for people with IDD across cultures. *Current Developmental Disorders Reports, 7*(3), 163–172. https://doi.org/10.1007/s40474-020-00206-w

Krull, K. R. (2022, January 29). *Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications*. UpToDate. https://www.uptodate.com/contents/attention-deficit-hyperactivity-disorder-in-children-and-adolescents-treatment-with-medications

Law, J., Dennis, J. A., & Charlton, J. J. V. (2017). Speech and language therapy interventions for children with primary speech and/or language disorders. *The Cochrane Database of Systematic Reviews, 2017*(1), CD012490. https://doi.org/10.1002/14651858.CD012490

Lee, M. Y. (2022). Living with tics: Nursing care of pediatric Tourette syndrome. *Biomedical Journal, 45*(2), 280–285. https://doi.org/10.1016/j.bj.2021.10.011

Lesser, J., & Ebert, K. D. (2020, April 24). Examining social communication effects of a picture communication board in a child with autism. *Perspectives of the ASHA Special Interest Groups, 5*(2), 492–505. https://doi.org/10.1044/2020_PERSP-19-00113

López-González, M. A., Morales-Landazábal, P., & Topa, G. (2021). Psychodrama group therapy for social issues: A systematic review of controlled clinical trials. *International Journal of Environmental Research and Public Health, 18*(9), 4442. https://doi.org/10.3390/ijerph18094442

Maenner, M. J., Warren, Z., Williams, A. R., Amoakohene, E., Bakian, A. V., Bilder, D. A., Durkin, M. S., Fitzgerald, R. T., Furnier, S. M., Hughes, M. M., Ladd-Acosta, C. M., McArthur, D., Pas, E., T., Salinas, A., Vehorn, A., Williams, S., Esler, A., Grzybowski, A., Hall-Lande, J., . . . Shaw, K. A. (2023). Prevalence and characteristics of autism spectrum disorder among children aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. *MMWR Surveillance Summaries, 72*(SS-2), 1–14. http://dx.doi.org/10.15585/mmwr.ss7202a1.

Mayo Clinic. (2018, August 8). *Tourette syndrome*. https://www.mayoclinic.org/diseases-conditions/tourette-syndrome/diagnosis-treatment/drc-20350470

Mayo Clinic. (2021, June 5). *Stuttering*. Retrieved July 31, 2023, from https://www.mayoclinic.org/diseases-conditions/stuttering/symptoms-causes/syc-20353572

Mayo Clinic. (2022, August 6). *Dyslexia*. Retrieved July 31, 2023, from https://www.mayoclinic.org/diseases-conditions/dyslexia/symptoms-causes/syc-20353552

Mayo Clinic. (2023a, February 18). *Learning disorders: Know the signs, how to help*. Retrieved July 31, 2023, from https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/learning-disorders/art-20046105

Mayo Clinic. (2023b, February 24.) *Antisocial personality disorder*. https://www.mayoclinic.org/diseases-conditions/antisocial-personality-disorder/symptoms-causes/syc-20353928

McDonald W. M. (2017). Overview of neurocognitive disorders. *Focus (American Psychiatric Publishing)*, *15*(1), 4–12. https://doi.org/10.1176/appi.focus.20160030

MentalHelp.net. (2023). *Treatment of communication disorders and recommended reading*. https://www.mentalhelp.net/disorders-of-childhood/treatment-of-communication-disorders-and-reading/

Miller, C. (2023). *What parents should know about Risperdal*. Child Mind Institute. https://childmind.org/article/what-parents-should-know-about-risperdal/

Mimmo, L., Hodgins, M., Samir, N., Travaglia, J., Woolfenden, S., & Harrison, R. (2022). 'Smiles and laughter and all those really great things': Nurses' perceptions of good experiences of care for inpatient children and young people with intellectual disability. *Journal of Advanced Nursing*, *78*(9), 2933–2948. https://doi.org/10.1111/jan.15256

Nam, S. H., Lim, M. H., & Park, T. W. (2022). Stimulant induced movement disorders in attention deficit hyperactivity disorder. *Soa--ch'ongsonyon chongsin uihak = Journal of Child & Adolescent Psychiatry*, *33*(2), 27–34. https://doi.org/10.5765/jkacap.210034

National Autism Association. (n.d.) *What we do*. https://nationalautismassociation.org/

National Federation of Families. (2023). *Conduct disorder resources*. https://www.ffcmh.org/resources-conductdisorder

National Institute of Mental Health. (2016, October). *Mental health medications*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications

National Institute of Mental Health. (2018, March 18). *Autism spectrum disorder*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd

National Institute of Mental Health. (2022, January). *Autism spectrum disorder (ASD).* U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

National Institute on Health. (2020, April 13). *Autism spectrum disorder: Communication problems in children*. https://www.nidcd.nih.gov/health/autism-spectrum-disorder-communication-problems-children

Neuchat, E. E., Bocklud, B. E., Kingsley, K., Barham, W. T., Luther, P. M., Ahmadzadeh, S., Shekoohi, S., Cornett, E. M., & Kaye, A. D. (2023). The role of alpha-2 agonists for attention deficit hyperactivity disorder in children: A review. *Neurology International*, *15*(2), 697–707. https://doi.org/10.3390/neurolint15020043

Newcorn, J. H., Huss, M., Connor, D. F., Hervás, A., Werner-Kiechle, T., & Robertson, B. (2020). Efficacy of guanfacine extended release in children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder. *Journal of Developmental & Behavioral Pediatrics, 41*(7), 565–570. https://doi.org/10.1097/DBP.0000000000000822

NIH, National Institute on Deafness and Other Communication Disorders. (2016, May 19). *Quick statistics about voice, speech, language*. https://www.nidcd.nih.gov/health/statistics/quick-statistics-voice-speech-language

PACER Center, Inc. (2018). *Action sheet: PHP-c267: School accommodation ideas for students who receive section 504 of special education services*. https://www.pacer.org/parent/php/PHP-c267.pdf

Paul, D., & Roth, F. P. (2011). Guiding principles and clinical applications for speech-language pathology practice in early intervention. *Language, Speech, and Hearing Services in Schools*, *42*, 320–330.

Porter, D. A. (2023). *Unspecified communication disorder DSM-5 307.9 (F80.9)*. Theravive.

https://www.theravive.com/therapedia/unspecified-communication-disorder-dsm--5-307.9-(f80.9)

Posar, A. & Visconti, P. (2022). Update about "minimally verbal" children with autism spectrum disorder. *Revista Paulista de Pediatria, 40*, e2020158. https://doi.org/10.1590%2F1984-0462%2F2022%2F40%2F2020158

Psychology Today. (2022, March 23). *Communication disorders*. Retrieved July 31, 2023, from https://www.psychologytoday.com/us/conditions/communication-disorders

Psychology Today. (2023). *Understanding child development*. https://www.psychologytoday.com/us/basics/child-development

Quality and Safety Education for Nurses (QSEN). (2022). QSEN Competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Roach, A. C., Lechowicz, M., Yiu, Y., Mendoza Diaz, A., Hawes, D., & Dadds, M. R. (2022, September 1). Using time-out for child conduct problems in the context of trauma and adversity: A nonrandomized controlled trial. *JAMA Netw Open, 5*(9), e2229726. https://doi.org/10.1001/jamanetworkopen.2022.29726

Rudy, L. (2023, July 28). *Understanding the three levels of autism*. verywellHealth. https://www.verywellhealth.com/what-are-the-three-levels-of-autism-260233

Special Olympics. (2023). *What is intellectual disability?* https://www.specialolympics.org/about/intellectual-disabilities/what-is-intellectual-disability

Texas Health and Human Services. (2023). *Family support services*. https://www.hhs.texas.gov/providers/health-services-providers/children-special-health-care-needs-services-program/family-support-services

Tourette Association of America. (n.d.). *What is Tourette*? https://tourette.org/about-tourette/overview/what-is-tourette/#1461071628539-4f1f68e0-cd8d

Ueda, K., & Black, K. J. (2021). A comprehensive review of tic disorders in children. *Journal of Clinical Medicine, 10*(11), 2479. https://doi.org/10.3390/jcm10112479

University of Michigan. (2023a). *Dyslexia help starts here*. https://dyslexiahelp.umich.edu/

University of Michigan. (2023b). *How dyslexia affects the curriculum*. https://dyslexiahelp.umich.edu/professionals/dyslexia-school/how-dyslexia-affects-the-curriculum

Virginia Commission on Youth. (2021). *The collection of evidence-based practices for children and adolescents with mental health treatment needs* (8th ed.). Virginia Commission on Youth. Retrieved July 30, 2023, from https://vcoy.virginia.gov/010%20Motor.pdf

Wüstner, A., Otto, C., Schlack, R., Hölling, H., Klasen, F., & Ravens-Sieberer, U. (2019). Risk and protective factors for the development of ADHD symptoms in children and adolescents: Results of the longitudinal BELLA study. *PloS one, 14*(3), e0214412. https://doi.org/10.1371/journal.pone.0214412

Younis, J. R., Shattla, S. I., Abed, G. A., Shereda, H. M. A., & Elyzeed, S. M. A. (2021). Developmental psychodrama therapy: Effect on social anxiety and self-esteem among children who stutter. *Clinical Schizophrenia & Related Psychoses, 15*, 1–11. https://doi-org.easydb.angelo.edu/10.3371/CSRP.RJIS.101121

Zhu, C., Huang, S., Evans, R., & Zhang, W. (2021). Cyberbullying among adolescents and children: A comprehensive review of the global situation, risk factors, and preventive measures. *Frontiers in Public Health, 9*. https://doi.org/10.3389/fpubh.2021.634909

CHAPTER 24
Older Adults

FIGURE 24.1 Understanding the psychiatric-mental health issues that can affect young people and older adults is important for a nurse to care for clients across the lifespan. (credit: "Ada's feet" by Christian Haugen/flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION The fastest-growing portion of the population, older adults, will call for nurses and other health-care professionals with specialized training to meet their needs. A holistic approach to nursing care for the older adult population is necessary to address the physical, psychological, social, and economic factors that affect the health of older persons. People age differently, so there are variations in older adults' physical, psychological, and cognitive health. Even though aging is associated with typical physiological changes, many people disregard symptoms by incorrectly attributing them to age. For instance, many older persons misunderstand the pain associated with arthritis and wrongly think it is a natural part of becoming older. As a result, they do not seek treatment, which results in a reduction in physical activity and an increased risk of acquiring chronic disease. Older clients can benefit from receiving specialized nursing care and client education that will help them take charge of their health.

24.1 Healthcare Concerns and Decisions of Older Adults

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss complexity of health status of older adults
- Summarize healthy aging and health literacy for older adults
- Outline resources available for planning care for older adults

A successful aging goal for older adults is staying as healthy as possible for as long as possible. Education that meets the person's health literacy can help with this goal. Health can be a complex situation for many older adults and requires not only the involvement of the client but also of the family or caregiver. Access to care is vitally important as is communication within the multidisciplinary health-care team. The nurse can provide the connection that keeps all the pieces together.

Complexity of Health Status in Older Adults

People of any age can have complex health statuses. With older adults, however, the chances are higher due to the normal aging process as well as the long-term effects of a long life lived. It is common for an older adult to have multiple illnesses that are complex on their own, but become more so when combined with other health issues. For example, a client may have high blood pressure with chronic kidney disease as well as depression. Managing each of these on their own requires knowledge and skill, but adding in how they interact with each other can make the care even more complicated. In this example, a medical provider must know how the treatment choices affect other systems or illnesses. If an antidepressant is prescribed for this client, how does it affect the kidneys and how do the kidneys process the medication? What are the drug-to-drug interactions? The age factor and treatments or medications affect the more fragile physiological systems of the client and all contribute to the complexity of the health status.

Access to Care for Older Adults

Access to care is a very complex issue for older adults for many reasons. For some older adults, access is no issue; for others, every step of the process is a barrier or a potential barrier. Challenges like locating providers and scheduling appointments, lack of transportation, lack of knowledge for use of technology, the general affordability of care, and cultural considerations that may lead to actual and perceived barriers to care may affect access to health care for older adults. The need to see various specialists and the possible need for more frequent visits may add to access issues.

Adults aged sixty-five and over have access to Medicare for health-care insurance coverage. Medicare Part A is available with enrollment, and Part B is available with enrollment and a premium. Medicare Part A covers hospital and rehabilitation care while Part B covers ambulatory or home care. Some older adults have secondary insurance to supplement Medicare. Older adults with limited income may be eligible for Medicaid, health insurance available based on income, in the state where they reside. Some clients have both Medicare and Medicaid.

Seeking medical care, particularly preventative care, is important for older adults. For older adults who are eligible for Medicare and/or Medicaid, there may be resources available for locating care. Some people have very little or no access to care, however. Older adults who do not hold citizenship or are visiting from other countries do not have access to Medicare or Medicaid in most circumstances. Those without insurance must either pay out of pocket for care if they can afford it or, if available, can access care in community-funded clinics or care systems.

Locating care in itself can be difficult in some cases. Even in large cities, insurers may limit coverage that providers accept. Resources, such as telehealth/e-health virtual services, that are mainly available via the Internet may not be available for, or understood by, older adults. Wilson et al. (2021), while acknowledging the benefit of improved electronic services design, assert that education in use of computerized data would greatly influence older adults' engagement with the resource. Further, such education could also address older adults' perceptions of information presented online and provide clarity. This educational aspect is an excellent opportunity for nurses. Whether as educators or facilitators, nurses are well positioned as trusted professionals to promote knowledge acquisition in the older adult community.

Transportation to appointments can be a major barrier to care. Many older adults may not drive, may not have

caregivers to assist, or may live in areas that do not have public transportation. Even those who do live in areas that have public transportation may not be able to afford the cost, or may be physically or mentally unable to navigate the complex routes.

Cultural barriers are complex because some of the barriers are perceived rather than actual; that does not, however, make them easier to navigate. This is particularly true in mental health care. According to the National Council for Mental Wellbeing (2019), culture can impact mental health by creating a cultural stigma (seeing mental health challenges as a weakness) that can cause people to avoid seeking care as well as attempt to hide their mental health challenges. Symptoms may be misunderstood when the mental health provider is of a different culture than the client because the descriptors may differ when describing physical and mental symptoms. Culture can determine the amount of support that a person can expect from their community or their family. Lastly, culturally specific resources may be difficult or time-consuming to locate (National Council for Mental Wellbeing, 2019).

CULTURAL CONTEXT

Coping Styles

Because coping styles vary according to cultural influence, the nurse must be sensitive to differences in clients' approach to health concerns. Some may avoid acceptance of problems, while others may turn to family members or spiritual advisors. Individuals may view seeking assistance from the health-care system in different ways; some behaviors may be based on mistrust or language barriers.

Providers of care may have their own cultural perspective, for example, valuing Western medicine or strict adherence to treatment guidelines. Providers may harbor implicit bias toward older adults as frail or cognitively impaired or believe that everyone has equal access to health care.

(Mental Health First Aid, 2019)

Partnering with Providers of Care for Older Adults

The family of the older adult is of primary importance. The family of the client needs support just like the client. In some cases, the definition of family includes a close trusted friend, an extended family member, a caregiver, care managers, or a guardian. The care of older adults may require a team, and in some cases, the team includes multiple health-care professionals. In addition to the client and their family caregivers, the team may include nurses, social workers, therapists, and case managers, as well as medical specialists. Communication between members of the team is imperative to prevent errors in care and ensure continuity (Bhatt & Swick, 2017).

Chronic Disease

The National Council on Aging provides statistics on chronic conditions in adults aged sixty-five and older. According to its research, 80 percent of older adults have at least one chronic condition, and up to 68 percent have two or more (National Council on Aging, 2023). There are many factors that affect a person's likelihood of developing a chronic disease, from genetic predisposition to risk factors like smoking or environmental exposure. People can make choices—like lifestyle changes and consistent medical care—in their lives to prevent or reduce the risks and effects of chronic illnesses if they choose to do so. Table 24.1 lists the top ten chronic conditions for adults over the age of sixty-five.

Condition	Percent of Older Adults Affected
Hypertension	60%
High cholesterol	51%
Arthritis	35%
Ischemic or coronary heart disease	29%

TABLE 24.1 Common Chronic Conditions for Older Adults (National Council on Aging, 2023)

Condition	Percent of Older Adults Affected
Diabetes	27%
Chronic kidney disease	25%
Heart failure	15%
Depression	16%
Alzheimer disease	12%
Chronic obstructive pulmonary disease	11%

TABLE 24.1 Common Chronic Conditions for Older Adults (National Council on Aging, 2023)

Healthy Aging

Staying well for as long as possible is **healthy aging**. It encompasses the whole person. Staying active, which entails safe driving, physical exercise, and activities of daily living can help older adults maintain functional independence and promote general independence. Staying connected with the community is another factor that plays a role in healthy aging. This may mean attending a church group, joining a Bingo or game group, spending time with family, volunteering, or participating at a community center.

Likewise, nutrition is an important part of healthy aging. Maintaining a healthy diet has many benefits, including a longer healthy life, maintenance of energy, and prevention or reduction of chronic illness. According to DeSilva (2021), older adults have a higher diet quality than younger people, but still have room for improvement. Encourage older adults to increase fruits and vegetables, whole grains, and dairy while cutting back on added sugars, sodium, and saturated fats. Older adults could also improve their protein consumption, particularly seafood, dairy, and alternatives, such as beans, lentils, and peas, which all have additional calcium, vitamins D and B12, and fiber (DeSilva, 2021). The absorption of vitamin B12 decreases as people age, particularly with the use of some medications and may require supplementation. If access is an issue, there are multiple programs available to help older adults with food availability, such as Meals on Wheels (https://openstax.org/r/77mealsonwheels) and Supplemental Nutrition Assistance Program (SNAP) (https://openstax.org/r/77SNAP) as well as local food banks and services.

Another critical component of healthy aging is maintaining mental and brain health. Mental health issues, such as depression, anxiety, mood disorders, and cognitive impairment, are common as people age. According to the National Council on Aging (Cameron, 2023), up to 25 percent of those age fifty-five and up are affected by a mental health issue. There are many resources available for mental health care, from primary care psychiatrists to various levels of mental health professionals, such as psychologists, counselors, therapists, social workers, nurse practitioners, peer specialists, and pastoral counselors (National Alliance on Mental Illness [NAMI], 2020). The brain changes with aging and more so with certain chronic illnesses, due to reduction in blood flow or neuronal activity or inflammation. Keeping the brain as healthy as possible involves keeping the body and mind as healthy as possible. Although some memory lapses are normal from time to time, there are resources available to help determine when the older adult should speak with their medical provider about concerning memory loss. A wealth of information for professionals who care for older adults can be found at the National Council on Aging's web site (https://www.ncoa.org/professionals/health/center-for-healthy-aging).

Managing chronic illness and preventing new illness, along with managing medications and treatments, help contribute to healthy aging. Knowing and understanding medications that are prescribed, as well as over-the-counter and supplemental medications can help with side effects and prevent interactions and duplications. Lastly, keeping vaccinations up to date prevents many communicable illnesses.

Self-Management

Chronic disease is a normal part of aging, and millions of people struggle to manage these chronic illnesses and

their symptoms. A person's active involvement in their own health-care decisions and intervention to promote their own best possible wellness with the help of the health-care team is considered **self-management**. Older adults age sixty-five and above are prescribed medications more commonly than any other age group in the United States. Being able to correctly self-manage medications involves establishing habits, establishing routines, setting reminders, and keeping track of current medications with dosages, frequency, and times.

There are available programs, such as the Chronic Disease Self-Management Program (CDSMP), that provide workshops for adults with at least one chronic disease. The focus is on decision-making, action planning, and problem-solving for disease management. It is an interactive program with goals to increase knowledge of ways to manage chronic disease; motivate older adults to manage the challenges associated with chronic diseases, as well as their physical and psychological well-being; and help increase confidence. The target audience is adults with arthritis, those with one or more chronic conditions, and older adults.

One of the most significant barriers to self-management of chronic health issues and medications is cognitive status. The older adult with cognitive issues, such as mild or moderate cognitive impairment, may be unable to adhere to medication regimens or make decisions. The management of chronic disease and management may fall to a family member or caregiver. Low health and medical literacy can also be a barrier to self-management. If a person or caregiver is unable to fully understand the illness or disease and the related treatment, it can compromise their ability to manage the illness or disease.

Health Literacy

As with all people, older adults have varying levels of cognitive ability, education, and general knowledge. The ability to obtain, comprehend, and utilize information in the process of making health decisions is called **personal health literacy**, according to the National Institutes for Health (NIH). It is a crucial component to healthy aging. Critical to this process are resources to inform a decision and the ability to understand and use the resources. Personal health literacy is a very important factor to consider when nurses provide education in any form, when giving instructions for care, and when asking a person to provide informed consent, for instance.

Defined by the Health Resources and Services Administration (HRSA), **organizational health literacy** is how well an organization assists clients and family members to receive and understand information used to render health decisions (2022). The ability of persons and families to make a well-informed health-care decision may be dependent on the hospital's ability to provide the needed information and professional staff to assist, in a way that consumers can understand. The seminal study by the National Center for Education Statistics (2006) reports that 71 percent of older adults age sixty and above have difficulty with using printed materials, 80 percent have difficulty with using forms or charts, and 68 percent have difficulty with interpreting numbers and doing calculations.

LINK TO LEARNING

Communicating with older adults can be challenging as is ensuring they have an adequate level of health literacy. The Centers for Disease Control and Prevention (CDC) has provided some suggestions for effective communication with older adults (https://openstax.org/r/77oldadultcomm) to help ensure they fully understand health-related messages.

Available Resources for Older Clients

There are many resources available for older adults in the United States: resources to help with services for older adults aging in place in their homes and living independently, help with taxes, help deciding about medical insurance, help securing transportation, help finding eligibility for government or state benefits, help modifying a home, or help finding a caregiver. In the following paragraph are listed some of the most frequently used resources.

The National Council on Aging (https://openstax.org/r/77NatlCounclAge) is a resource that works with nonprofit organizations, government programs, and businesses to provide community programs and services. It is a great place to locate programs that are available to assist with healthy aging and financial security for people sixty years old and above.

The American Association of Retired Persons (AARP) (https://openstax.org/r/77AARP) is a nonprofit organization

that focuses on helping people aged fifty and older and improving their quality of life. The website has information, discounts, products, and news that is specific to older adults. AARP also has the AARP Foundation, which works to assist low-income older adults with getting many necessities, such as food, affordable housing, legal assistance, and social connections.

The Eldercare Locator (https://openstax.org/r/77Eldercare) is a free national resource provided by the U.S. Administration of Aging (AoA) and the National Association of Area Agencies on Aging (n4a). The goal is to help older adults find local resources, such as the following types of programs:

- nutrition and meal programs, such as Meals on Wheels or nutritionists
- caregiver support, such as support groups, caregiver training, or possibilities for respite care
- information about state or local assistance programs, such as the state's department of aging or local volunteer groups
- health insurance/benefits counseling
- resources for help with applications, such as for Medicaid, respite care, and veterans' programs

The National Institute on Aging (NIA) (https://openstax.org/r/77NIA) is a subsection of the National Institute on Health that conducts research dedicated to aging, health, and well-being of older adults. It also runs an interactive site called Go4Life (https://openstax.org/r/77Go4Life) for adults aged fifty years and older for starting a home exercise and physical activity routine. There are many other national, state, and local resources that are available to families and older adults online.

Nutrition and Housing

The U.S. Department of Agriculture (USDA) has a long list of resources for older adults and nutrition as well as other helpful resources, such as an older adult care locator, exercise and physical activity guidance, and general health tips. The MyPlate Plan (https://openstax.org/r/77myplateplan) gives a personalized food plan based on a person's age, sex, height, weight, and physical activity level. Figure 24.2 shows a sample meal plan appropriate for a ninety-year-old female who is 5ft 2in and 110 pounds and is minimally active. For older adults, the MyPlate recommendations include the following:

- Make eating a social event.
- Drink plenty of liquids.
- Add a touch of spice.
- Make the most of your food choices.
- Be mindful of your nutrient needs.
- Keep food safe (U.S. Department of Agriculture, 2022).

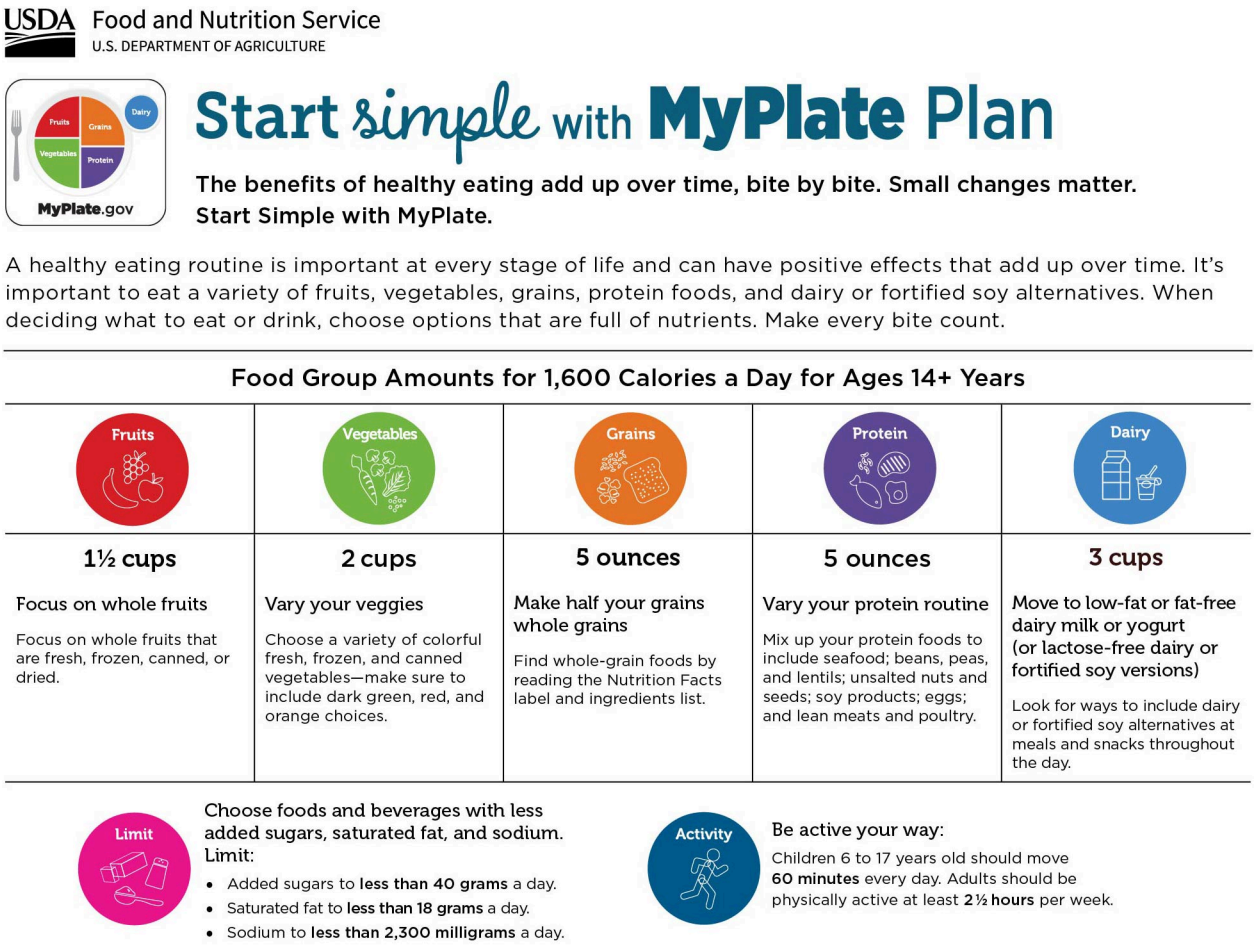


FIGURE 24.2 MyPlate Plan offers customized nutrition plans for individuals. (credit: "Start simple with MyPlate Plan" by USDA Food and Nutrition Service/U. S. Department of Agriculture, Public Domain)

According to Feeding America (2023), 5.5 million seniors (sixty and over) experienced hunger in 2021. That represents 7.1 percent of all seniors or one in fourteen. Seniors' health is severely affected by hunger, which exacerbates chronic illnesses, including diabetes, asthma, and depression. Federal poverty income guidelines for 2024 are set for individuals as annual income of $15,060 (Healthcare.gov, 2024). Older adults who have an income at or below 185 percent of the federal poverty income guidelines are eligible for the Supplemental Nutrition Assistance Program (SNAP). SNAP provides a debit card that can be used to buy food. Moreover, Meals on Wheels is a community-based meal program and provides healthy meals to homebound older adults who have limited resources.

Housing also plays a major role in older adults aging in a healthy manner. Older adults live in a variety of types of housing: individual homes, alone or with family; standard apartments or senior apartments; independent living facilities; assisted living facilities; personal care homes; memory care facilities; and nursing homes. The most challenging part of housing for older adults is paying for care when they can no longer live independently or when they require significant care. Private caregivers are very expensive as is institutional care. Most of this is paid privately. Medicaid and long-term care insurance are the only means of funding for facility-based long-term care, with Medicaid only paying for nursing home care for eligible people.

Individual homes, apartments, and senior apartments are generally the same in terms of services. Either independent older adults provide their own care, transportation, and management or family/caregivers assist them. A senior adult apartment complex may provide additional services, such as activities, meals, and on-site home health or pay-for-service caregivers. Independent living facilities usually provide some or all meals, nursing staff in an emergency, as well as utilities and routine housekeeping.

Characteristics of assisted living facilities (ALF) differ from state to state, are regulated by the states, and are

generally licensed in categories based on intensity of services. All levels of assisted living (sometimes referred to as Level 1, 2, or 3) help with activities, meals, housekeeping, caregiving, and employ varying levels of nursing staff. The independent living category requires that residents are able to evacuate in an emergency, get to the dining room under their own power, and may receive minimal supervision and assistance. The second category includes facilities that provide more care and can have residents that require assistance with mobility and activities of daily living, more hands-on care, and more supervision. The third category may be known as memory care and provides secured facilities or units within a larger assisted living. Residents of these facilities range from those who wander independently to those who require total care by caregivers, but not intensive nursing care.

As far as nursing staff, most facilities have licensed vocational nurses (LVN)/licensed practical nurses (LPN) to provide direct care and administer medications; a registered nurse is designated in a supervisory role. Medication aides may be present in some facilities. Nursing assistants generally provide most of the basic direct care twenty-four hours a day, as well as caregivers the residents may have individually.

Personal care homes are considered assisted living facilities but are different in that they are usually standard houses in neighborhoods housing multiple residents and maintaining caregivers twenty-four hours a day. This type of housing runs the entire spectrum of care, from houses that care for younger people with psychiatric or developmental issues who only require medication administration and supervision, to total care residents who are ventilator-dependent with feeding tubes. The staff in these facilities are trained on the job and do not require licensing or formal training programs. According to the Compendium of Residential Care and Assisted Living Regulations and Policy (Carder et al., 2015) published by the Department of Health and Human Services, the range of in-service or continuing education time that states required of the direct care staff ranges from unstated to eleven+ hours. There is no requirement to have a nurse on staff. Most states require licensing, but do not stop unlicensed facilities from opening and continuing to care for clients.

Some long-term or extended care facilities are categorized as “nursing homes” and provide full care for multiple residents with varying levels of need and ability. These facilities are staffed twenty-four hours a day with nurses, usually LVNs/LPNs, with RNs designated in a supervisory role, and nursing assistants providing the personal care. Within these facilities are residential clients as well as skilled nursing clients. “Skilled” is a reimbursement term, which means the service will qualify for insurance coverage. Such services include rehabilitative therapies and complex nursing care that has more of a medical focus, such as wound care or intravenous therapy. Clients admitted for skilled care remain for a temporary time before they return to their previous living situation, usually after an acute hospital stay.

LINK TO LEARNING

Medicare.gov provides a description of skilled nursing facility (SNF) care (https://openstax.org/r/77skillnursing) and costs in Medicare.

Caregiver Considerations for Older Adults

Resources for older adults often include finding caregivers. A caregiver for an older adult must be prepared to provide multiple types of support and assistance. The goal should always be to provide assistance in a way that promotes as much independence as possible while maintaining safety. Autonomy is an important goal to maintain as long as possible because it contributes to quality of life. A caregiver should be prepared to provide several basic types of care. Personal care entails helping with activities of daily living (ADLs), such as bathing, dressing, grooming, or other personal care that the client may require. Household help or instrumental activities of daily living (IADLs) include cleaning, laundry, cooking, yard work, or repairs. Emotional support means spending time, talking, or otherwise offering reassurance that the client is cared for. Health-care support involves assisting with going to doctor appointments, handling medication, and even making medical decisions if the client is not able to and the caregiver has the legal authorization to represent the client.

Quality of Life in Older Clients

Many factors affect our lives on a daily or continual basis. Some factors may not seem like they would significantly affect our lives, but the buildup of frustration due to lack of resources or any number of difficulties in accessing care

or day-to-day necessities can lead to dissatisfaction with life or with a period of life. A person's individual view of their health, comfort, and ability to enjoy activities of daily living is considered their **quality of life (QOL)**. This is a very individual concept and would be different for each person asked. QOL also changes as a person ages and as their physical and medical situation changes. For example, a healthy person in their sixties may consider a high QOL to mean being active, engaged, and healthy. A person in their nineties with severe cognitive impairment, on the other hand, may define QOL as being provided comfort care and an ability to eat and enjoy their food. QOL is rooted in a person's culture, faith, condition, and personal life experiences. Consider QOL when making decisions on care both medically and in caregiving.

Advance directives are documents that describe the person's wishes in advance of when the information may be needed and usually include a living will or health-care surrogate designation. An advance directive is created by a person when they are still in a cognitively intact status; it gives directions to their medical providers to be used in certain situations, such as code status when they have an irreversible terminal illness. Advance directives are very helpful in making sure that the health-care team follows the client's wishes even if they cannot speak for themselves. They are also helpful for the family so that they do not have to guess what their loved one wants for end of life or in the case of a terminal illness. These legal instructions also prevent a family member from making changes to the end-of-life plan when the client is no longer able to participate in the conversation. Refer families interested in creating advance directives to the National Institute on Aging (https://openstax.org/r/77NatlInstAging).

REAL RN STORIES

Nurse: Bruce, RN
Years in Practice: Twenty-two
Clinical Setting: Assisted living facility
Geographic Location: Texas

Bruce is an RN and the director of nursing for a Level 2 assisted living facility with a memory care unit. He is working with a resident and his family in the memory care unit. The resident is a ninety-six-year-old man with advanced dementia. He has multiple medical issues that are currently managed but is now having difficulty swallowing. The current options are either to leave him eating foods by mouth with the knowledge that he may be aspirating (getting food in his lungs) or to have a feeding tube put in his stomach. Bruce must discuss the change with the resident's family and the medical provider in charge of his care. Because Bruce's first concern is safety, he suggested to the family to have a feeding tube put in. This suggestion has a secondary effect in that the resident will have to move into a nursing home because his care becomes more complex and his medication will have to be given through the feeding tube. Bruce discusses both options with the family and leaves them to make the final decision. The family brings up the question of quality of life and states that the resident has said that if he cannot eat foods that he loves, he does not want to be alive. The family elects not to place a feeding tube and to allow him to eat as he chooses. Should he aspirate, the family will consider hospice to provide comfort and symptom management.

24.2 Depression

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the potential changes in mental status for older adults
- Describe ways to prevent depression in older adults
- Outline the approaches to treating an older adult with depression
- Support the family with an older adult who has depression

Depression is not a normal part of aging, but it is also not an uncommon occurrence in older adults. There are many factors that can contribute to depression in older adults, but in many cases, depression is preventable. The signs and symptoms are frequently overlooked or dismissed as normal parts of aging. It is well within the nurse's scope of practice to recognize when a client may be depressed or be at risk for depression.

Mental Changes Associated with Aging

Aging affects the entire body, including the brain, even in those with "normal" aging. With normal aging, certain parts of the brain shrink, and in certain brain areas, the neurons may not be able to communicate as effectively. Blood flow to the brain may be less due to cholesterol deposits or atherosclerosis and narrowing of blood vessels. Inflammation, which is a normal response to injury or disease, increases with age. All of these changes can affect a person's mental function. Complex memory and learning tests may be more difficult. Learning new tasks may take more time. The brain does, however, maintain the ability to change and adapt to manage new challenges with aging.

Chronic illness can exponentially increase the changes to the brain. Microvascular changes, or tiny, microscopic strokes that occur with high blood pressure, add up over time and can lead to vascular neurocognitive disorder in some people. Larger strokes, such as those caused by atrial fibrillation, also have significant effects both short- and long-term. There are things that people can do to slow or reduce the chances of changes to the brain, such as not smoking, limiting alcohol use, being physically active, receiving proper medical care, taking medications as prescribed, keeping appointments with providers, and eating a healthy balanced diet.

The older a person becomes, the more loss they may encounter. They may lose pets, friends, family, possibly a spouse or even a child. The loss of independence and/or loss of function also happens to some aging adults. This may happen gradually or suddenly. All of this loss must be processed and grieved. Bereavement is associated with cognitive decline (Atalay & Staneva, 2020).

Development Task: Integrity versus Despair

One cannot discuss changes to the brain through aging without considering psychosocial changes. Integrity versus despair is the final stage of Erik Erikson's stages of psychosocial development, beginning at age sixty-five and ending at death. (See 2.2 Interpersonal Theories and Therapies for more information on Erikson's theory.) In this final phase, individuals reflect on their lives and achieve either integrity, when they feel fulfillment, or despair, when they identify regrets and missed opportunities.

The benefits of integrity are acceptance of life, peace and fulfillment, and wisdom. The successful resolution of crises of this stage is called **ego integrity**. With peace and fulfillment, people can reflect back on their lives with satisfaction and approach death with wisdom and no regrets. Wisdom is defined by Erikson (1964) as an "informed and detached concern with life itself even in the face of death itself" (p. 133).

The consequences of despair are increased depressive symptoms, increased regret, and decreased life satisfaction. These can have detrimental effects on a person's health and well-being as they age. Increased depressive symptoms can lead to feelings of sadness, low mood, hopelessness, and feelings of worthlessness. Increased regret happens when people look back at their lives with guilt and fixate on mistakes. Feeling less satisfied with life can reduce resilience and hinder stress management.

People can improve their integrity and reduce their despair with counseling, seeking meaningful relationships, or working to repair damaged relationships. They also have the option to reframe their thinking by looking back at the mistakes and focusing on what can be learned from mistakes rather than thinking about personal failures.

Functional Ability and Comorbidities

Functional abilities are the fundamental self-care activities that people perform in their everyday lives. There are two types of functional abilities: activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which are activities that are necessary to living independently. These specifically include using the telephone, shopping, preparing food, housekeeping, doing laundry, independently transporting oneself, managing medication, and handling finances.

The ability to provide for one's care and be as independent as possible is very important for quality of life and for maintaining self-esteem and self-worth in many people. This is not the case for all older adults because some can maintain healthy outlooks even with low functional ability. Some adults who have lived independently for all or the majority of their lives have emotional difficulty when faced with dependence or with loss of functionality. This emotional difficulty can transition to depression in some older adults when the loss of function continues or becomes permanent. Chronic illness can also cause emotional difficulty that can lead to depression. This can be compounded when there is loss of functional ability and/or independence as well.

Common medical conditions that impair functional ability include cardiovascular diseases, neurological disorders, diabetes mellitus, cancer, obesity, dementia, emotional disorders, eye and hearing disorders, fractures, and stroke. The incapacitating effects of an ailment differ depending on what the client is trying to accomplish. Stroke can cause severe incapacitation and challenges with self-care. Arthritis is generally less serious but is more common and may make high-activity work (e.g., housework) difficult.

CULTURAL CONTEXT

Culture and Instrumental Activities of Daily Living

There are several cultures where older adults are not required to perform household tasks or IADLs. For example, Hispanic culture traditionally is one of respect for one's elders and dictates that it is the duty of the family to care for family members who can no longer care for themselves. The Korean culture is another example where the younger members have a duty to care for aging family members. In cultures such as these, a decline in IADLs can easily be overlooked and considered "normal aging." Sometimes, it results in dementia being more advanced when discovered due to the person not having the responsibility of performing any of these activities.

Prevention of Depression in Older Adults

The first step in preventing depression is to understand the factors that lead to the onset of symptoms and to understand what those symptoms are in older adults. According to the World Health Organization (WHO, 2023), roughly 14 percent of those over sixty years old experience a mental health issue, most commonly anxiety and depression. Over 27 percent of deaths by suicide are those over the age of sixty, worldwide (WHO, 2023).

The risk of depression for older adults increases by factors, such as limited access to education, the adoption of risky lifestyle habits (such as substance use, inactivity, and obesity), poor social support, financial stress, a lack of a confidant, chronic medical conditions, significant life events (such as death, divorce, trauma, or abuse), and the effect of material or functional losses (WHO, 2023). Interventions that can have the most significant effect are social activities that improve positive mental health, quality of life, and life satisfaction. Supportive therapies and programs that aim to promote social interactions and decrease loneliness can improve mental health among older communities (WHO, 2023).

Older adults may have different symptoms than younger ones, making it challenging to identify depression in older adults. Sadness is not the major symptom of depression in some older adults. In contrast, they may experience more numbness or a lack of interest in activities. They might not be as eager to discuss their feelings.

Keep in mind, everyone experiences depression differently, and may have symptoms other than those listed here. However, the common symptoms include:

- a persistently depressed, nervous, or "empty" feeling
- a sense of powerlessness, guilt, or worthlessness
- irritability, restlessness, or difficulties staying still
- decreased energy or fatigue
- slower movement or speech
- difficulty concentrating, remembering, or making decisions
- difficulty sleeping, waking up too early in the morning, or oversleeping
- eating more or less than usual, typically with unplanned weight gain or loss
- thoughts of death or suicide or attempts at suicide

Another possible sign and symptom of severe depression in an older adult is **pseudodementia**, a cognitive impairment that looks like dementia but is actually due to depression. The common symptoms include memory loss and impaired executive functioning. Unlike dementia, though, pseudodementia is reversible with treatment of the depression.

Socialization

Socialization is crucial for older adults. Those who have an active and fulfilling social life are less likely to experience many of the physical, cognitive, and emotional issues that isolated older adults face (WHO, 2023). Socially active

older adults have higher levels of physical activity, more positive moods, and fewer negative feelings. They also frequently score higher on cognitive testing. There are many other benefits of socialization, including longer lifespan and reduced stress, which can result in better cardiovascular health and an improved immune system, better fitness, reduced risk of anxiety and depression caused by isolation, and greater self-esteem. The National Council on Aging (Garcia & Jordan, 2022) reports that social isolation and loneliness can increase the risk of mortality by 50 percent, which is higher than the effects of obesity and alcohol abuse.

As many benefits as there are to socialization of older adults, there are many barriers, too. Those with mobility issues may not be physically able to leave the home. The loss of a spouse or other close loved one may cause situational depression that can lead to isolation and loss of social contacts. Real or perceived cognitive decline can isolate older adults by the fear and anxiety of forgetting important social information or by altering inhibitions, which can upset peers. There are ways that older adults can increase their social sphere:

- maintaining relationships with children and grandchildren
- volunteering to increase social exposure and a sense of purpose
- taking advantage of community resources, such as church activities and senior centers
- going to a daycare center for older adults
- moving to a retirement or senior apartment complex that has activities and social events
- organizing events with other seniors, like a game night or book club
- having a dog or other pet to decrease loneliness; having a dog can increase socialization on walks, as well as help maintain physical activity

Physical Health

Maintaining functional mobility and physical condition is an important part of healthy aging and can help with the symptoms of depression. Mobility helps older adults achieve the best quality of life, by maintaining independence, helping prevent and manage chronic illness, and even helping with the pain of osteoarthritis. Being physically active can also lead to social interaction.

Resources for physical activity information with the goal of managing arthritis and other chronic conditions include the following:

- *How Much Physical Activity Do Older Adults Need?* (https://openstax.org/r/77physactiviy) from the CDC
- *Physical Activity and Educational Programs Proven to Help Arthritis* (https://openstax.org/r/77arthritis) from the Arthritis Foundation
- *Physical Activity* (https://openstax.org/r/77WHOactivity) from the WHO

Maintaining physical health also plays a large part in maintaining emotional health and preventing depression. A person who feels good physically will have more energy and is less likely to suffer from depression compared with a person who is chronically ill and with chronic fatigue. A physically healthy person is also much more likely to be engaged socially and with their family because they have the energy to do so.

Treatment for Depression in Older Adults

The American Psychological Association's (APA, 2023) clinical practice guidelines recommend a combination of psychotherapy interventions, including suicide assessment, and second-generation antidepressants. The three psychotherapy interventions most effective in treating depression for older adults include group cognitive behavioral therapy (Group-CBT), interpersonal psychotherapy (IPT), and group review/reminiscence therapy.

Group-CBT focuses on the relationship between behaviors, ideas, and feelings; tackles existing issues and symptoms; and seeks to change those patterns that limit pleasure and hinder a person's capacity for optimal performance. IPT focuses on resolving challenging situations and relationships that are most directly related to the current depressive episode. Group review/reminiscence therapy assists older adults in focusing on their life's journey while analyzing and reflecting on changes and difficulties in order to have a more balanced and accepting outlook on life. Group therapy can provide peer support, reduce social isolation, and enhance coping skills (APA, 2023).

Most importantly, assess suicide potential with an evidence-based lethality assessment for suicide ideation. Clients with suicidal ideation vary widely in their risk for a suicide attempt depending upon whether they have a plan, intent,

or past history of attempts. In-depth assessment of clients who screen positive for suicide risk will help providers make a plan to keep them safe from harm. Assessment for suicide risk includes asking about their suicidal ideation (i.e., thoughts of suicide), if they have a plan for committing suicide, their intent on completing the plan, previous suicidal or self-harm behaviors, risk factors, and protective factors. When assessing for a suicide plan, the goal is to determine if they have a plan, if it is specific, and if they have thought of a method that they plan to use. The risk of acting on suicidal thoughts increases with a specific plan. The risk also increases if the plan includes the use of a lethal method that is accessible to the client.

An example of an evidence-based suicide risk assessment tool is the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). The C-SSRS is a six-question tool containing a series of simple, plain-language questions that anyone can ask. The answers can provide insight into suicide risk and needed support.

LINK TO LEARNING

The Columbia Lighthouse Project (https://openstax.org/r/77LighthousePjt) provides education on assessing for suicide risk as well as training on how to use it.

Treatment for depression can be provided in the hospital setting or in the outpatient setting. Psychotherapy may be used alone for treatment of mild depression or in combination with antidepressant medications for moderate to severe depression. Psychotherapy may involve only the individual, but it can include others, such as family members or couples therapy to help address issues within these close relationships. Depending on the severity of the depression, significant improvement can be made in ten to fifteen sessions. Group therapy brings people with similar disorders together in a supportive environment to learn how others cope in similar situations.

Medications and Electroconvulsive Therapy

Selective serotonin reuptake inhibitors (SSRIs) are common antidepressants that increase the levels of serotonin in the brain to stabilize mood. This class of antidepressants is better tolerated by older adults than most other antidepressants and generally has successful outcomes in treating depression (APA, 2023). The most commonly used and best-tolerated SSRIs are sertraline, citalopram, and escitalopram. All antidepressants carry the possibility of side effects and there are a few specific side effects that may cause the person to feel that the medication is not worth the benefit. The inability to feel pleasure, **anhedonia**, is one of those unwanted side effects. Anhedonia can cause people to withdraw from social activities due to reduced pleasure from daily activities.

According to published research, ECT is a treatment that sends an electric current through the brain, in effect triggering a small seizure, and is a safe and effective therapy option for older adults with significant depression, even when are very old older than eighty-five years). When compared with younger individuals, the effectiveness of ECT is noticeably higher in older adults. Research revealed that older persons with serious depression who had ECT lived longer and showed more clinical recovery than those who just received medication (Kerner & Prudic, 2014). ECT can be done in the ambulatory or outpatient setting.

Nurses' Role in Collaborative Care

The role of a nurse in treating older adult clients with depression is part of primary nursing care. Nurses also work with interprofessional teams that may include a psychiatrist, psychologist, social worker, or other health-care professionals. Each team member's role and practice are defined in their professional licensure.

The duty of the psychiatric-mental health nurse includes a clinical component in both hospital and ambulatory settings. Nurses use their clinical assessment skills and by implementing treatments that will improve the client's ability to care for themselves and advance toward optimal health, nurses who are serving in the capacity of case managers help the client function at their maximum level. Risk assessment; supportive counseling; problem-solving; instruction; medication and health status monitoring; comprehensive care planning; and linking to, identifying, and coordinating a variety of different health and human services are just a few examples of these interventions. Table 24.2 provides the most common signs and symptoms of depression with possible nursing interventions.

Signs and Symptoms	Nursing Interventions
Sleep disturbance	Teach to prepare for sleep by stopping use of electronics, avoiding caffeine or alcohol, setting a bed time and engaging in relaxing activity, such as slow breathing or stretching exercise to encourage sleep
Reduced interest and pleasures	Encourage participation in activities
Feelings of guilt or of worthlessness	Have the client think of and list positive self-characteristics
Reduced energy or fatigue; appetite or weight change	Educate to eat healthy and monitor intake; schedule rest periods; monitor weight; consult nutritionist
Decreased concentration and attention	Engage the client in a therapeutic relationship
Depressed mood	Reinforce therapy and medication teaching; review and evaluate coping strategies and support systems
Suicidal thoughts	Monitor for suicide risk; keep the environment safe and free of objects that could be used to self-harm
Slowed movements and speech	Assist mobility; use empathy when communicating
Withdrawal from normal activities	Have the client set a realistic goal for the day and the means of goal achievement; include family in care if client is agreeable
Psychomotor disturbances	Monitor medication effectiveness; collaborate with prescriber

TABLE 24.2 Nursing Interventions for Signs and Symptoms of Depression

Family Support for an Older Adult with Depression

To assist a loved one living with depression, the family may consider the following:

- Encourage your loved one to remain in treatment by encouraging them to take their medication as directed and to fulfill their scheduled visits.
- When asked, be prepared to listen without passing judgment. Pay close attention when they are speaking. Avoid making too many judgments or offering too much advice. Being receptive and understanding can be a very effective healing strategy.
- Give encouraging feedback. Remind them of their strengths and how much they mean to others.
- Offer to help. It can be difficult for someone with depression to perform some activities. Offer to help with the chores that they are struggling to complete.
- Aid in creating a routine. An older person may find it challenging to make good decisions if they are depressed. It becomes essential to establish routines and make time for daily tasks. Make a timetable for meals, medication, physical exercise, sleep, time outdoors or in nature, and other duties.
- Make plans together. Invite them to go on a stroll, to a movie, or to work on a hobby or other activity together. Don't try to compel the person to act in a certain way.

- Do not rush. After beginning medication, symptoms for some people may immediately become better. Others will find it takes a lot longer.
- Do not forget to look after yourself. It's difficult to watch a loved one battle with depression while realizing you can't help. Recognize that whatever feelings you feel, including irritation, helplessness, anxiety, guilt, or wrath, are normal reactions. It's crucial to look after your needs as well.

24.3 Anxiety

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Understand the presentation, causes, and levels of anxiety in older adults
- Perform a nursing assessment of anxiety in an older adult
- Plan nursing care within a collaborative approach to treating an older adult with anxiety

Older adults frequently experience underdiagnosed and undertreated anxiety. Complex physiological conditions can confuse the older adult's presentation or report of anxiety. Stress/loss, sadness, underlying medical illness, substance addiction, adverse drug/herb interactions, withdrawal syndromes, or general incapacity may all present as late-life anxiety symptoms.

Levels, Causes, and Support for Anxiety in Older Adults

Hildegard Peplau (1909–1999), the well-known psychiatric-mental health nurse theorist, developed a model describing four levels of anxiety: mild, moderate, severe, and panic. Behaviors and characteristics can overlap across these levels, but it can be helpful to tailor interventions based on the level of anxiety the client is experiencing. Nurses should learn to recognize these levels and utilize approaches most effective (Table 24.3).

Anxiety Level	Behavior	Nursing Approach	Example Statement
Mild	Client may be irritable, restless	This stage actually may increase ability to learn; nurse should use most communication here	"Let's talk this through."
Moderate	Client verbalizes feeling tense, may complain of headache	Perceptual field narrowed; nurse's communication should be focused	"Walk with me."
Severe	Client loses perspective, needs assistance, may cry, cannot learn	Give specific direction and repeat, offer comfort measures	"Put your sweater on, I will stay here with you."
Panic	Client must get relief, loses personal control, heart rate increases, safety risk, seeks escape	Manage the environment, reduce stimuli, repeat simple directions in calm manner, use client's name and verbalize intent before taking any action	"Sarah, here is your wheelchair, we are going to another room now."

TABLE 24.3 Anxiety Level and Nursing Approaches

LINK TO LEARNING

Mental Health America offers fact sheets on anxiety in older adults (https://openstax.org/r/77MtlHltAmerica) including types, risk factors, screening, treatment, and Medicare coverage.

Etiology and Symptoms

Anxiety disorders are thought to have a complex etiology, with major contributions from both hereditary and

environmental factors. Heritable factors, however, have less of an effect on older adults; instead, more attention is paid to the role of the biochemical changes that come with aging, illness, and neurodegenerative changes. In the context of polypharmacy, the role of medications, including drug interactions and side effects, should be taken into account. In this population, social and psychological factors are also important in the development of anxiety. Older adults may experience anxiety, for instance, in stressful situations like driving in heavy traffic. Anxiety may be precipitated by changes in the older adult's routine, pain, fear, stressors in the environment, or worry. Frustration with mobility limitations, sensory impairment, or attitudes and behaviors of others can manifest as anxiety. It is imperative to take into account concerns related to life transitions, including but not limited to bereavement, financial strains, and relocation or downsizing. Feelings of helplessness resulting from the following circumstances can trigger anxiety: losing a partner or other sources of support, experiencing medical conditions that impair senses, and losing control or mastery over oneself.

In contrast to younger adults, older adults are more likely to exhibit physical symptoms like tachycardia or digestive problems. They may also be more prone to fatigue, tense muscles, and sleep disturbances. The following are indicators and symptoms of anxiety disorders in older adults:

- tachycardia, dyspnea, trembling, nausea, diaphoresis
- depression
- lack of routine or consumed by routine
- excessive or irrational worry/fear
- sleep disturbances (insomnia, oversleeping, nightmares)
- avoidant behavior, especially of social environments
- excessive concern for safety
- muscle tension, pain, or weakness
- hoarding
- alcohol or other CNS depressant misuse

Supporting Older Adults with Anxiety

Having a relationship with an individual who is compassionate and addresses inactivity and isolation directly can be very beneficial for some older adults suffering from anxiety disorders. This could be a friend, relative, health-care provider, employee of an assisted living facility, chaplain or clergyman, or someone else entirely. Getting anxious people involved in creative, social, or other enjoyable activities can be quite beneficial. It can make a big difference to assist older adults in managing issues that could cause anxiety, such as handling health issues, financial matters, and worries about burdening others. Some tasks support people can help with include the following:

- acknowledge concerns and deal with any fears that are manageable
- assist in implementing deep abdominal breathing, prayer, meditation, and stress-reduction strategies
- encourage talk with family, a friend, or a spiritual leader
- arrange for or join in exercise
- caution avoidance of triggers for anxiety, such as caffeine, smoking, alcohol, or other substance use
- share news of current events to keep them informed but not trigger anxiety
- allow time for treatment to work

Table 24.4 provides the most common signs and symptoms of anxiety as well as possible nursing interventions.

Type	Signs and Symptoms	Interventions
Physical	Restless, agitated, fatigued, headache, gastric distress, body aches, heart racing, sweating, trembling, trouble sleeping	Remain supportive. Encourage safe physical activity: walking, stretching, yoga, deep breathing, meditation, reading, music. Teach to reduce triggers like alcohol, tobacco, and caffeine.
	Shortness of breath, chest pain	Nursing assessment: vital signs, rule out need for emergency care.
Psychological	Difficulty concentrating, irritability, excessive worry, feeling of being out of control or in danger	Remain supportive. Ensure safety. Assess cognition for education on coping, healthy lifestyle, and medications.

TABLE 24.4 **Nursing Interventions for Signs and Symptoms of Anxiety**

Nursing Assessment

As discussed, recognition of behavioral cues can prompt focused care planning. Clients who are restless, tremulous, agitated, or socially withdrawn may benefit from anxiety reduction, which the nurse can plan. Anxious clients may not be capable of identifying the cause of their feelings, so nursing assessment becomes important. An inability to employ personal strategies to manage psychological distress, or **ineffective coping**, may be another priority problem.

The behaviors of anxiety in older adults are often different than in younger people. Behaviors may overlap with illnesses and other medical conditions. Complaints may present as medical or somatic, such as pain as opposed to psychological distress. Anger, agitation, or sleep disturbance may be results of underlying anxiety. This frequently leads health-care practitioners to miss the anxiety and possibly misdiagnose the client.

Older individuals who are anxious may become less self-reliant, which could place stress on family. Low compliance with medical treatment is linked to anxiety problems, and this could exacerbate chronic medical diseases and raise the chance of nursing home admission. Older adults who are anxious report having less life satisfaction, memory loss, a worsening self-perception of their health, and more loneliness.

Older adults may have more topics of worry than younger people, such as memory loss, medical illnesses, and fear of falls. One component of anxiety is **worry**, persistent, uncontrollable negative thoughts, ideas, and verbalizations resulting from attempts to problem-solve issues with uncertain outcomes (Makovac et al., 2018). Worry can have a protective role by shielding individuals from the full effects of the fear and motivating them to take prompt action toward resolution which, in effect, is a coping mechanism. As a coping mechanism, the person is creating a scenario where they rehearse and anticipate a fearful event so that they can prevent or mitigate the effects of the scenario in question. Worry is a problem when it becomes a negative feedback loop that the person struggles to escape.

Nurses' Role in Collaborative Management

The primary role of the nurse in collaborative management is one of assessment, support, advocacy, and education of the client. Support and advocacy are built into the framework of all types of nursing care and are essential qualities in mental health care, especially with older adults. This population is high risk and frequently requires a high level of support and frequent advocacy, particularly if there is no or minimal family support. It is not uncommon for adults and older adults with mental health issues to become estranged from family and therefore no longer have support. In these cases, the nurse may be the one person who makes the difference in advocating for an older adult who, due to anxiety, has difficulty advocating for themselves and interacting with the team. The nurse can also serve as a major communicator for the medical provider in the client's care. The nursing assessment is valuable to the client and their management team. As the person who spends the most time with the client, the nurse can see the bigger picture of how the client's anxiety is affecting the thought process, functioning, and daily life. Nurses provide supportive care in helping with coping techniques and nonpharmacological interventions. Nurses also provide

education about coping mechanisms.

Nurses can educate clients about the symptoms of their anxiety and techniques to manage it. For some individuals, even being aware that something is a symptom of anxiety, naming it, and connecting it to anxiety can help reduce the intensity of the anxiety.

Certain substances, such as caffeine, some over-the-counter cold medicines, illicit drugs, and herbal supplements may aggravate the symptoms of anxiety or interact with prescribed medications. Clients should be advised to avoid or minimize use of these substances.

Physical exercise and meditation are highly effective in reducing stress. Older adults can learn progressive muscle relaxation to refocus away from emotional stress. Other stress reduction activities include sharpening cognitive skills with puzzles, games, music, and art. Spending time outdoors or interacting with companion animals can be effective as well.

Nurses can teach and coach self-management and offer honest praise for the older person's accomplishments. These interventions serve to promote the activities, and also to enhance the person's self-esteem.

24.4 Delirium

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify risk factors for delirium in older adults
- Comprehend the three categories of delirium in older adults
- Identify ways to detect delirium in an older adult
- Discuss the nurse's role in planning care for an older adult with delirium

Medical and psychological problems co-occur often in older persons who are hospitalized for medical, psychiatric, and surgical reasons. In a U.S. teaching hospital's quality improvement program, prospective chart reviews of medical records revealed comorbidity of delirium in 10.1 percent of the cases (Bayer et al., 2022). Delirium can occur in any setting.

Risk Factors

Psychosis caused by medical issues is often referred to as delirium, which is a mental state in which the client becomes temporarily confused, disoriented, and not able to think or remember clearly. It usually starts suddenly and can indicate the onset of a life-threatening medical condition. Delirium resolves as the underlying condition is effectively treated.

Causative Factors of Delirium

The first step in managing delirium is to address the causative factors. There are many common causes of delirium, including the following:

- dehydration and/or electrolyte imbalances
- dementia
- hospitalization, especially in intensive care
- intoxication or withdrawal from alcohol or drugs
- kidney or liver failure
- medications, such as sedatives, opioids, anesthesia, antihistamines, anticholinergics, antidepressants, antipsychotics, or anticonvulsants
- metabolic disorders, such as diabetic ketoacidosis (DKA)
- serious infections, such as urinary tract infections, pneumonia, and influenza
- severe pain
- sleep deprivation

If the cause is infection, the delirium resolves as it is treated. If it is a medication, then stopping the medication should resolve the delirium. Frequently, there are multiple causative factors and some can be difficult to address. For example, Teng and Frei (2022) found that antibiotics produced a higher delirium rate in individuals sixty-five years of age and older than in younger people, and some antibiotics are included on prescribers' reference lists as

inappropriate for older persons.

A person with dementia can become delirious with a change of environment where orienting cues are not available. When the causative factor is unavoidable, such as hospital admission or postanesthesia, supportive care can help to resolve the delirium over time. The state of delirium may wax and wane, which means that the client has periods of confusion followed by periods of clarity in waves. Over time, the periods of confusion or inattentiveness become less and less until the person is back to their baseline level of cognition. Delirium superimposed on dementia appears as new onset behavior, distinct from the changes in memory and cognition that occur with the gradual progression of dementia over months or years.

Risk Factors Due to Comorbidities

There are many risk factors for older adults for delirium; comorbidities can contribute significantly and exacerbate those risk factors. Any older person with multiple medical issues, and particularly those with any level of cognitive impairment, is at risk for developing delirium. An alteration in cognition that causes a decline in memory and thinking that happens with age and many medical and inherited factors is considered **cognitive impairment**. Delirium is not only an issue for hospitalized people but can happen in the home or any other residential setting. There are many factors that can contribute to delirium, with many being preventable. The most preventable are those caused or contributed to by medications. Polypharmacy (the use of five or more medications simultaneously) increases this risk with each medication added. Especially high risk are anticholinergics, narcotics, and sedative-hypnotics. Some antibiotics can increase risks as well. In some people, it is not the addition of a drug that causes delirium, but the removal with withdrawal. Infection is another very common cause of acute delirium.

HealthInAging.org (Health In Aging, 2023) displays the following map outlining the reversible causes of delirium using the acronym, DELIRIUM:

- **D**rugs, including any new medications, increased dosages, drug interactions, over-the-counter drugs, alcohol, etc.
- **E**lectrolyte disturbances, especially dehydration and thyroid problems
- **L**ack of drugs, such as when long-term sedatives (including alcohol and sleeping pills) are stopped, or when pain drugs are inadequate
- **I**nfection, commonly urinary or respiratory tract infection
- **R**educed sensory input, which happens when vision or hearing are poor
- **I**ntracranial (referring to processes within the skull), such as a brain infection, hemorrhage, stroke, or tumor (rare)
- **U**rinary problems or intestinal problems, such as constipation or inability to urinate
- **M**yocardial (heart) and lungs, such as heart attack, problems with heart rhythm (arrhythmia), worsening of heart failure, or chronic obstructive lung disease

Risk Factors Due to Psychosocial Status

Biopsychosocial status is an important factor in delirium. A low functional capacity, poor general health, or lack of social support can increase the risk of developing delirium when the body and mind are challenged by exposure to a high-risk factor. According to Ormseth et al. (2023), factors decreasing the risk of delirium are strong and consistent family involvement, frequent reorientation, and supportive environmental cues. Physical wellness, enhanced by sleep, oxygenation, and hydration, with good social support provides a higher resistance to delirium.

Categories of Delirium

Delirium is divided into three types based on the symptoms. The three types are hyperactive, hypoactive, and mixed. In older adults, hypoactive and mixed delirium are the most common. Frequently, the nurse or the family are the first to notice that a client is “not themselves” or has had a change in mental status from their baseline. Figure 24.3 provides a visual representation and summary of the two main forms of delirium.

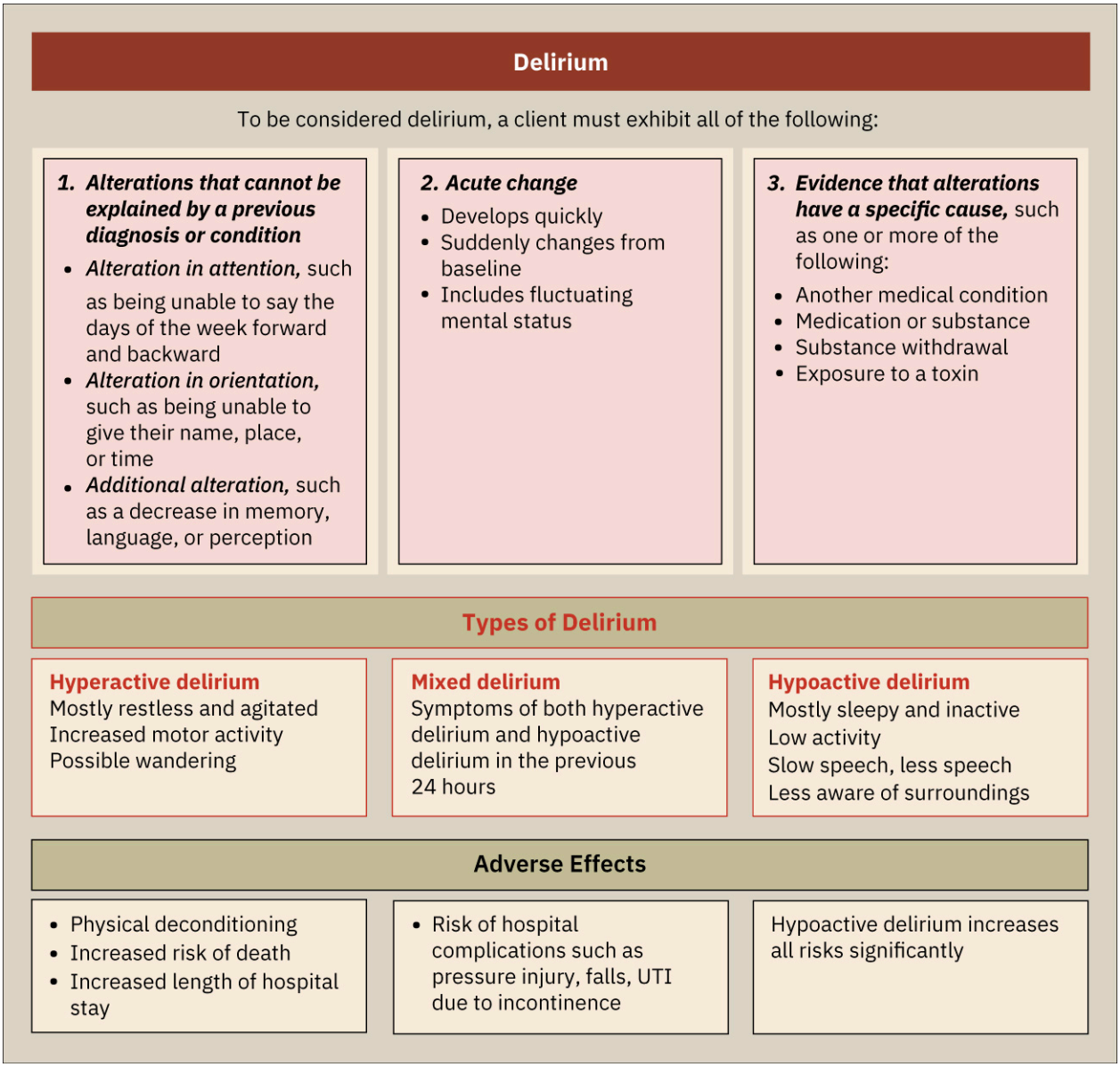


FIGURE 24.3 Delirium can be identified by applying these descriptions and classifications to avoid these adverse outcomes. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Hyperactive

Hyperactive delirium will usually entail restlessness, anxiety, and sometimes aggressiveness, as well as potential hallucinations. Mood swings are also common. This is the easiest type to recognize because the clients frequently resist care.

Hypoactive

Hypoactive delirium is often overlooked as delirium because the client is quiet and withdrawn. Hypoactive delirium is characterized by symptoms of drowsiness and inactivity. The clients may seem to be in a daze and not interact with family or others. It is more difficult to recognize and is associated with poorer outcomes than hyperactive delirium.

Mixed

Mixed delirium is a combination of hyperactive and hypoactive delirium and may fluctuate between the two.

Identifying Delirium

One of the most frequent tools used to identify delirium is the Confusion Assessment Method (CAM). The CAM is a

bedside screening tool used to determine if a client is showing signs of delirium. The CAM-ICU is also available for ICU clients and can be used for clients who are unable to speak due to being on a ventilator or other reason.

The CAM is a questionnaire that prompts assessment answers of yes/no or entering a descriptive term, such as *alert* or *lethargic*. The tool includes assessment data, such as onset, thought process, distractibility, level of consciousness, orientation, and agitation. The scoring alerts to the need for follow-up care.

LINK TO LEARNING

The American Nurses Association (ANA), in partnership with the American Delirium Society, has published a health and safety resource (https://openstax.org/r/77delirium) titled "Delirium: Prevent, Identify, Treat" on the ANA website.

Onset, Presentation, Signs, Symptoms, and Nursing Interventions

The symptoms of delirium usually start suddenly, over a few hours or a few days, and they often come and go. The most common symptoms are as follows:

- changes in alertness (usually more alert in the morning, less at night)
- changing levels of consciousness
- confusion
- disorganized thinking or talking in a way that doesn't make sense
- disrupted sleep patterns or sleepiness
- emotional changes: anger, agitation, depression, irritability, or overexcitement
- hallucinations and delusions
- incontinence
- trouble concentrating

Table 24.5 indicates the most frequent signs of delirium along with proposed nursing interventions.

Signs and Symptoms of Delirium	Nursing Interventions
Changes in alertness (usually more alert in the morning, less at night)	Making sure the room is quiet and well-lit with blinds or curtains open for exposure to daylight; getting clients up and out of bed when possible
Changing levels of consciousness	Having clocks and calendars within view
Confusion	Inviting family members to spend time in the room
Disorganized thinking or talking in a way that doesn't make sense	Ensuring hearing aids and glasses are worn
Disrupted sleep patterns or sleepiness	Allowing for uninterrupted sleep when possible
Emotional changes: anger, agitation, depression, irritability, or overexcitement	Calm approach, inform before touching or moving; administering prescribed medications to distressed clients at risk to themselves or to others to calm and settle them (administer medications with caution because oversedation can worsen delirium)

TABLE 24.5 Signs and Symptoms of Delirium

Signs and Symptoms of Delirium	Nursing Interventions
Hallucinations and delusions	Controlling pain with pain relievers (unless the pain medication is causing the psychosis)
Incontinence	Avoiding the use of restraints
Memory problems, especially with short-term memory	Prompt with environmental and verbal cues
Trouble concentrating	Speak clearly, repeat as necessary

TABLE 24.5 Signs and Symptoms of Delirium

LINK TO LEARNING

Read this article regarding delirium care (https://openstax.org/r/77delirium) for some information about nonpharmacological nursing interventions.

Identifying Delirium in a Person with Dementia

A person with dementia, no matter the type of dementia, is automatically at very high risk of developing delirium. To make it more complicated, delirium can be difficult to recognize. A person with dementia may already exhibit behaviors that are consistent with delirium. The most notable difference is inattention. A person with dementia can be disoriented at baseline, but they are attentive. A change in mental status of a person with dementia at times can be the first indication of an acute illness and delirium. The most difficult factor in dementia with superimposed delirium can be figuring out the precipitating factors. When there was a recent medication or treatment addition, it can be easy, but when it is a possible infection, pain, sleep issue, or other seemingly small factor, it can be difficult to recognize.

Care Partner Engagement for Older Adults with Delirium

To improve care, clients, their families, and health-care professionals must actively participate at all levels of the health-care system. This is known as care partner (client and family) engagement and can be applied to collaborative care of the older adult with delirium.

Engagement of care partners at the level of direct care can take several forms, from consultation and participation in decision-making to the delivery of direct care. It can also take place at the corporate and societal levels when developing health-care policy through shared leadership. With this model, both the quality of care and the quality of life are improved because of care partners' active involvement in decision-making and care management.

The characteristics of the individual client, the preparedness of the care partner, including their knowledge and skills, and the capacity and preparedness of the care team all have an impact on the implementation of care partnerships in the delivery of care to delirium clients. A five-step engaged caring approach is used to operationalize care partnerships. It consists of negotiation and risk assessment, awareness and information support, a joint monitoring plan, shared decision-making and early intervention, and making adjustments (Hill et al., 2014).

CLINICAL JUDGMENT MEASUREMENT MODEL

Evaluate Outcomes: Intervening on Delirium

The client is resting in the bedside chair watching a church service on television. The client answers to their name. The family states the client is better than yesterday. Nursing knowledge is required to recognize

improvements in prior problems of agitation, distractibility, disorientation, and family's report of client behaviors unlike baseline. The nursing action is to continue providing orienting cues and comfort measures to the client, monitor hydration status and laboratory test values, and encourage family involvement. The nurse will reassess as needed and continue care to the next identified problem.

24.5 Alcohol Use

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss risks, screening, and stigma related to alcohol use in older adults
- Outline the clinical management of an older adult with alcohol use problems
- Summarize aftercare for older adults in alcohol use recovery

Older adults are likely to be living with chronic health problems, using prescription and nonprescription medications and remedies. In addition, older adults generally have a lower physical tolerance for alcohol. These factors put older adults at risk for falls, accidents, injuries, drug interactions, and medical complications (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020). While many sources caution "limited" alcohol consumption for older adults, a safe intake level may be difficult to determine.

Alcohol Use in Older Adults

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) reports that alcohol is the most used and misused substance among older adults, and more than 10 percent engage in binge drinking. Friends and family may overlook an older adult's alcohol use, and alcohol consumption may be socially accepted (National Institute on Aging, 2022). Tolerance for alcohol and the cumulative effects of drinking change over the lifespan, however (National Institute on Aging, 2022).

Effects and Risks for Older Adults in Relation to Alcohol Abuse

As stated, there are effects of using alcohol that are unique to older adults. As people age, the body has a lower tolerance for alcohol, leading to a faster feeling of the effects of alcohol. This can create higher risks that the older adult can fall, have a car accident, or become injured.

Alcohol consumption can also worsen many health conditions. With diabetes, the liver stops releasing glucose while processing alcohol, which can drop blood glucose quickly. This causes hypoglycemia and, with the effects of the alcohol, it is easy to miss the symptoms of hypoglycemia. Severe hypoglycemia can lead to seizures, coma, and death. With hypertension, drinking too much alcohol can increase blood pressure and, with regular overuse of alcohol, can lead to uncontrolled hypertension and the associated risks. Chronic heavy alcohol use increases the risk for osteoporosis by decreasing bone density and weakening bones. Alcohol worsens memory issues and, in some cases, with long-term use, can cause dementia. Given that alcohol is a depressant, it will naturally contribute to mood disorders. All of this is on top of the long-term effects that chronic use of alcohol has on people of all ages, such as liver problems.

Mixing alcohol and prescriptions and even over-the-counter medications can be very dangerous. Some frequently used drugs that can cause serious alcohol interactions include, but are not limited to the following (National Institute on Alcohol Abuse and Alcoholism, 2019):

- nonsteroidal anti-inflammatory drugs (NSAIDs), which can increase risk of strokes, ulcers, and stomach bleeding
- blood-thinning medications, which can cause bleeding from minor injury, stomach or GI bleeding, and bruising
- sleep medications, which can cause impaired breathing, drowsiness, lack of motor control, and falls
- acetaminophen (Tylenol; also can be an ingredient in over-the-counter products and some prescription medications) combined with alcohol is one of the most common causes of major liver damage
- over-the-counter antihistamines, which may cause increased sleepiness and falls
- herbal treatments may have effects with alcohol, such as drowsiness, blood pressure changes, or liver damage

Screening for Older Adults Who Abuse Alcohol

All older persons should be screened for alcohol, tobacco, prescription drug, and illicit drug use at least once a year, according to the consensus panel's recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020). It is important to start with a complete history of substance use. Screening can result in better health and earlier treatment. There are a variety of screening tools available, but one, the Short Michigan Alcoholism Screening Test–Geriatric Version (SMAST-G), is specific to older adults.

LINK TO LEARNING

This presentation describes substance use disorder and addictions (https://openstax.org/r/77SMASTG) among older adults in health centers. The adapted SMAST-G is shown as well as how to generally screen older adults and provide brief interventions.

Stigma and Ageism

In the United States, older adults abusing alcohol is underestimated, underreported, misdiagnosed, and untreated. Many factors contribute to this, such as mistaking symptoms for other issues, a lack of education, denial, ageism, myths, stigma, and scant study and data. Stigma is a negative view that society holds on a specific group of people or on a behavior that a group exhibits. Discrimination of older adults due to stereotypes that are negative and inaccurate is considered **ageism**.

In the case of alcohol use disorder (AUD), older adults face ageism and stigma from all levels of society, including health-care professionals. Glazier and Ko (2023) write that nurses and medical providers may interact with older adults differently than with younger clients, listen less, and attribute sensory impairments to cognitive decline. Providers may order less diagnostic testing and may minimize some complaints as due to older age. According to Glazier and Ko (2023), geriatricians may be more effective as primary care providers for older adults.

PSYCHOSOCIAL CONSIDERATIONS

Assessing Alcohol Misuse

When talking with older adults about alcohol use, be mindful that some misuse may be unintended. The older adult may not realize the potential for alcohol to interact with medications. Be aware also of the older adult history, when alcohol consumption was an acceptable social activity and substance use in general may have been a societal norm.

Some signs of alcohol use may be mistaken for signs of aging and, therefore, not addressed. Negative attitudes toward substance use may prevent older adults from seeking help. Approach the topic of alcohol without judgment and with an educational perspective so that older adults can have positive outcomes of treatment with resulting improvement in health.

(SAMHSA, 2020)

Clinical Management for Alcohol Abuse in Older Adults

The treatment of AUD in older adults should be very closely monitored by a medical provider. It has been found that brief interventions for alcohol misuse can help with AUD and risk reduction. Brief interventions can be the starting point for many before moving into more intensive treatment. The focus is on helping the client to abstain or reduce their alcohol intake to decrease their health-related risks. Brief intervention starts with screening and a discussion of their alcohol use and determination of heavy use versus AUD. If AUD is determined, assess readiness to change and discuss reduction of intake and/or referral to treatment. If a client needs detoxification, the decision should be made of outpatient versus inpatient. Given medical comorbidities, outpatient detoxification is not common.

Withdrawal from Alcohol for Older Adults

Alcohol withdrawal is characterized by two or more of the following symptoms:

- autonomic hyperactivity

- increased tremor
- sleeplessness
- nausea or vomiting
- transitory visual, tactile, or auditory hallucinations or illusions
- psychomotor agitation
- anxiety
- grand mal seizures

Although only around 5 percent of drinkers experience delirium or seizures during withdrawal, older adults with co-occurring medical issues and limited physiologic reserve require monitoring while undergoing detoxification. In a study of alcohol withdrawal among hospitalized clients, the older clients had a higher risk of delirium, falls, and reliance on others to perform everyday tasks (Joshi et al., 2021). Older adults may experience protracted confusion, which could lengthen their hospital stay and increase their chance of being sent to an extended care facility after discharge. Hospitalization is frequently advised for older clients with AUD undergoing detox for close monitoring.

Hospital or Home Care for Older Adults with Alcohol Abuse Issues

As in the preceding discussion, the decision to treat the older adult in inpatient treatment or with outpatient treatment is complex. Given the risks of outpatient detoxification, inpatient care may be more advantageous for this age group. The risks of withdrawal are high, and the medications used to manage the withdrawal have their own risks when used in older adults. Figure 24.4 shows the treatment algorithm for alcohol use in older adults.

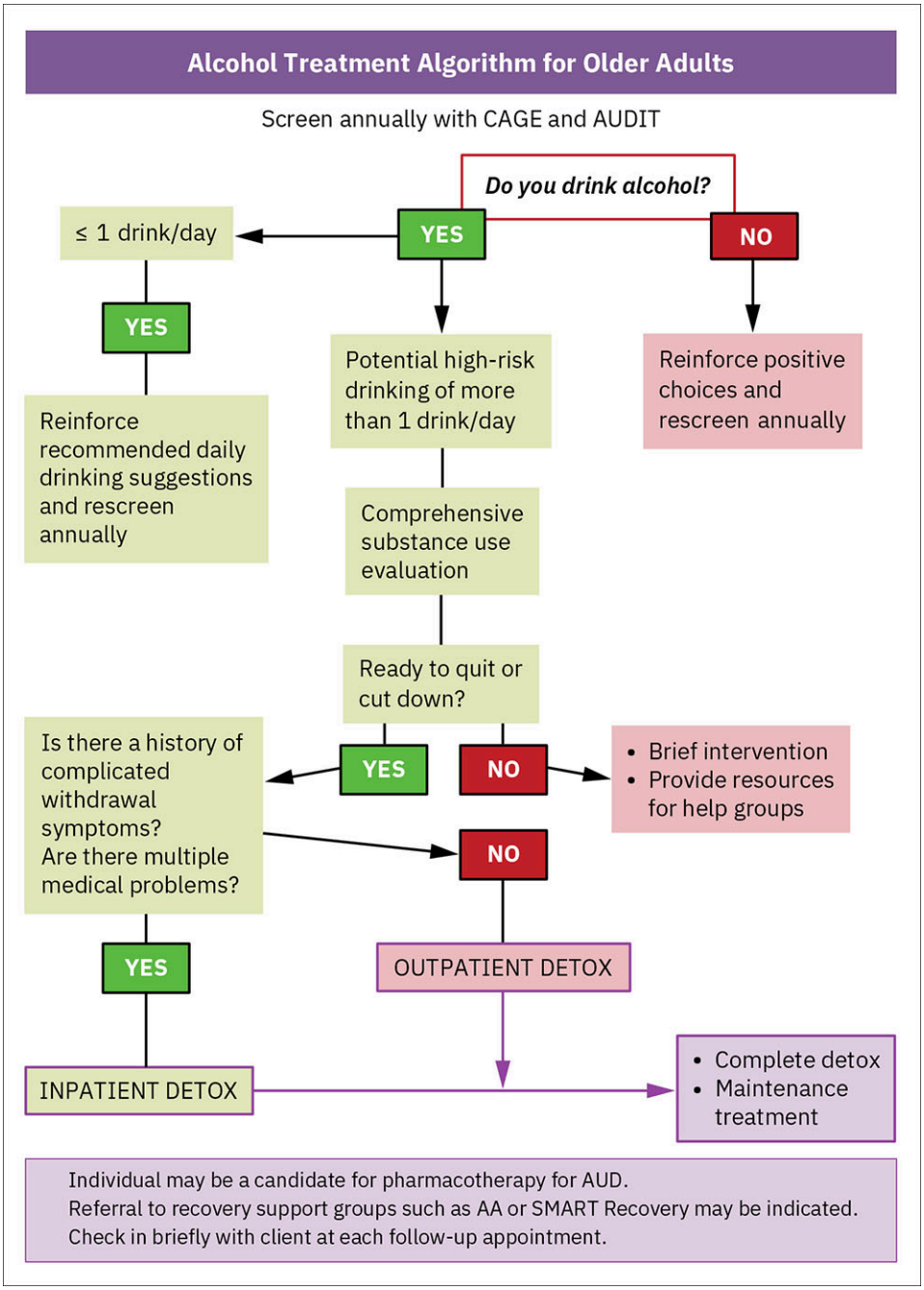


FIGURE 24.4 Alcohol use history can guide planning for evaluation and treatment. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Pharmacology

The cornerstone of pharmacologic therapy of alcohol withdrawal is the use of benzodiazepines; these can be given either regularly or as symptoms arise. Currently, there are no specific guidelines for managing withdrawal with benzodiazepines in older adults. When considering risk versus benefit, the benefit of using benzodiazepines may outweigh the risks. The risks of withdrawal with seizures and death are greater than the risks of acute delirium due to the use of benzodiazepines. Acute delirium is a common withdrawal symptom even without the use of benzodiazepines. Supplementing with thiamine and other vitamins, addressing electrolyte imbalances, and receiving general supportive care are all examples of concurrent treatment during detoxification. There are several medications available for treatment of AUD; some are used clinically but are not approved by the FDA for that use.

- Acamprosate (approved by the FDA) is used for maintenance of abstinence from alcohol in those who have completed detoxification and are currently abstinent. It promotes balance of neurotransmitters and should

not be used in those with reduced kidney function.

- Disulfiram causes an unpleasant reaction when alcohol is consumed and is appropriate for highly motivated clients who have completed detoxification. This drug should not be taken within twelve hours of alcohol consumption in any form (mouthwash, cough syrups), and should not be used by individuals with heart disease or cardiovascular disease, risk of liver toxicity, or those with high levels of impulsivity or suicide risk.
- Naltrexone reduces alcohol cravings and can reduce the number of drinks that a daily drinker consumes. It should not be used in those with liver dysfunction.
- Gabapentin is not FDA approved for AUD, but it may still be helpful, used off-label, for mild withdrawal. As an anticonvulsant, gabapentin reduces central nervous system excitation. It should not be used in those with kidney disease, and it increases risk of falls.
- Topiramate is not approved for AUD, but it may be helpful in reducing cravings. Extended release should not be used in those with recent alcohol use. There is also a risk of weight loss and short-term cognitive impairment, so it should not be a first-line choice in older adults.

Aftercare for Older Adults in Recovery

After initiating treatment, it is important to implement continual follow-up to monitor clients during acute and chronic recovery and to prevent relapse. Provide continuous education through all levels of treatment and recovery by providing training on how to manage stress, triggers, and cravings. Education and skills training should focus on three foundational skills: coping skills, social skills, and communication skills.

An advocate and support system can make the difference between success and failure. Older adults encounter a lot of loss, so grief is frequent and can lead to relapse. Moreover, the physical, social, and health changes that come with aging can be stressful, so those without a strong support system or with poor coping mechanisms will always be at high risk for relapse.

Twelve-Step Program for Older Adults

Twelve-step programs can be very beneficial for older adults. These programs address both loneliness and addiction. One of the tenets of twelve-step programs is being of service and accepting help. This is vital to older adults who may not have a social network or support system. The program connects people in order to support each other and therefore provides socialization that can help prevent relapse. The segregation between young and old that is seen in the general community is not present in twelve-step groups. Older adults receive respect and younger members value their life experience (Gibson, 2021). Older adults are encouraged to share how they managed life's challenges and how they persevered to make it through. The groups foster acceptance.

Family Support, Referrals for Older Adults with Alcohol Abuse Issues

Family support for older adults with AUD can help both the family and the client. Families who participate in therapy with their loved one benefit as much as the person with AUD. There are also mutual help groups like Al-Anon that provide support for children, spouses, and other family members of people with alcohol addiction. Family members must be careful to avoid a situation of **codependency** where they are potentiating the problem by enabling the addicted person to continue their self-destructive behavior. Support groups can be very helpful in pointing out these behaviors and helping the enabler to alter their behaviors. A primary care provider can refer older adults with AUD or clients can self-refer. Nurses can provide support by advocacy and education. An individual's health insurance company is a good place to start to find out what the benefit coverage is as well as if there are local in-network treatment options. There are also multiple online resources for finding and accessing treatment:

- Substance Abuse and Mental Health Services Administration: Find Help (https://openstax.org/r/77FindHelp)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA): Alcohol Treatment Navigator (https://openstax.org/r/77AlcoholTx)
- Medicare Rights Medicare Interactive: Treatment for Alcoholism and Substance Use Disorder (https://openstax.org/r/77MedAlcSUD)
- Center for Medicare Advocacy: Medicare Coverage of Mental Health and Substance Abuse Services (https://openstax.org/r/77MedicareTx)
- Alcoholics Anonymous: *A.A. for the Older Alcoholic—Never Too Late* (https://openstax.org/r/77AlcoholAnon)
- Al-Anon Family Groups: Who Are Al-Alanon Members? (https://openstax.org/r/77AlAnon)

24.6 Pain

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Classify types and levels of pain
- Describe nursing assessment related to pain
- Plan individualized pain management

Older adults are at increased risk for undertreatment of pain. Many older adults in the community or living in long-term care centers have significant pain due to chronic conditions (AgeWays, 2019). Pain is often underassessed in older adults because they are less likely to report it and also because it may not present with a clearly identifiable cause (AgeWays, 2019).

Types and Levels of Pain

What distinguishes administering pain management in mental health settings from other acute care settings? It is the complicated interaction between mental illness, analgesic drugs, and related addiction, along with the necessity of preserving the environment's safety in order to establish and maintain the therapeutic relationship, which is client centered. The American Nurses Association (ANA Center for Ethics and Human Rights, 2018) presents a position statement that describes the nurse's ethical responsibility to relieve pain and to customize the nursing interventions.

Onwumere et al. (2022) assert that the experience of those with mental illness who also experience pain is complex and requires understanding from caregivers. Accurate assessments are essential. Intervention must be individualized, such as physical activity as a therapy, and pain management must be considered within the overall care (Onwumere et al., 2022). Behavior may project anxiety, distress, or fear. Behavioral assessment tools for pain may be impacted by many other stressors. It can be difficult to separate emotional responses from sensory aspects.

Pain can be divided into visceral, deep somatic, superficial, and neuropathic pain. Visceral organs are midline in the body within the abdomen, highly sensitive to stretch, ischemia, and inflammation. Visceral pain is diffuse, and often referred outward to other locations in the body. It may be accompanied by nausea and vomiting and may be described as sickening, deep, squeezing, and dull.

Deep somatic pain comes from stimulation of nociceptors in ligaments, tendons, bones, blood vessels, fascia, and muscles and is a dull, aching, poorly localized pain. Examples include sprains and broken bones.

Superficial pain comes from the activation of nociceptors in the skin or other superficial tissue and is sharp, well-defined, and clearly located. Examples of injuries that produce superficial somatic pain include minor wounds and minor (first-degree) burns.

Neuropathic pain is defined as pain caused by a lesion or disease of the somatosensory nervous system. It is typically described by clients as "burning" or "like pins and needles." Neuropathic pain can be caused by several disease processes, such as diabetes mellitus, strokes, and HIV, and is generally undertreated because it typically does not respond to **analgesics**. Medications, such as tricyclic antidepressants and gabapentin, typically manage this type of pain.

Pain can radiate from one area to another. For example, back pain caused by a herniated disk can cause pain to radiate down an individual's leg. Referred pain is different from radiating pain because it is perceived at a location other than the site of the painful stimulus. For example, pain from retained gas in the colon can cause pain to be perceived in the shoulder. See the following figure (Figure 24.5) for an illustration of common sites of referred pain.

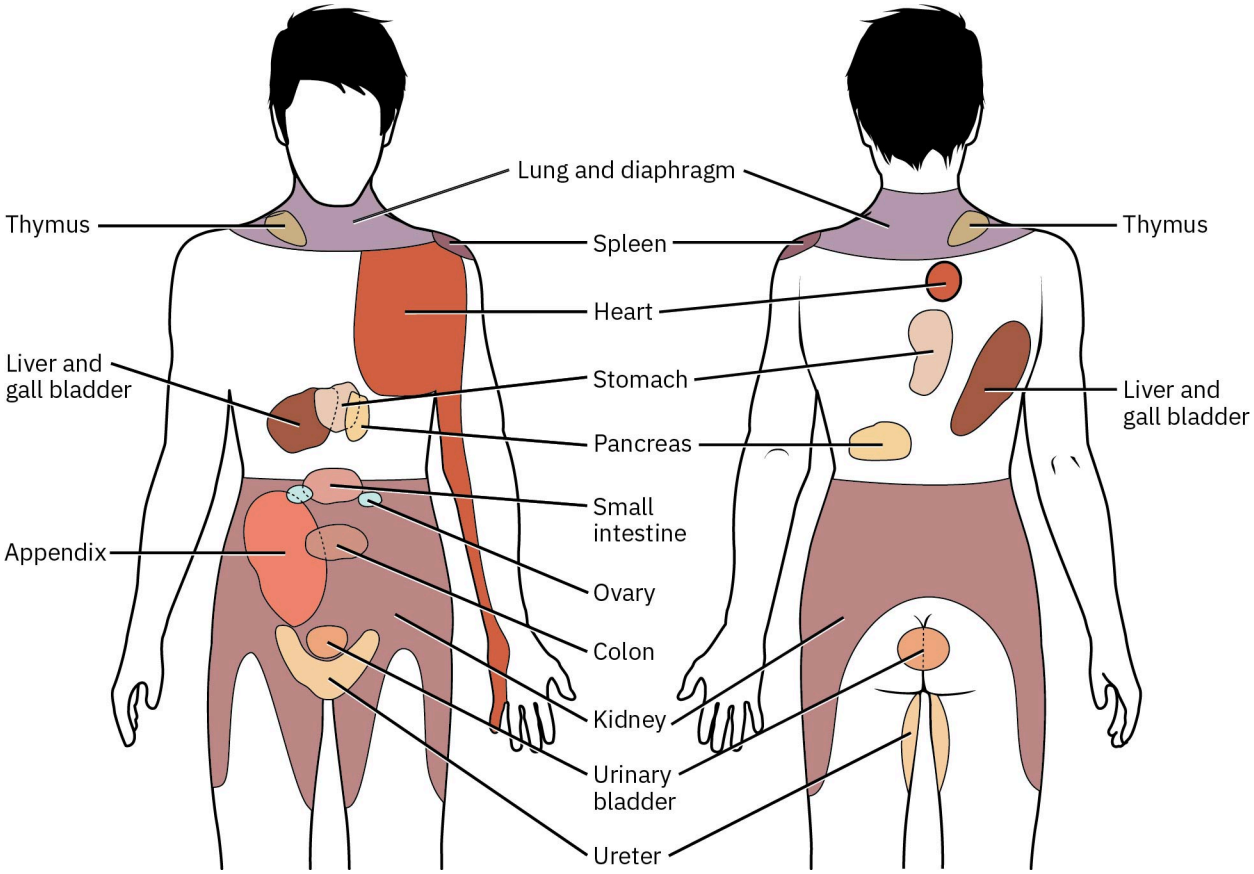


FIGURE 24.5 Conscious perception of visceral sensations map to specific regions of the body, as shown in this chart. Some sensations are felt locally, whereas others are perceived as affecting areas that are quite distant from the involved organ. (modification of work from *Anatomy and Physiology*, 2e. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Duration

Pain is also differentiated by duration, or acute pain and chronic pain. When the pain has limited duration and is associated with a specific cause, it is considered to be **acute pain**. It usually creates a physiological response resulting in increased pulse, respiration, and blood pressure. It may also cause diaphoresis (sweating, especially to an unusual degree). Examples of acute pain include postoperative pain; burns; acute musculoskeletal conditions like strains, sprains, and fractures; labor and delivery; and traumatic injury.

When pain is ongoing and persistent for three to six months or more, it is considered to be **chronic pain**. It typically does not cause a change in vital signs or diaphoresis. It may be diffuse and not confined to a specific area of the body. Chronic pain often affects an individual's psychological, social, and behavioral responses and can influence daily functioning. Chronic medical problems, such as osteoarthritis, spinal conditions, fibromyalgia, and peripheral neuropathy, are common causes of chronic pain. Chronic pain can continue even after the original injury or illness that caused it has healed or resolved. Some people suffer chronic pain even when there is no past injury or apparent body damage.

People who have chronic pain often have physical effects that are stressful on the body. These effects include tense muscles, limited ability to move around, lack of energy, and appetite changes. Emotional effects of chronic pain include depression, anger, anxiety, and fear of reinjury. These effects can limit a person's ability to return to work or participate in leisure activities. It is estimated that chronic pain affects 50 million U.S. adults, and 19.6 million of those adults experience high-impact chronic pain that interferes with daily life or work activities. For older adults, chronic pain may be a part of life due to arthritis in the joints and back or due to previous injuries. They can also have a higher risk of falls due to stiffness in the morning and when standing as well as knees that "give out." Whereas some older adults consider this "just a part of getting old," others struggle with the limitations and can become withdrawn, depressed, or lash out. This can cause frustration for both the client and the caregiver. Caregivers can need support as well and caregiver burden and burnout are also within the nurse's scope of assessment.

Severity and Assessment

Pain severity refers to a person's individual concept of the level of discomfort that they are experiencing at a point in time. Generally, severity is measured in terms, such as none, mild, moderate, and severe, though more detailed assessments may come into play. Pain is a very subjective concept as is the severity of that pain. Each person is different, and their pain perceptions can vary by personality, experiences that they have had in their lives, and past experience with pain.

Asking a client to rate the severity of their pain on a scale from zero to ten, with zero being no pain and ten being the worst pain imaginable is a common question used to screen clients for pain. The Joint Commission, an accrediting body for health-care organizations, requires this quick question to be followed by a thorough pain assessment. Additionally, providers must assess the client's comfort-function goal. The comfort-function goal provides the basis for the client's individualized pain treatment plan and is used to evaluate the effectiveness of interventions. The same assessment tool utilized to plan care for pain management should also be used to evaluate relief and plan further care.

The mnemonics "OLDCARTES," which stands for onset, location, duration, character, aggravating/relieving, time, and severity, or "COLDSPA," which stands for character, onset, location, duration, severity, pattern, and associated factors, can be helpful in remembering a standardized set of questions used to gather additional data about a client's pain. "PQRSTU" is another tool assessing these categories. Table 24.6 lists the questions utilized with a "PQRSTU" assessment framework. While interviewing a client about pain, use open-ended questions to allow the client to elaborate on information that further improves understanding of their concerns. Most older adults are fully able to participate in the pain interview, but for those who are unable, use alternative pain scales or more subjective pain assessment. If their answers do not seem to align, continue to ask focused questions to clarify information. For example, if a client states that "the pain is tolerable" but also rates the pain as a "seven" on a zero to ten pain scale, these answers do not align, and the nurse should continue to use follow-up questions using the PQRSTU framework.

Upon further questioning, perhaps this client will explain that they rate the pain as a "seven" in their knee when participating in physical therapy exercises, but currently feel the pain is tolerable while resting in bed. Another question that can be asked is what is a pain level that is acceptable to them. This additional information assists the nurse in customizing interventions for effective treatment with reduced potential for overmedication with associated side effects. Assessment of pain and ongoing assessment of pain is important as pain is not always stated as a complaint. Sometimes pain is an underlying cause of behavior or mood. In some cultures, pain is not to be expressed or complained about and pain is expressed by withdrawal, making assessment more important.

PQRSTU	Questions Related to Pain
Provocation/ palliation	What makes your pain worse? What makes your pain feel better?
Quality	What does the pain feel like? You can provide suggestions for pain characteristics, such as "aching," "stabbing," or "burning."
Region	Where exactly do you feel the pain? Does it move around or radiate elsewhere? Instruct the client to point to the pain location.
Severity	How would you rate your pain on a scale of zero to ten, with zero being no pain and ten being the worst pain you've ever experienced?

TABLE 24.6 Sample PQRSTU Focused Questions for Pain

PQRSTU	Questions Related to Pain
Timing/ treatment	When did the pain start? What were you doing when the pain started? Is the pain constant or does it come and go? If the pain is intermittent, when does it occur? How long does the pain last? Have you taken anything to help relieve the pain?
Understanding	What do you think is causing the pain?

TABLE 24.6 **Sample PQRSTU Focused Questions for Pain**

Pain Scales

Pain assessments should be specific to the client. A client with psychosis, severe cognitive impairment, or socially withdrawn may not be accurately assessed with questionnaires. Nursing observations are sometimes more effective, such as monitoring vital signs, facial expressions, or vocalizations. Other physical signs that could indicate pain are diaphoresis, muscle tension, agitation, or poor response to general comfort measures.

The FACES scale, for example, is a visual **pain scale** tool for assessing pain with children and others who cannot quantify the severity of their pain on a scale of zero to ten. Figure 24.6 shows a sample pain rating scale. To use this scale, explain to the client that each face represents a person who has no pain, some pain, or a lot of pain. "Face 0 doesn't hurt at all. Face 2 hurts just a little. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain." Ask the person to choose the face that best represents the pain they are feeling. This can be very helpful in the older adult with cognitive impairment, illiteracy, or a language barrier because they may not be able to understand the number scales.

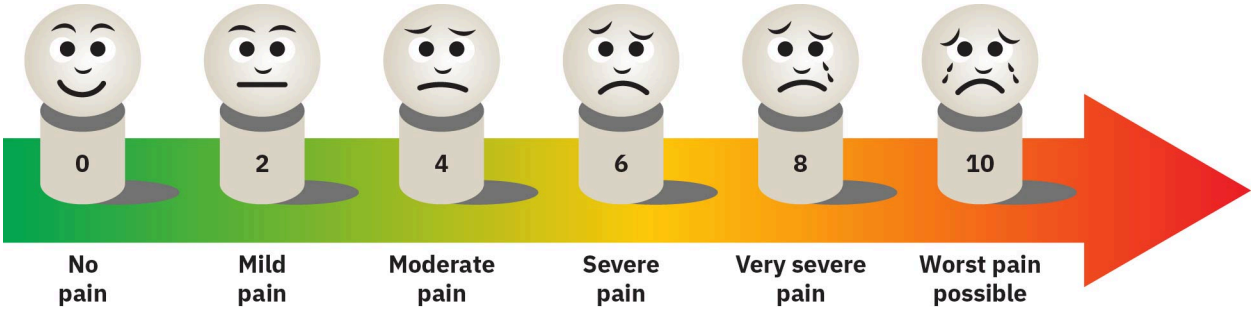


FIGURE 24.6 A pain scale that uses faces and numbers is an effective way to quantify a client's level of pain. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Presentation and Tolerance

Some older adults may not complain of pain, particularly those with cognitive impairment, but will show signs in other ways. There may be subtle signs, such as a change in functional status or body posture and gait. They may socially isolate, even from family. Others may become agitated, or more agitated, or confused. Those who are nonverbal may moan or grimace. Naturally, very functional older adults will complain of pain or increased pain to loved ones or their medical providers. There also may be an association with depression or anxiety to pain.

Pain tolerance or sensitivity to pain is a very individual experience, particularly for older adults. Life experience plays a very large role as previous exposures to pain and general discomfort impact how much acute pain a person can tolerate. For example, a person who has had a low level of arthritis pain for many years will likely not report as high of a level of acute pain as a person who has been largely without pain most of their lives. Pain tolerance or expression of pain can be cultural as well. In some cultures, pain is expressed freely, in others, expression of pain is discouraged. When the same dose of a drug has been given repeatedly, clients may demonstrate a reduced response to pain medication called **tolerance**, requiring a higher dose of the drug to achieve the same level of response. For example, when a client receives morphine for palliative care, the dosage often needs to be increased over time because the client develops a tolerance to the effects of the medication.

Quality of Life

Pain is a huge component of quality of life. A person cannot live their best life if they are uncomfortable. The medical team and the client's family, as well as the client, have a responsibility to manage discomfort in ways that maximize that person's function and day-to-day life. Ongoing evaluation of the older adult with acute or chronic pain should be part of every assessment in order to monitor management of the pain.

Person-Centered Care in Pain Management

Person-centered care is defined by the Centers for Medicare and Medicaid Services as integrated health-care services delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences, in a system that empowers clients and providers to make effective care plans together (Centers for Medicare & Medicaid Services, n.d.). This includes:

- care that is influenced and informed by the objectives, tastes, and values of the person
- person-reported outcomes being used to gauge success
- integrated care across health systems, providers, and care settings, that is coordinated
- managing persistent and complicated disorders
- relationships that are anchored in mutual trust and dedication to long-term well-being

Person-centered care for pain, particularly chronic pain, is a holistic and therapeutic form of treatment allowing the client to take ownership of their pain management. The health-care provider's role is to guide the client in finding the best way to manage their pain. This may include medications but will also include possible alternative methods, such as massage, exercise, acupuncture, Tai Chi, supplements, and possibly addressing the underlying social and behavioral components of their pain. By addressing the spiritual, emotional, and psychosocial components of the whole person, the team provides more holistic care. This model is about listening to the individual and working with them closely to understand them as a person and empathize with them.

CLINICAL JUDGMENT MEASUREMENT MODEL

Taking Action/Evaluating Outcomes: Monitoring Effectiveness of Pain Management

As the nurse enters a client's room, the client has just finished combing his hair. The client is smiling as he greets the nurse.

Nursing knowledge is required to recognize the effect of pain-relieving medication one hour after administration. The client had been unable to perform personal grooming due to arthritic shoulder pain rated 6/10 on pain scale. The client had displayed a sad facial expression. The client elected to use the pain-relieving medication ordered on an as-needed basis, every six hours offered by the nurse. The nurse administered the medication.

The nursing action is to apply the same assessment scale to the client's pain now as was used prior to medication administration. The client rates current pain as 2/10 on the scale.

The nurse monitors for adverse effects of the medication, noting that the client has consumed 75 percent of his breakfast meal and denies nausea.

The nurse will reassess as needed.

Perspectives of Client and Family

As part of person-centered care, the family plays a large role in pain management. The family has a strong influence on an individual's beliefs and behaviors surrounding pain as well as health and illness. The family can be an integral part of the pain management plan and treatment or can have a negative effect due to dysfunctional relationships and reactions. A positive family relationship can help a person cope with pain as well as work through strategies of pain relief. An individual with a dysfunctional family will frequently require more medication intervention, have more depressive symptoms, have lower activity levels, and will have more pain behaviors and more emotional distress (American Association of Colleges of Nursing, n.d.).

Treatment Modalities

Treatment modalities are an integral part of person-centered care as the client can work with the physical therapist

to choose the modality that is best for them. The therapist and the client work as a team with the therapist providing instruction and support that respects the client's experience. A pain treatment modality is a method of treatment utilizing electrical, thermal, mechanical energy, or medication that affects the body's physiology. Examples of these are transcutaneous electrical nerve stimulation (TENS), heat or cold therapy, or vibration. These modalities are typically used in physical therapy to reduce swelling, enhance circulation, and relieve pain. Physical therapy is an integral part of both acute and chronic pain management. Incorporating these modalities in the pain management plan with traditional physical therapy, such as exercise and massage, reduces the need for as many pharmacological analgesics.

Pharmacological

When pharmacological pain agents are utilized in older adults, significant oversight and care is required. The current trend has been toward multimodal pain management with nonopioid drugs for acute pain. There are limits to this approach, however, depending on the chronic medical issues of the client and on drug interactions. There are also times when **opioids**, narcotics that are powerful pain-reducing medications that carry a high risk of dependency, must be used due to high levels of pain or limited options. The goal with opioid use is to use the lowest dose for the least amount of time possible, while appropriately managing pain. Opioids in older clients should not be avoided if needed, but they can cause delirium at higher doses, and all can increase risk of falls.

Nonopioid analgesics include acetaminophen and NSAIDs. Acetaminophen (Tylenol) is used to treat mild pain and fever but does not have anti-inflammatory properties. Acetaminophen is safe for all ages and can be administered using various routes, such as orally, rectally, and intravenously. Many over-the-counter (OTC) medications contain acetaminophen, along with other medications. Acetaminophen has a greater pain-relieving effect as a person ages and can be a very effective pain reliever in older adults, particularly in the very older adult.

Duloxetine is a SNRI, which can help with painful neuropathies, low back pain, fibromyalgia, and chronic musculoskeletal pain due to osteoarthritis. Titrate slowly to effect and to improve tolerability. Avoid in renal or hepatic impairment.

The class of drugs called **nonsteroidal anti-inflammatories (NSAIDs)** provides mild to moderate pain relief and also reduces fever and inflammation by inhibiting the production of prostaglandins. They can also be used as an adjuvant with opioids for severe pain. Examples of NSAIDs include ibuprofen, naproxen, and ketorolac. All NSAIDs, except aspirin, increase the risk of heart attack, heart failure, and stroke, with the risk being higher if the client takes more than is directed or takes it for longer than directed. Common side effects include dyspepsia, nausea, and vomiting, so it is helpful to administer this medication with food. Older adults and those taking NSAIDs concurrently with other drugs, such as warfarin or corticosteroids, are at elevated risk for gastrointestinal bleeding. Renal failure can also occur with NSAIDs. Generally, avoid giving NSAIDs to adults over seventy-five due to the risks for GI bleeding, hypertension, renal injury, and fluid retention or edema.

Topical agents range from active numbing to using heat or cooling sensation to reduce pain. Lidocaine comes in many forms and is applied as needed. It comes in prescription strength and there are many formulations of OTC topical pain lotions, patches, and roll-ons that can be heat-creating, menthol, or capsaicin-containing.

LINK TO LEARNING

Read this article about pain management for older adults (https://openstax.org/r/77painmgmt) from the University of Iowa.

Nonpharmacological

Nonpharmacological interventions can be used with or without pharmacologic interventions and often provide tremendous benefits to the client. Clients can select from a variety of techniques according to what best fits their needs and goals. Nonpharmacological interventions should be documented in the plan of care and their effectiveness evaluated in terms of their ability to meet the client's goals for pain relief.

LINK TO LEARNING

Read this article for more about complementary approaches to treat pain (https://openstax.org/r/77treatpain) from the National Center for Complementary and Integrative Health.

Table 24.7 provides examples of several types of nonpharmacological interventions.

Intervention	Examples
Distraction	Describing photos, telling jokes, and playing games
Relaxation	Rhythmic breathing, meditation, prayer, imagery, and music therapy
Basic comfort measures	Proper positioning and therapeutic environment; avoiding sudden movement; reducing pain stimuli within the environment
Cutaneous stimulation	Acupuncture and acupressure massage: three to five minutes offers benefits Transcutaneous Electrical Nerve Stimulation (TENS) unit: a specialized stimulator placed over the area of pain
Application of heat or cold	Heat: vasodilation increases blood flow; duration should be five to twenty minutes based on client tolerance Cold: vasoconstriction reduces blood flow; cold numbs nerve sensations; duration should be no longer than twenty minutes Cool baths and moist, cool compresses
Mind-body therapies	Biofeedback Meditation and mindfulness
Aromatherapy	Lotions and moisturizing cream avoiding strong smells
Exercise	Physical activity, Tai Chi Yoga
Therapy	Physical therapy, occupational therapy

TABLE 24.7 Nonpharmacological Interventions

Clients may also consider using complementary health approaches to manage chronic pain. Complementary approaches include acupuncture, massage therapy, meditation, relaxation techniques, spinal manipulation, Tai Chi, yoga, and dietary supplements.

LINK TO LEARNING

Read this Joint Commission document titled "Non-pharmacologic and non-opioid solutions for pain management" (https://openstax.org/r/77managepain) for more information on complementary techniques to manage pain.

24.7 Psychiatric-Mental Healthcare Nursing Interventions

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Outline how care is customized for older adults
- Understand the role of the psychiatric-mental health nurse in providing care for older adults within a collaborative approach to treatment

Caring for older adults can be very complex because there are many factors to consider and manage. It is also very rewarding and is different than caring for any other age group. Older adults have so much to share about their lives and experiences. They have problems and issues just like any other person, but so much can be learned from the ways that they have overcome hardships in their lives. Frequently, caring for an older adult includes caring for children or other family members as well. The care must be customized to include caregivers in that plan. Nursing interventions should be specifically tailored to this population.

Customized Care for the Older Adult

Just like younger adults, each older adult is different. For example, one person who is eighty years old may be very functional and even still working. Yet another eighty-year-old may be functionally dependent and ill. Each individual person deserves customized care based on their level of health and function. Some older adults require direct involvement of a family member for personal care or supervision whereas others may not require family involvement. Communication is the key to discovering what is important to each person and the others potentially involved in their care.

Therapeutic Communication

In all nursing care, the therapeutic relationship with the client is essential. This is especially so in psychiatric care, where the therapeutic relationship is considered to be the foundation of client care and healing. Nurses engage with clients in caring, supportive, nonjudgmental interactions within a safe environment, often during a stressful period for the client. Being present and actively listening is the most valuable tool that the nurse has. For older adults with sensory or cognitive impairment, the environment is very important for privacy and quiet with few distractions.

CLINICAL SAFETY AND PROCEDURES (QSEN)

Using Effective Communication Skills Promotes Quality Mental Health Care

Tips for effective communication from the WHO *mhGAP Intervention Guide* include the following:

- Create an environment that facilitates open communication.
- Involve the person.
- Start by listening.
- Be friendly, respectful, and nonjudgmental.
- Use good verbal communication skills.
- Respond with sensitivity when people disclose traumatic experiences (i.e., sexual assault, violence, or self-harm).

(WHO, 2019)

Comprehensive Assessment

To develop a practical and client-centered treatment plan, older persons with unexplained or ambiguous symptoms will benefit from a **comprehensive geriatric assessment (CGA)**, which assesses older adults across various domains of health. The CGA assesses the following major areas: functional status, gait speed, cognition, mood, nutritional status, comorbidity, polypharmacy, geriatric syndromes, social support, financial concerns, environmental suitability, and advance care planning. The CGA helps to prioritize treatments that are in line with client goals by attempting to understand disease in the context of function and adaptation. It may also spot opportunities to improve health status by gaining access to community resources or by stopping treatments that are out of line with client goals. The CGA utilizes evidence-based evaluation instruments in a variety of areas, including mood and anxiety, in addition to an interdisciplinary approach.

Outcomes of Care

An **outcome** is a client behavior that can be measured in response to an intervention used by a nurse. The Outcomes Identification Standard of Practice by the American Nurses Association states, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation." The registered nurse:

- engages with the health-care consumer, interprofessional team, and others to identify expected outcomes
- collaborates with the health-care consumer to define expected outcomes integrating the health-care consumer's culture, values, and ethical considerations
- formulates expected outcomes derived from assessments and diagnoses
- integrates evidence and best practices to identify expected outcomes
- develops expected outcomes that facilitate coordination of care
- identifies a time frame for the attainment of expected outcomes
- documents expected outcomes as measurable goals
- identifies the actual outcomes in relation to expected outcomes, safety, and quality standards
- modifies expected outcomes based on the evaluation of the status of the health-care consumer and situation

After implementing nursing interventions, the nurse evaluates if the outcomes were met in the time frame indicated for that client. Outcome identification includes setting short-term and long-term goals and then creating specific expected outcome statements for each nursing diagnosis. Outcome statements are always client-centered. They should be developed collaboratively with the client and individualized to meet the client's unique needs, values, and cultural beliefs. They should start with the phrase "The client will . . . " Outcome statements should be directed at resolving the defining characteristics for that nursing diagnosis. Additionally, the outcome must be something the client finds worth achieving.

Outcome statements should contain five components easily remembered using the "SMART" mnemonic (Figure 24.7).

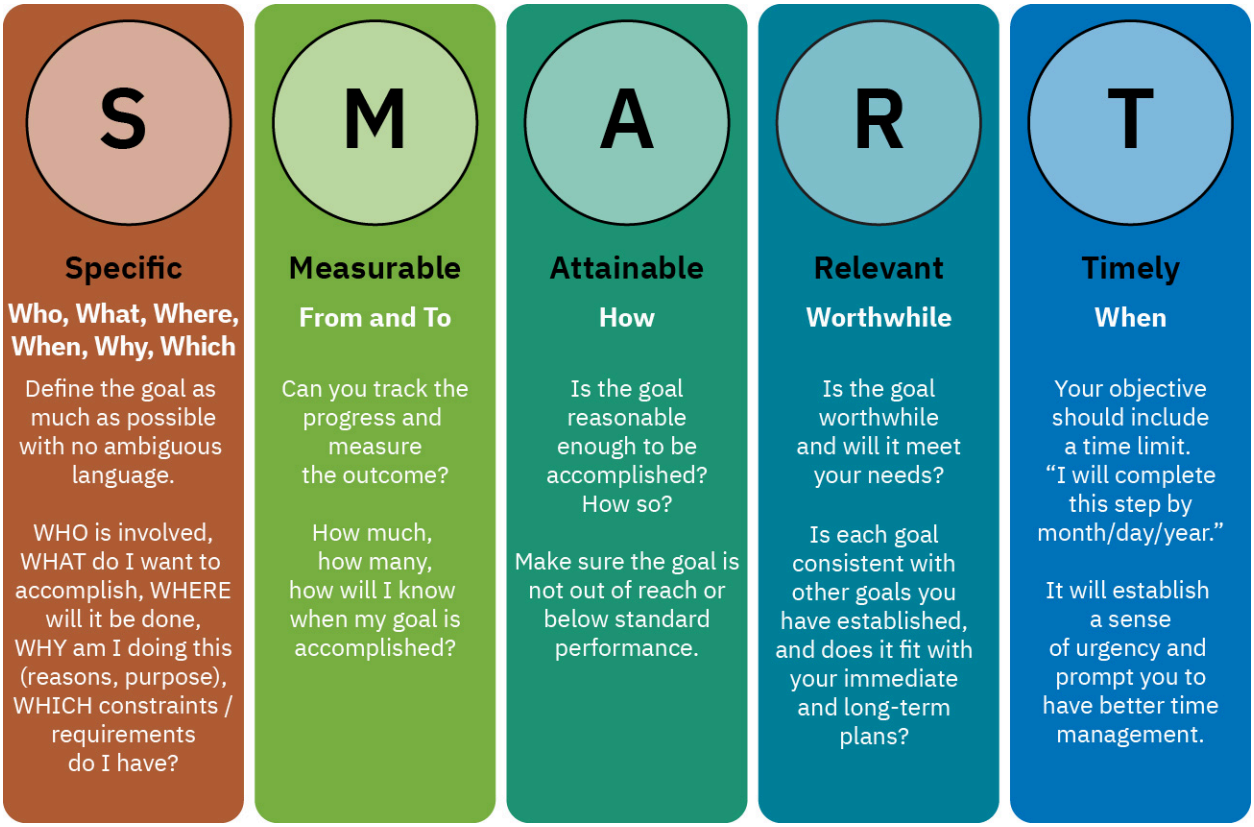


FIGURE 24.7 SMART goals ensure that the outcomes are specific, measurable, attainable, relevant, and timely for the client. (modification of work from *Clinical Nursing Skills.* attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Nurses' Role in Collaborative Care

Nurses are collaborating with others in client care on a regular basis. All nursing interactions with another team member involved in the care of a client is a collaboration. For example, when a client is struggling with their pain, the nurse may discuss and collaborate with the provider about the medications or a change in the treatment plan. They may also collaborate with the client's social worker or case manager about increasing caregiver time or any number of possible social supports that the client may need or be eligible for. The nurse also may collaborate with the client's family if they are directly involved in the care. Psychiatric-mental health nurses participate in this care constantly, whether it is formal (i.e., the treatment team) or informal (i.e., discussing client care during a family visit).

Nursing Interventions

Implementation of interventions requires the nurse to use critical thinking and clinical judgment. After developing the initial plan of care, the nurse should continually assess the client to detect any changes in condition requiring modification of the plan. Should a modification be needed, the nurse collaborates with the team to make those modifications. The need for continual client reassessment underscores the dynamic nature of the nursing process and is crucial to providing safe care.

During the implementation phase of the nursing process, the nurse prioritizes planned interventions, assesses client safety while implementing interventions, delegates interventions as appropriate, and documents interventions performed. Prioritizing implementation of interventions follows a similar method to prioritizing nursing diagnoses. Maslow's Hierarchy of Needs and the ABCs of airway, breathing, and circulation help to establish top-priority interventions. When possible, use the least restrictive interventions possible.

It is essential to consider client safety when implementing interventions. At times, clients may experience a change in condition that makes a planned nursing intervention or provider prescription no longer safe to implement. For example, an established nursing care plan for a client states, "The nurse will ambulate the client 100 feet three times daily." During assessment this morning, however, the client reports feeling dizzy, and their blood pressure is 90/60 mmHg. Using critical thinking and clinical judgment, the nurse decides not to implement the planned intervention of ambulating the client and notifies the provider of suspected side effects of the client's antidepressant medication. This decision, supporting assessment findings, and notification of the provider should be documented in the client's chart and also communicated during the shift handoff report (Table 24.8).

Subcategories: Implementation Standard of Care	Sample Nursing Interventions
Coordination of care	• Refer to community support groups for optimal recovery. • Advocate for dignified care with the interprofessional team. • Communicate client trends with interprofessional team members such as medication acceptance, increased agitation, or propensity toward violence.
Health teaching and health promotion	• Deliver health teaching to clients about self-care and stress management techniques. • Promote health by teaching about adaptive coping strategies, such as journaling and daily exercise.
Pharmacological, biological, and integrative therapies	• Provide health teaching about medications' mechanisms of action, intended effects, potential adverse effects, and ways to cope with transitional side effects.

TABLE 24.8 Categories of Nursing Mental Health Interventions

Subcategories: Implementation Standard of Care	Sample Nursing Interventions
Milieu therapy	• Encourage client participation within the therapeutic milieu by attending support groups and exercise groups. • Perform intentional rounding at varying times between every fifteen and sixty minutes and document. Varying rounding times helps prevent suicide attempts. • Advocate for the least restrictive environment necessary to maintain the safety of the individual and others. • Perform environmental safety scans and eliminate any devices or objects that can cause injury. Remove strings, cords, and drawstrings.
Therapeutic relationship and counseling	• Observe for, document, and communicate changes in behavior. • Demonstrate caring behaviors. • Utilize therapeutic communication techniques.

TABLE 24.8 **Categories of Nursing Mental Health Interventions**

Nursing Competency

APNA's Pharmacological, Biological, and Integrative Therapies Competencies states that a psychiatric-mental health registered nurse (PMH-RN) applies clinical skills with knowledge of pharmacological, biological, and complementary interventions to improve and maintain clients' health (APNA, 2022). As a result, the PMH-RN applies current research findings to guide nursing actions related to pharmacology, other biological therapies, and integrative therapies. The nurse also assesses the health-care consumer's response to biological interventions based on current knowledge of pharmacological agent's intended actions, interactive effects, potential untoward effects, and therapeutic doses. Another competency includes medication management to support health-care consumers in managing their own medications and adhering to a prescribed regimen. The nurse provides health teaching about mechanism of action, intended effects, potential adverse effects of a proposed prescription, ways to cope with transitional side effects, and other treatment options, including the selection of a no-treatment option. In terms of the team, the nurse communicates observations about the health-care consumer's response to biological interventions to other health clinicians.

Advocacy and Teaching

ANA's Health Teaching and Health Promotion Competencies include nursing education. Nurses should offer opportunities for the health-care consumer to identify needed health promotion, disease prevention, and self-management topics, such as healthy lifestyles; self-care and risk management; and coping, adaptability, and resiliency. Nurses should make sure to use health promotion and health teaching methods, including technology, in collaboration with the health-care consumer's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status. They should also use feedback from the health-care consumer and other assessments to determine the effectiveness of the employed strategies. Nurses also provide anticipatory guidance to health-care consumers to promote health and prevent or reduce risk.

Family Support and Transitional Care

Any move of a client from the hospital to skilled nursing, skilled nursing to home, inpatient mental health facility to outpatient mental health or psychiatrist is considered to be a **transition of care**. There are many possible transitions, and they can be difficult for the client and the family. This is also a time that has a high possibility for errors in communication and in medications. These errors have also been shown to be linked to adverse effects, low satisfaction, and high rehospitalization rates. The nurse can be pivotal in many of these issues by providing a detailed and carefully reviewed discharge and handoff to the client and the family. Follow-up calls to the client and families are also helpful in being able to review the handoff education and medications.

Summary

24.1 Healthcare Concerns and Decisions of Older Adults

As older adults live longer, there are key factors that nurses can address to make sure that this population has the tools available for healthy aging. Chronic disease management and the ability to self-manage are two factors to consider. When self-management no longer seems possible, nurses should review options regarding care and advance directives with families and caregivers. Nurses must consider healthy aging and quality of life to be the overriding goals when offering education and other interventions. Health literacy and other obstacles to receiving care, such as transportation, technological abilities, and cultural issues, should also be front of mind when providing care to this population.

24.2 Depression

While not a normal part of aging, depression is also not uncommon in older adults. Older adults have higher rates of chronic illness and loss of functional independence than younger people. They also have a general loss of independence and loss of friends and family. Lack of support from family and community, lack of resources, lack of medical care, and many other factors contribute to depression, though depression can be preventable and treatable. Nurses are well positioned to recognize when a client may be depressed or be at risk for depression. Nursing interventions include collaborative practice with other professionals and advocacy for the client and family.

24.3 Anxiety

Anxiety in older adults is complicated and can be very different than in younger adults both in presentation and in management. Anxiety may be underdiagnosed and undertreated in older adults due to various factors, such as beliefs about aging and existence of medical comorbidities. Nonetheless, anxiety is treatable with the right supports and counseling. Nursing assessment and collaboration with other professionals can lead to effective interventions for older adults experiencing anxiety. Nurses are in the best positions to be able to help clients and their families with education and interventions that can truly make a difference for those living with anxiety.

24.4 Delirium

Delirium is a complication in medical care or in cognitive status for older adults and may occur in any setting. Risk factors include changes to medications or environment, infection, or dehydration. Delirium may occur in different categories with different presentations. Each situation is unique and requires careful nursing assessment and collaborative practice with the health-care team. Nurses are the primary contacts and drivers in acknowledging and assessing for delirium as well as the nonpharmacological interventions that are very important in management, treatment, and education of family.

24.5 Alcohol Use

Problematic alcohol use in older adults and older adults with AUD are frequently underreported and more frequently left unaddressed by providers. When treatment is sought, the care must be appropriate for older adults. The pharmacology of treating withdrawal and the AUD cravings is specialized for older adults. Brief interventions can be helpful in this population to reduce quantity and frequency of alcohol intake before moving into the need for more intensive interventions.

24.6 Pain

Pain in the older adult is more challenging than in the general adult population. Every person is individual as to their pain tolerance and perception of pain. Older adults who live with a mental health concern and also experience physical discomfort need specialized care. Opioids can have different effects and can have significant side effects on older adults, particularly those with cognitive impairment. There are also many medications that are used in younger adults that are not used in older adults due to kidney function, side effects, or risks for delirium. Acetaminophen has a greater effect on older adults than it does on younger adults. All of this adds up to a very different management based on the age of the client. The goal is to treat pain while causing as few side effects as possible. Managing pain leads to a higher quality of life, but only if done in a way that maximizes independence and function for as long as possible.

24.7 Psychiatric-Mental Healthcare Nursing Interventions

Providing care for older adults with mental health concerns has its challenges, and is also rewarding. Collaboration and teamwork are keys to success in providing appropriate and outcome-driven care. Outcomes should be measurable using the SMART statement and should include appropriate and data-driven nursing interventions. Geriatric comprehensive assessment is imperative for this population and should be ongoing. The family should be included in all steps if appropriate and if the client is in agreement. Transitions of care are highly important as many avoidable errors happen during this time and the nurse can be the key to stopping these errors before they happen with care and attention to detail.

Key Terms

acute pain caused by injury, surgery, illness, trauma, or by a medical procedure that is short term in duration
ageism discrimination against older adults
analgesics class of drug specifically created to relieve pain
anhedonia inability to feel pleasure
chronic pain lasts over three months
codependency imbalanced relationship where a person enables another person's self-destructive behavior
cognitive impairment alteration in cognition that causes a decline in memory and thinking that happens with age and many medical and inherited factors
comprehensive geriatric assessment (CGA) multidisciplinary assessment that identifies the functional, medical, and psychosocial capabilities in an older adult
ego integrity resolution of crises and acceptance of life in final stages
healthy aging supporting the body and well-being, including functional ability through aging
ineffective coping inability to employ personal strategies to manage psychological distress
nonsteroidal anti-inflammatory drugs (NSAIDs) medications that provide mild to moderate pain relief and also reduce fever and inflammation by inhibiting the production of prostaglandins
opioids compound drug that is derived from or synthetically resembles opium and has addictive properties
organizational health literacy degree to which organizations enable individuals to find, understand, and use information to make informed, health-related decisions
outcome client behavior that can be measured in response to an intervention used by a nurse
pain scales tool used to measure pain as reported by clients
personal health literacy ability to obtain, understand, synthesize, communicate, and apply health-related information
pseudodementia reversible cognitive impairment caused by severe depression
quality of life (QOL) extent to which life is comfortable or satisfying
self-management person's active involvement in their own health-care decisions and intervention to promote their own best possible wellness with the help of the medical team
tolerance when the same dose of a drug has been given repeatedly, clients demonstrate a reduced response to pain medication
transition of care movement of a client from one setting to another, including their care plan
worry to think about problems or issues that may happen in the future that cause anxiety

Assessments

Review Questions

1. What term is defined as the ability to obtain, understand, synthesize, communicate, and apply health-related information?
   a. advanced directives
   b. personal health literacy
   c. organizational health literacy
   d. information literacy

2. What is the number one chronic illness according to the National Council on Aging?

a. heart failure
b. diabetes
c. arthritis
d. hypertension

3. What is a nursing intervention for a depressed client who reports reduced interest and pleasures?
a. encouraging participation in activities
b. collaborating with the prescriber
c. assisting the client to list positive self-characteristics
d. scheduling rest periods

4. What is a cause of pseudodementia?
a. medication reaction
b. severe depression
c. old age
d. genetics

5. Why should the nurse determine the level of anxiety displayed by the older adult client?
a. to administer the appropriate medication
b. to use an effective nursing intervention
c. to offer the appropriate diet
d. to report accurately to the prescriber

6. How can a nurse determine that a client is experiencing ineffective coping?
a. The client is engaging in problem-solving with family members.
b. The client is motivated to change behaviors.
c. The client has difficulty managing day-to-day stress.
d. The client has lost interest in life.

7. What type of alteration is more specific to delirium than to dementia?
a. alteration developing over months
b. alteration in memory
c. alteration in attention
d. no alteration in baseline

8. What are the three types of delirium?
a. hyperactive, hypoactive, and depression
b. hypoactive, mixed, and confused
c. dementia, hyperactive, and hypoactive
d. hyperactive, hypoactive, and mixed

9. Nurse Julie recommends that the family of a client with a substance-related disorder attend a support group, such as Al-Anon. In addition to helping family members understand the problem, what is the purpose of these groups?
a. to change the problem behaviors of the client
b. to learn how to assist the client in getting help
c. to maintain focus on changing their own behaviors
d. to prevent substance problems in vulnerable family members

10. What is a risk of alcohol intake in an older adult that is not as high of a risk in a younger adult?
a. risk for osteoporosis
b. risk of car accidents
c. risk for hallucinations

d. risk for vomiting

11. What intervention should the nurse include as a nonpharmacologic pain-relief intervention for chronic pain?
a. referring the client for hypnosis
b. administering pain medication as prescribed
c. removing all glaring lights and excessive noise
d. using over-the-counter transcutaneous electric nerve stimulation

12. What term refers to the pain that has a slower onset, is diffuse, radiates, and is marked by somatic pain from organs in any body activity?
a. acute pain
b. chronic pain
c. superficial pain
d. visceral pain

13. What is the term for clients' movement between treatment settings?
a. rehospitalization
b. adverse event
c. readmission
d. transition of care

14. When performing a comprehensive geriatric assessment of an older adult, what aspect of the client should the nursing assessment focus on?
a. physical signs of aging
b. immunological function
c. functional abilities
d. chronic illness

Check Your Understanding Questions

1. Describe the purpose of an advance directive.

2. What are the nursing considerations for a client with depression?

3. What are some stress reduction techniques?

4. What are three nursing interventions for a client with delirium?

5. What does codependency mean?

6. What is person-centered care?

7. What are some ways that a nurse can provide health teaching and health promotion?

Reflection Questions

1. What does quality of life mean to you?

2. What is the role of nurses in suicide prevention?

3. How would you respond when a nursing assistant asks: "My eighty-year-old grandfather worries all the time. But isn't that just normal for an old person?"

4. How can a nurse determine that a client with dementia also has delirium?

5. How can a nurse make sure that they are not perpetrating ageism?

6. What are some nonpharmacological interventions that nurses can suggest for pain management?

7. Describe the concept of customized care in the older adult.

What Should the Nurse Do?

1. Doris, a seventy-eight-year-old female, presents at the geriatric clinic accompanied by her daughter. Doris's daughter expresses concern about her mother's recent changes in behavior. Doris has been withdrawing from social activities, experiencing disrupted sleep patterns, and expressing feelings of sadness. Her medical history includes hypertension and osteoarthritis, and her vital signs are stable (heart rate of 78 bpm, respiratory rate of 16 breaths per minute, blood pressure of 130/80 mmHg, and temperature of 98.4°F). How might Doris's medical history of hypertension and osteoarthritis contribute to the analysis of her depressive symptoms, and what additional information might be valuable in understanding the context of her condition?

Randolph is eighty years old and is brought to the emergency department by his daughter due to acute changes in mental status. Randolph has a history of hypertension and recently underwent hip replacement surgery. His daughter reports that over the past twenty-four hours, he has become disoriented, agitated, and is experiencing vivid hallucinations. His vital signs show an elevated heart rate (100 bpm), increased respiratory rate (22 breaths per minute), elevated blood pressure (150/90 mmHg), and a mild fever (100.5°F).

2. How might Randolph's recent hip replacement surgery and history of hypertension contribute to the analysis of his delirium symptoms, and what additional information would you seek to understand the context of his acute mental status changes?
3. As a nurse, how would you collaborate with the health-care team to investigate the potential causes of Randolph's delirium, and what steps would you take to involve his daughter in the care planning process?

Vivian, a seventy-two-year-old female, is admitted to the geriatric clinic by her daughter due to concerns about her alcohol use. Vivian has a medical history of hypertension and osteoarthritis. Lately, her daughter has noticed increased forgetfulness, unsteady gait, and a distinct smell of alcohol on her breath. Vivian's vital signs are within normal ranges (heart rate of 80 bpm, respiratory rate of 18 breaths per minute, blood pressure of 140/90 mmHg, and temperature of 98.6°F).

4. What interventions would you propose to address Vivian's alcohol use, considering her age, medical conditions, and the potential impact on her overall well-being? How would you involve her daughter in the development of these interventions?
5. How should a nurse initiate a conversation with Vivian about her alcohol use, and what steps should a nurse take to address any potential resistance or denial? How might a nurse involve other health-care professionals in Vivian's care?

Competency-Based Assessments

1. As a nursing student, how might you adapt your communication strategies to enhance health literacy for an older adult with limited literacy skills? Why is effective communication essential for promoting health literacy and ensuring patient understanding of health-care instructions?
2. Discuss the role of community resources in supporting older adults' overall well-being and create a list of resources available to this population in your community.
3. As a clinical nurse, how would you describe the potential challenges in distinguishing symptoms of anxiety from symptoms of medical conditions common in older adults? Propose a strategic plan to overcome these challenges during the nursing assessment.
4. How would you engage the older adult and their family in collaborative decision-making regarding the nursing care plan for anxiety, and what factors would you consider to ensure cultural competence in the provision of care?
5. Describe some communication strategies you would employ when collaborating with the health-care team and the older adult's family in planning care for an individual experiencing delirium.
6. What are some of the potential challenges in assessing alcohol use in older adults, and what are some strategies to overcome these challenges while maintaining client confidentiality and trust?
7. Explain the rationale behind including counseling and support groups in the care plan for an older adult with alcohol use problems. How might a nurse address potential resistance to participating in these interventions?

8. What are some of the potential challenges in assessing pain in older adults, and some of the related strategies to overcome these challenges while ensuring the accuracy of pain assessment?
9. Do some research into some ways that cultural beliefs can influence a client's perception of pain. How would you address these influences in the care plan?
10. As a clinical care nurse, describe two specific examples of how you might collaborate with other health-care professionals, such as physicians or physical therapists, in the care of an older adult. Explain how this collaborative approach enhances the overall quality of care for older adults.

References

A Train Education. (n.d.). *Screening tools for delirium*. https://www.atrainceu.com/content/4-screening-tools-delirium-0

AgeWays. (2019). *Guide to managing chronic pain in the elderly*. https://www.ageways.org/2019/06/21/elderly-chronic-pain/

Aging in Place. (2023, April 25). *10 resources for living independently as a senior*. https://aginginplace.org/10-resources-for-living-independently-as-a-senior/

Almeida, O. P. (2014). Prevention of depression in older age. *Maturitas*, *79*(2), 136–141. https://doi.org/10.1016/j.maturitas.2014.03.005.

American Association of Colleges of Nursing. (n.d.). *Person-centered care*. https://www.aacnnursing.org/5B-Tool-Kit/Themes/Person-Centered-Care

American Nurses Association Center for Ethics and Human Rights. (2018). *The ethical responsibility to manage pain and the suffering it causes*. Position Statement. https://www.nursingworld.org/~495e9b/globalassets/docs/ana/ethics/theethicalresponsibilitytomanagepainandthesufferingitcauses2018.pdf

American Psychiatric Nurses Association. (2022). *Psychiatric-mental health nursing: Scope and standards of practice, 3rd edition.* APNA.

American Psychological Association. (2023). *Depression treatments for older adults*. https://www.apa.org/depression-guideline/older-adults

Ardelt, M., & Oh, H. (2016). *Theories of wisdom and aging*. George Fox University. https://digitalcommons.georgefox.edu/cgi/viewcontent.cgi?article=1025&context=sw_fac

Atalay, K., & Staneva, A. (2020). The effect of bereavement on cognitive functioning among elderly people: Evidence from Australia. *Economics and Human Biology, 39*, 100932. https://doi.org/10.1016/j.ehb.2020.100932

Bayer, T., Epstien-Lubow, G., Van Patten, R., Rudolph, J., & Hershkowitz, D. (2022). Comorbidity and management of concurrent psychiatric and medical disorders. *Psychiatric Clinics of North America*, *45*(4), 745–763. https://www.sciencedirect.com/science/article/pii/S0193953X22000624

Bhatt, J., & Swick, M. (2017). *Focusing on teamwork and communication to improve patient safety*. https://www.aha.org/news/blog/2017-03-15-focusing-teamwork-and-communication-improve-patient-safety#:~

Cameron, K. (2023). *Why we must address the rising mental health needs of our growing older adult population*. The National Council on Aging. https://www.ncoa.org/article/why-we-must-address-the-rising-mental-health-needs-of-our-growing-older-adult-population

Carder, P., O'Keefe, J., & O'Keefe, C. (2015, June 15). *Compendium of residential care and assisted living regulations and policy: 2015 edition*. Retrieved January 18, 2024, from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//73501/15alcom.pdf

Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. (2008). *The state of mental health and aging in America. Issue brief #1: What do the data tell us?* Retrieved January 18, 2024, from https://www.cdc.gov/aging/pdf/mental_health.pdf

Centers for Disease Control and Prevention. (2021, April 16). *Chronic disease self-management program (CDSMP)*. https://www.cdc.gov/arthritis/interventions/programs/cdsmp.htm

Centers for Medicare & Medicaid Services. (n.d.). *Person-centered care*. https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care

Cherry, K. (2021, April 21). *Integrity vs. despair in psychosocial development*. www.verywellmind.com/integrity-versus-despair-2795738

Colón-Emeric, C. S., Whitson, H. E., Pavon, P., & Hoenig, H. (2013). Functional decline in older adults. *American Family Physician*, *88*(6), 388–394. www.aafp.org/pubs/afp/issues/2013/0915/p388.html

Crocco, E. A., Jaramillo, S., Cruz-Ortiz, C., & Camfield, K. (2017). Pharmacological management of anxiety disorders in the elderly. *Current Treatment Options in Psychiatry*, *4*(1), 33–46. https://doi.org/10.1007/s40501-017-0102-4

DeSilva, D. (2021). *Nutrition as we age: Healthy eating with the dietary guidelines*. https://health.gov/news/202107/nutrition-we-age-healthy-eating-dietary-guidelines

Erikson, E. H. (1964). *Insight and responsibility. Lectures on the ethical implications of psychoanalytic insight.* Norton.

Feeding America. (2023). *The state of senior hunger in 2021*. https://www.feedingamerica.org/research/state-senior-hunger

Forsman, A. K., Nordmyr, J., & Wahlbeck, K. (2011). Psychosocial interventions for the promotion of mental health and the prevention of depression among older adults. *Health Promotion International*, *26*(suppl_1), i85–i107. https://doi.org/10.1093/heapro/dar074

Garaschuk, O. (2021). Understanding normal brain aging. *Pflugers Archiv, 473*(5), 711–712. https://doi.org/10.1007/s00424-021-02567-6

Garcia, E., & Jordan, R. (2022). *Navigating social isolation and loneliness as an older adult*. National Council on Aging. https://ncoa.org/article/navigating-social-isolation-and-loneliness-as-an-older-adult

Gibson, S. M. (2021, April 23). *Age segregation, loneliness and addiction: Why aren't we connecting the dots?* https://www.nextavenue.org/12-step-programs-loneliness-and-addiction/

Glazier, E. M., & Ko, E. (2023). *Ageism is prevalent in medical care*. https://www.uclahealth.org/news/ageism-prevalent-medical-care

Granier, K. L., & Segal, D. L. (2021). Diverse aspects of worry among younger and older adults: A multifaceted approach. *Psychology*, *12*(03), 441–461. https://doi.org/10.4236/psych.2021.123028

Health in Aging. (2023). *Delirium*. https://www.healthinaging.org/a-z-topic/delirium/causes

Health Resources and Services Administration. (2022). *Health literacy*. https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy

Healthcare.gov. (2024). *Federal poverty level (FPL)*. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

Hellmann, J. (2023, June 13). Ageism, stigma hinder response to older adults' alcohol issues. *Honolulu Star-Advertiser.* https://www.staradvertiser.com/2023/06/13/live-well/ageism-stigma-hinder-response-to-older-adults-alcohol-issues/

Hill, N. L., Yevchak, A., Gilmore-Bykovskyi, A., & Kolanowski, A. M. (2014). The model of care partner engagement: Use in delirium management. *Geriatric Nursing*, *35*(4), 272–278. https://doi.org/10.1016/j.gerinurse.2014.02.023

Hosker, C., & Ward, D. (2017). Hypoactive delirium. *BMJ*, *357*, 2047. https://doi.org/10.1136/bmj.j2047

Jonas, W. (2020). Person-centered care: Lessons from the VA's whole health model. *Practice I*, *20*(6). https://www.medcentral.com/biz-policy/person-centered-care-lessons-va-whole-health-model

Joshi, P., Duong, K. T., Trevisan, L. A., & Wilkins, K. M. (2021). Evaluation and management of alcohol use disorder among older adults. *Current Geriatrics Reports, 10*, 82–90. https://doi.org/10.1007/s13670-021-00359-5

Kerner, N., & Prudic, J. (2014). Current electroconvulsive therapy practice and research in the geriatric population. *Neuropsychiatry, 4*(1), 33–54. https://doi.org/10.2217/npy.14.3

Kreps, J. M. (2022). *Automation and the older worker: An annotated bibliography prepared for the committee on employment and retirement of the national council on the aging* (classic reprint). Forgotten Books.

Lenze, E. J., & Oughli, H. A. (2019). Antidepressant treatment for late-life depression: Considering risks and benefits. *Journal of the American Geriatrics Society, 67*(8), 1555–1556. https://doi.org/10.1111%2Fjgs.15964

Makovac, E., Smallwood, J., Watson, D. R., Meeten, F., Critchley, H. D., & Ottaviani, C. (2018). The verbal nature of worry in generalized anxiety: Insights from the brain. *Neuroimage: Clinical, 17*, 882–892. https://doi.org/10.1016/j.nicl.2017.12.014

Mattison, M. (2024). *Hospital management of older adults.* https://www.uptodate.com/contents/hospital-management-of-older-adults?source=see_link

Mental Health First Aid. (2019, July 11). *Four ways culture impacts mental health*. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

Munir, S., Takov, V., & Coletti, V. A. (2021). *Generalized anxiety disorder (Nursing)*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK568696/

National Alliance on Mental Illness. (2020). *Types of mental health professionals*. https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals

National Center for Education Statistics. (2006). *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy*. https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006483

National Center for Equitable Care for Elders. (n.d.) *Substance use disorders (SUD) and addictions among older adults in health centers*. https://ece.hsdm.harvard.edu/files/ece/files/sbirt_for_older_adults.1.14.19_pdf.pdf

National Council for Mental Wellbeing. (2019). *Four ways culture impacts mental health*. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

National Council on Aging. (2023). *The top 10 most common chronic conditions in older adults*. https://www.ncoa.org/article/the-top-10-most-common-chronic-conditions-in-older-adults

National Institute of Mental Health. (2022, April). *Anxiety disorders*. https://www.nimh.nih.gov/health/topics/anxiety-disorders

National Institute on Aging. (2017). *How the aging brain affects thinking.* www.nia.nih.gov/health/how-aging-brain-affects-thinking.

National Institute on Aging. (2021, July 7). *Depression and older adults*. www.nia.nih.gov/health/depression-and-older-adults.

National Institute on Aging. (2022). *Facts about aging and alcohol*. https://www.nia.nih.gov/health/alcohol-misuse-or-alcohol-use-disorder/facts-about-aging-and-alcohol

National Institute on Alcohol Abuse and Alcoholism. (2019, April 25). *Harmful interactions*. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines

Nazem, B. (2011). How anxiety presents differently in older adults. *Current Psychiatry*, *10*(3), 65–72. https://www.mdedge.com/psychiatry/article/64224/anxiety-disorders/how-anxiety-presents-differently-older-adults

Onwumere, J., Stubbs, B., Stirling, M., Shiers, D., Gaughran, F., Rice, A. S. C., C de C Williams, A., & Scott, W. (2022). Pain management in people with severe mental illness: An agenda for progress. *Pain, 163*(9), 1653–1660. https://doi.org/10.1097/j.pain.0000000000002633

Ormseth, C. H., LaHue, S. C., Oldham, M. A., Josephson, S. A., Whitaker, E., & Douglas, V. C. (2023). Predisposing and precipitating factors associated with delirium: A systematic review. *JAMA Netw Open, 6*(1), e2249950. https://doi.org/10.1001/jamanetworkopen.2022.49950

Rigler, S. K. (2000). Alcoholism in the elderly. *American Family Physician*, *61*(6), 1710–1716. https://www.aafp.org/pubs/afp/issues/2000/0315/p1710.html

Stokes, L. (2018). *ANA position statement: The ethical responsibility to manage pain and the suffering it causes*. https://ojin.nursingworld.org/table-of-contents/volume-24-2019/number-1-january-2019/ana-position-ethical-responsibility-manage-pain/

Substance Abuse and Mental Health Services Administration. (2020). Treating substance use disorder in older adults. Treatment Improvement Protocol (TIP) Series No. 26, SAMHSA Publication No. PEP20-02-01-011.

Taylor, G. B., Radhakrishnan, N., Fisher, C. L., Price, C., Tighe, P., Le, T., & Bylund, C. L. (2021). A qualitative analysis of clinicians' communication strategies with family members of patients experiencing hospital-acquired delirium. *Geriatric Nursing*, *42*(3), 694–699. https://doi.org/10.1016/j.gerinurse.2021.02.009

Teng, C., & Frei, C. R. (2022, March). Delirium associations with antibiotics: A pharmacovigilance study of the FDA Adverse Event Reporting System (FAERS). *Drugs Real World Outcomes, 9*(1), 23–29. https://doi.org/10.1007/s40801-021-00268-1

Themes, U. F. O. (2017, September 16). *Psychiatric case management*. Nurse Key. https://nursekey.com/psychiatric-case-management/

U.S. Department of Agriculture and U.S. Department of Health and Human Services. (2020). Dietary Guidelines for Americans, 2020-2025. 9th Edition. https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

U.S. Department of Agriculture. (2022, March). *Healthy eating for older adults*. https://myplate-prod.azureedge.us/sites/default/files/2022-04/TipSheet_21_HealthyEatingForOlderAdults.pdf

Vaillancourt, M. (2010). *Therapeutic modalities*. Physiopedia. https://www.physio-pedia.com/Therapeutic_Modalities

Waichler, I. (2022, February 1). *Anxiety in older adults: Signs, treatments, & ways to cope*. https://www.choosingtherapy.com/anxiety-older-adults/

Wilson, J., Heinsch, M., Betts, D., Booth, D., & Kay-Lambkin, F. (2021). Barriers and facilitators to the use of e-health by older adults: A scoping review. *BMC Public Health, 21*, 1556. https://doi.org/10.1186/s12889-021-11623-w

World Health Organization. (2019, June 24). *mhGAP intervention guide. Version 2.0*. https://www.who.int/publications/i/item/9789241549790

World Health Organization. (2023). *Mental health of older adults*. https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

CHAPTER 25
Community Mental Health Treatment

FIGURE 25.1 Community-based programs approach mental health treatment from a cooperative perspective. (credit: "Compassion" by Sonya Revell/Flickr, CC BY 2.0)

CHAPTER OUTLINE

INTRODUCTION The word *community* may conjure images of a neighborhood, friend group, place of worship, or elsewhere. It is likely a group of people who offer support and a sense of connection.

Community is a vital part of the human experience. Humans are social creatures and thrive as part of a group or community. Community provides a sense of belonging, a support system, a place to share experiences, and a sense of security. Communities offer opportunities for people to learn from one another, exchange ideas, and collaborate. Additionally, communities often have shared values and goals, which can give individuals a sense of purpose and meaning. Overall, communities provide a sense of identity and a feeling of being part of something greater than oneself, which is essential to human well-being.

Community-based mental health services provide accessible and affordable mental health care to individuals within their own communities, offering a range of support. Community-based mental health services work to reduce the stigma surrounding mental illness by promoting awareness and understanding with advocacy and positive outcomes. They can also help to prevent mental health crises by providing early intervention and support. By offering services within a community, people can receive the care they need without having to travel long distances or face other barriers that may prevent them from seeking help. Ultimately, community-based mental health

services help to improve the overall mental health and well-being of communities. Nurses play an important part in helping clients as they navigate community-based mental health care.

25.1 Identifying Varying Types of Care

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify varying types of care in the community
- Describe the varying types of care available for clients across the life span
- Determine the most appropriate type of care for a client

Mental health is not always seen as the public health issue that it is. When an individual has unaddressed mental health issues—approximately one in five people with mental health disorders seek mental health services (Bruckner et al., 2019)—these can turn into issues for the public as a whole. These issues may manifest as safety concerns, homelessness, unemployment, poverty, or effects on the local economy (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Resolving these underlying issues is a large part of the purpose of public community care.

All nurses will encounter clients with mental health diagnoses and needs. According to the American Hospital Association, about one in four clients who are admitted to a general hospital have a mental health diagnosis (2022). Additionally, the evolution of the modern American mental health-care system has placed the burden of care increasingly on the community level. Over 100 million people live in areas with shortages of psychiatric providers. There is also a nationwide shortage of in-facility psychiatric beds that has led to an increase in emergency department visits for behavioral health-related issues.

Community mental health offers services to these clients who might otherwise have difficulty in accessing mental health care. Nurses should be able to identify the different types of care available in the community and help identify the most appropriate type of care for the client to connect them with the best services for them.

Types of Care in the Community

Mental health treatment and activities that occur outside of an institution compose **community mental health** (American Psychological Association [APA], 2018). Care in the community may be classified into a number of different groups: ambulatory care programs, support groups, community-based behavioral health programs, home visiting services, school-based programs, intensive community/outpatient programs, programs in treatment settings, partial hospitalization or day treatment, and substance misuse services. Federal and state funds, financial grants, fundraising efforts, and donations support community mental health. Some clients have Medicare, Medicaid, private health insurance, or children's health programs to pay for covered services.

Client-centered care with shared decision-making is a critical aspect of community mental health care. It involves tailoring treatment and support to the specific needs of each person with mental illness. Negative public attitudes and stigma regarding mental health may make clients resistant to receiving care in a public setting.

Different geographic or catchment areas offer different types of services; they can be dependent on the demographics (National Alliance on Mental Illness [NAMI], 2023c). For those with limited resources or lack of support, or who are unhoused or uninsured, community health programs can be crucial to their health, support, and safety. Often, medication adherence can mean the difference between stability and relapse. Community mental health programs can assist individuals to manage medications and access prescriptions, therapy, education, and support to help them remain consistent with their treatment regimens. These community programs can support people in their communities and help to prevent hospitalization. There are a number of different types of mental health-care workers in the area of community health who are trained to respond to crises or provide psychotherapy, education, and consultation to those in need. Community health programs do not end with prevention, access, and education. Mental health clients may also recover at cooperative living environments, halfway houses, or group homes that are supportive and supervised residences. These clients may also benefit from supportive work arrangements in which mental health-care workers can help with maintaining employment. Adolescents and children may access special education or integrated educational program services. Clients across the life span can benefit from in-home or home care services, family support, personal-care assistance, case management and services coordination, and the use of mental health clinics. Telehealth may also be an option for clients who cannot

attend an in-person treatment program.

The quality of this vast array of services and support groups depends highly on the commitment of the community itself. Cultural norms, local government funding, political climate, and environment can all affect the types of community services available. People in the community may have to work together to create needed services if they do not currently exist.

LINK TO LEARNING

The National Alliance on Mental Illness (NAMI) periodically conducts and publishes community surveys (https://openstax.org/r/77comsurveys) in order to assess and evaluate public attitudes and perceptions toward various aspects of mental health.

Private Care within the Community

Community mental health care offers a range of care options that cater to the unique needs of individuals seeking mental health support. Private treatment, which does not receive governmental support, can vary widely in availability and cost. Because of this, it is not accessible to everyone. A portion of the cost of care may be covered by insurance, or the client may be required to pay out of pocket (NAMI, 2022). Some private treatment services accept Medicaid or Medicare as payment for services while others may not. Private services may take place in a variety of settings and at different intervals depending on the treatment plan. For example, faith communities can play a central role in the mental health of individuals in many communities by providing education and support to both the client and their family. Many private faith-based services offer their own counseling centers or support groups.

Some other private care options available in community mental health care include individual therapy, group therapy, medication management, and case management. Individual therapy involves one-on-one sessions with a mental health professional that are tailored to the individual's specific needs and concerns, while group therapy involves participating in therapy sessions with a group of people who are facing similar challenges. Medication management involves working with a licensed mental health provider, such as a psychiatric nurse practitioner or psychiatrist, to develop an appropriate medication regimen to manage symptoms. Case management involves working with a mental health professional who can help coordinate care and connect individuals with additional resources and support as needed. Some of these resources include the following:

- Supportive community living services: Housing with support services focused toward independent living
- Day habilitation: Provision of regular activities scheduled to enhance self-care skills and maintain or improve functional ability, such as assistance with adaptation to the environment for adults or reaching developmental milestones for children
- Transitional/day programs: Assist with clients progressing between levels of function, from dependent or assisted to self-care, that is, personal care, social skills, money management, transportation, or employment training

Community Care: Public Resources

Public resources in community mental health care play a vital role in filling the gaps in access for clients who may not be able to use private resources. Public forms of community mental health care can include crisis intervention services, outpatient counseling, substance misuse counseling, and medication management. Crisis intervention services offer immediate support to individuals who are experiencing mental health emergencies, such as suicidal ideation or psychosis. Additionally, community mental health care can provide support groups, case management, and vocational services to help individuals achieve their goals and improve their quality of life. The availability of these services may vary depending on the location and resources of the community.

Community health centers have expanded over the last decade and aim to target underserved populations in specific communities, offering treatment and preventative health services. These facilities are also known as Federally Qualified Health Centers. These types of health centers offer an array of medical services, including mental health, and are important safeguards in limited resource areas, qualifying for specific reimbursement systems (such as Medicare and Medicaid) and other government funding. Clients seen at Federally Qualified Health Centers typically are on Medicaid or do not have health insurance and are offered adjusted payment options; many

community health centers strive to remain affordable.

Places that provide care to clients with all levels of mental illness and substance use, including those with complex needs or at high risk, and specialize in treating these individuals is a **community mental health center**. They can assist with medication, case management, community services, or intensive community services (NAMI, 2022). In addition, they may be used when a referral to a private provider is not possible for a variety of reasons. These centers are often interdisciplinary, with a team working to provide care to the client. Clients who are seen at these public facilities often are eligible for Social Security disability income and Medicare benefits.

Certified Community Behavioral Health Clinics (CCBHCs) represent a significant advancement in the provision of comprehensive mental health and substance use disorder services in the United States (SAMHSA, 2023a). These clinics are part of a federal initiative designed to offer a holistic and integrated approach to mental health care and are funded through federal and state grants. They are required to provide timely treatment to any client requesting care for mental health or substance use issues, regardless of the client's ability to pay.

LINK TO LEARNING

SAMHSA describes how a CCBHC ensures access to coordinated comprehensive behavioral health care (https://openstax.org/r/77CCBHC) for all clients of all circumstances.

CCBHCs provide a broad range of services, including community mental health treatment, substance use disorder services, crisis intervention, and even primary care services in some cases. These clinics play a pivotal role in addressing the gaps in the traditional mental health-care system, ensuring that individuals receive the full spectrum of care they need to manage their mental health conditions effectively. Every state is required to meet the federal guidelines and deadlines for the CCBHC programs.

PSYCHOSOCIAL CONSIDERATIONS

Peer Support Centers

Peer support centers are a free or low-cost resource for people recovering from severe mental illness. Individuals use their own recovery experience and training to provide support, encourage hope, and promote social interaction. The goal is to aid people with mental illness on their recovery journey to live meaningful lives in their community. Resources offered at peer support centers can range from counseling to different therapies, such as art or pet therapy, crisis support, and long-term programs for those who may have greater needs as they transition back to the community. H.E.A.R.T.S. Peer Support of Greater Nashua, New Hampshire (https://openstax.org/r/77HEARTS), is one example of a peer support center that offers a wide range of resources for those seeking peer support in mental health recovery.

Community Care: Individual-Focused

Individualized care in the community can include individual counseling, psychotherapy, medication therapy, or rehabilitation (CDC, 2011). Some of the different kinds of individual-focused care available in community mental health care include cognitive behavioral therapy, dialectical behavior therapy, and trauma-focused therapy.

Community mental health-care providers may also offer specialized services for individuals with specific mental health issues, such as addiction treatment or eating disorder treatment. Integrated Health Homes (IHH) (https://openstax.org/r/77IHH) are offered in nineteen American states. IHH are team-based professionals collaborating in holistic care for adults or children with severe mental illness.

Housing and transportation circumstances can affect an individual's ability to access treatment options. Individuals with stable housing may be more likely to participate in treatment, as the treatment may be located at their home (U.S. Department of Health and Human Services, 2021a). As more treatment shifts to a virtual environment, this has become more commonplace. The COVID-19 pandemic required many treatments to move to an online environment, and many clients who either would not previously engage in therapy due to stigma or lack of transportation were now able to receive services. Many of these services were found successful and even preferred by the clients, and

thus many of these community treatment options have continued in a virtual environment.

PSYCHOSOCIAL CONSIDERATIONS

Telehealth for Mental Health Services

Telehealth has emerged as a transformative approach to delivering mental health services, offering a multitude of benefits for clients seeking support and treatment. One significant advantage is enhanced accessibility, allowing individuals to receive care regardless of geographical location or physical mobility. This is especially crucial for clients residing in remote or underserved areas, as well as those with mobility challenges or transportation barriers. Telehealth eliminates the need for travel and enables clients to engage in therapy or consultations from the comfort of their homes, promoting regular attendance and reducing the likelihood of missed appointments.

Telehealth promotes convenience and flexibility. Clients can schedule sessions that align with their daily routines, making it easier to integrate mental health care into their lives. This flexibility extends to the availability of therapists and specialists, allowing clients to access a wider range of expertise and therapeutic modalities that may not be readily available locally. For clients who experience anxiety or discomfort in traditional clinical settings, telehealth offers a more relaxed and private environment, potentially fostering increased openness and engagement. Additionally, telehealth preserves anonymity, making it an appealing option for those concerned about social stigma associated with seeking mental health support (NAMI, 2023f).

Community Care: Family-Focused

Family-focused care is an important part of community mental health care. Family-focused care recognizes the role that family members and caregivers can play in supporting individuals with mental health issues. Different kinds of family-focused care available in community mental health care include family therapy, education, support groups, and respite care.

Family therapy involves working with the family as a whole to address issues within the family unit and to develop strategies to support the individual with mental health issues, including communication techniques for improved understanding and coping skills for family members. Family therapy may be helpful in cases of clients with severe, chronic illness, such as schizophrenia, or someone who is in active recovery from substance misuse. It is especially valuable when working with children and adolescents with mental health issues. Family education involves educating family members about mental health issues, treatment options, and other ways to support their loved one. Support groups are a way for family members to connect with others in similar situations, share their experiences, and receive education and emotional support.

Respite care varies by state, with some states capping the number of days that the service may be provided in their managed care contracts. Respite care provides temporary relief for family member caregivers and can be provided in the home or in a facility where respite workers assume care, provide therapies, and supervise the client.

Community mental health-care providers also may offer services specifically for children and adolescents, such as family-based interventions for early-onset psychosis (SAMHSA, 2022a). NAMI provides support groups for families who are supporting people with mental illnesses; these group sessions are virtual or in person. The family may also participate in group therapy with the affected client.

Community Programs: IOPs and PHPs

An intensive community program, or **intensive outpatient program (IOP)**, is a type of community care that provides structure and support for clients in a community setting, allowing them to receive intensive treatment without the disruption of hospitalization (New York Office of Mental Health, 2023). IOPs are an important component of community mental health care because they offer a higher level of care than traditional community services but do not require the same level of commitment as hospitalization with twenty-four-hour supervision. IOPs typically involve frequent and intensive therapy sessions, as well as additional support services, such as medication management and group therapy. Clients attend these sessions as scheduled.

IOPs can be an effective way to provide targeted and intensive care for individuals with mental health disorders and substance use disorders while allowing them the flexibility to continue to live in their communities and maintain

their daily routines. They can also be a more cost-effective option than hospitalization; they do not require the same level of resources, and can help prevent hospital readmissions. Community mental health-care providers may offer IOPs for a variety of mental health issues, including depression, anxiety, and eating disorders. For those with substance use disorders, an IOP can be helpful for those who do not require detoxification in a hospital setting (National Institutes of Health [NIH], 2014) or have recently completed the detoxification or hospital stay and are receiving treatment in the community. Other IOPs may be for adolescents with behavioral or psychiatric conditions; this may involve participation of the adolescent's family.

A partial hospitalization program (PHP) is a step-down program for clients who require a higher level of care and support than that offered by IOPs, but who do not need twenty-four-hour supervision. These programs require more of a time commitment than IOPs, ranging from several hours per day to full-day sessions, multiple days per week. They take place in a hospital or clinic setting, providing a highly structured and supportive environment for participants. PHPs offer a comprehensive range of therapeutic services, including individual therapy, group therapy, family therapy, medication management, medical monitoring, and other specialized interventions. The treatment team usually includes psychiatrists, psychologists, nurses, social workers, and other mental health professionals. PHPs often serve as a step-down program for people who have recently been discharged from hospitalization and still require support before transitioning to less intensive levels of care.

Types of Care across the Life Span

Different age groups have varying psychosocial needs to consider when developing an effective community health-care plan. Certain mental health conditions may be more prevalent in certain age groups. For instance, ADHD is more commonly diagnosed in children, while depression and anxiety disorders are more common in adults. Also, different age groups may require different approaches to treatment. For example, children and adolescents may benefit from play therapy and family therapy, while adults may benefit from individual therapy and group therapy. Older adults may require more assistance and support due to physical and cognitive limitations and may benefit from interventions that address their social isolation and loneliness. It is important for nurses to consider age when developing treatment plans and interventions for individuals.

Care of Children and Adolescents

Mental health disorders in children can be defined as a disturbance in thoughts, emotions, and/or behaviors that deviate from developmental norms for a child's age, and which cause distress, impairment in functioning, or both. Like adults, adolescents and children may experience a variety of mental health disorders, such as ADHD, anxiety, depression, behavior disorders, or substance misuse. Children are not "little adults," however, and often respond differently to medications and treatments than adults (U.S. Department of Health and Human Services, 2021b). Additionally, the diagnosis process for mental health disorders in children and adolescents is complex and usually includes in-depth family interviews, gathering information from the child's school related to behavior, and professional observation and testing. It is important to know the adolescent or child's diagnosis and coordinate with the appropriate support systems to be able to provide care in the community.

Evaluating a child's developmental milestones can provide crucial insights into their mental health because these milestones are closely linked to the child's cognitive, emotional, social, and physical development. Children who experience delays or difficulties in achieving these milestones may be at risk for mental health problems, such as anxiety, depression, and ADHD (Centers for Disease Control and Prevention [CDC], 2021). For example, if a child is not meeting their developmental milestones for language, it could be an early warning sign of communication or social difficulties that could affect the child's mental health and development.

A child's school and certain test results can be an important source of information on their behavior. Records can help reveal if children are reaching important developmental and emotional milestones. A thorough family history and interview about the history of the child will be part of a mental health evaluation. Home visits or in-clinic evaluations by professionals can also reveal any issues with developmental milestones. Early identification and intervention can help prevent or minimize the impact of mental health issues and support healthy development.

LINK TO LEARNING

Screenings, such as the Denver II Developmental Screening Test (https://openstax.org/r/77devscreen) can help assess developmental milestones in children and adolescents, which can support early diagnosis of a mental health disorder or behavioral concern.

Bullying can have a significant impact on the mental health of children and adolescents; research has uncovered correlations between bullying and generalized anxiety disorder, panic attacks, agoraphobia, and depression (U.S. Department of Health and Human Services, 2021b). Bullying can also lead to social isolation, which can further exacerbate mental health issues. Children who are bullied may struggle with making friends, and may feel like they do not belong, which can lead to feelings of loneliness and depression. In some cases, bullying can also lead to more serious mental health issues, including suicidal thoughts. Suicide is a major concern as the third leading cause of death for those fifteen to twenty-four years old (U.S. Department of Health and Human Services, 2021b). Children who experience severe or chronic bullying may be more likely to struggle with these issues. It is important for parents, teachers, and other adults to be aware of the signs of bullying and to take steps to intervene when necessary. Providing support and resources for children who have experienced bullying can help to mitigate the negative effects on their mental health.

Prevention is a major intervention in the care of the adolescent or child in the community. There are several effective ways that prevention can be used as an effective strategy for managing community mental health care for children and adolescents:

- Early identification and intervention take place through screening programs, regular check-ins with mental health professionals, and outreach programs that target high-risk populations.
- Promoting mental health and well-being in children and adolescents happens through programs that focus on building social and emotional skills, promoting healthy lifestyles, and addressing risk factors for mental health problems. Such programs can be conducted in schools, through community health centers, or with assistance from individual health-care workers.
- Education can help increase awareness and understanding of mental health issues in the community, reduce stigma, and encourage people to seek help when they need it. Schools can also be a major influence in identifying behavioral disorders in children, and in providing services that can support these children. Studies have shown that of those adolescents with a diagnosable psychiatric disorder, only half of them finish high school (U.S. Department of Health and Human Services, 2021b).
- Targeted interventions are aimed at specific mental health issues, such as depression, anxiety, or substance use. For example, prevention issues related to alcohol and drugs can delay the first drink of the individual, thus decreasing the risk of binge drinking, heavy alcohol use, and drug use (U.S. Department of Health and Human Services, 2021b). This can decrease the likelihood of the individual developing a substance use disorder as an adolescent or even later in life.

Adolescents and children with mental health disorders may receive their mental health services in conjunction with their educational services. The Individuals with Disabilities Education Act (IDEA, 2004) provides public funding for special education services, mandating that the services be provided in the least restrictive environment.

LIFE-STAGE CONTEXT

Services for Children and Adolescents

There are multiple community-based services and toolkits to support mental health in the child and adolescent populations. One community-based program supporting children and adolescents is Project Advancing Wellness and Resiliency in Education (AWARE). Project AWARE (https://openstax.org/r/77AWARE) partners state mental health agencies (SMHAs) with state educational agencies (SEAs) to increase mental health awareness and resiliency among this population (SAMHSA, 2022b). Another is the Toolkit for Community Conversations about Mental Health (https://openstax.org/r/77DHSToolkit) produced by the U.S. Department of Health and Human Services, which

provides those in the community with information, discussion guides, planning guides, and infographics that can assist with creating community care for the adolescent and child population (U.S. Department of Health and Human Services, 2021b). SAMHSA also offers a toolkit specifically for high schools to provide education, support, and intervention (https://openstax.org/r/77SAMHSATool) for those at risk.

For those children or adolescents with anxiety or depression, behavior therapy or cognitive behavioral therapy may work using an individual, group, or family approach (CDC, 2022a). Individuals can find a provider for this type of therapy in the community through a variety of locator tools (for example, the APA Psychologist Locator or the American Academy of Child and Adolescent Psychiatry Finder) or through the parent's insurance network.

As part of the mental health-care community, parents, educators, and health-care partners all play a role. Schools can provide care in the community by referring students to mental health services, integrating social-emotional learning into their curriculum, training staff appropriately, supporting mental health of the staff, maintaining equitable discipline policies for students, and providing a safe and supportive environment. Parents and caregivers should communicate openly and honestly with their children, support healthy decision-making, enjoy shared activities together, volunteer or be engaged in school activities, provide help with homework, and communicate on a regular basis with teachers and administrators. Health-care providers can use routine appointments to provide education about development and risky behaviors, screen about relationships, and encourage positive parenting (Division of Adolescent and School Health, 2023).

Care of the Adult

The adult population is a large one that encompasses people from ages eighteen through sixty-four. It is important to note that younger adults can have different mental health issues than older adults. For instance, in 2020, young adults aged eighteen to twenty-five years had the highest prevalence of mental illness (30.6 percent) compared with adults aged twenty-six to forty-nine years (25.3 percent) and adults aged fifty and older (14.5 percent) (U.S. Department of Health and Human Services, 2022a). Nevertheless, the percentage of young adults aged eighteen to twenty-five years with mental illness who received mental health services was the lowest of all three groups at 42.1 percent, with adults aged twenty-six to forty-nine years at 46.6 percent and aged fifty and older at 48 percent. Table 25.1 compares the unique challenges that can affect the mental health of the young adult and middle-aged adult populations.

Rank	Young Adults, Ages 18–44	Middle-Aged Adults, Ages 45–64
1	Transitional challenges: Younger adults may experience difficulties adjusting to new life stages, such as leaving home, entering the workforce, and starting a family. These transitions can be stressful and may lead to depression, anxiety, and other mental health problems.	Stress-related disorders: Middle-aged adults often experience significant stress from work, family, and other responsibilities, which can lead to stress-related disorders, such as anxiety and depression.
2	Substance misuse: Younger adults may be more likely to engage in risky behaviors, such as experimenting with drugs and alcohol. Substance misuse can lead to addiction, as well as other mental health problems.	Substance misuse: Middle-aged adults may turn to alcohol or drugs as a way to cope with stress, leading to substance misuse and addiction.
3	Academic and career pressures: Younger adults may face pressure to succeed in their academic and career pursuits. These pressures can lead to stress, anxiety, and depression.	Health problems: As people age, they become more vulnerable to physical health problems. Chronic illnesses and physical disabilities can increase the risk of depression and other mental health problems.

TABLE 25.1 Mental Health Challenges Affecting Adult Populations

Rank	Young Adults, Ages 18–44	Middle-Aged Adults, Ages 45–64
4	Social media and technology: Younger adults are more likely to use social media and technology, which can lead to issues such as social isolation, cyberbullying, and addiction.	Relationship issues: Divorce, loss of a spouse or significant other, and other significant relationship changes can be especially difficult for middle-aged adults, leading to depression, anxiety, and other mental health issues.
5	Mental health stigma: Younger adults may face stigma and discrimination related to mental health. This can prevent them from seeking help when they need it and can exacerbate mental health problems.	Caregiving responsibilities: Many middle-aged adults are caring for aging parents or other family members, which can be emotionally and physically demanding, leading to caregiver burnout, depression, and anxiety.
6	Trauma and adverse childhood experiences: Younger adults may have experienced trauma or adverse childhood experiences, such as abuse or neglect, which can lead to mental health problems later in life.	Empty nest syndrome: When children leave home, parents may experience feelings of sadness, loneliness, and a sense of loss, leading to depression and other mental health problems.
7		Financial stress: Middle-aged adults may experience financial stress due to mortgage payments, college expenses, and other financial obligations, leading to anxiety, depression, and other mental health problems.

TABLE 25.1 **Mental Health Challenges Affecting Adult Populations**

Depending on the severity of their illness and functional ability, clients may need assistance with determining what care is needed, finding resources for housing, securing public health insurance if unemployed, managing medications, and locating mental health therapies. NAMI (2023d) provides support groups in both English and Spanish, either in person or virtual. Additionally, community outreach and education programs can help reduce stigma and increase awareness about the importance of mental health. Support groups, individual counseling, and other resources can provide much-needed support and guidance to this population. Those with income limitations or serious mental health illnesses may benefit most from a community mental health center.

There are successful Assertive Community Treatment (ACT) model-based programs for the adult population. The **Assertive Community Treatment (ACT)** program delivers individualized mental health services to individuals in the community and aims to reduce clients' dependence on hospitalization. For clients with the most severe, persistent mental illnesses and the greatest level of functional impairments, an evidence-based practice model, such as the ACT model, can be beneficial in providing a framework for strategies to identify at-risk individuals (SAMHSA, 2019). ACT teams work with individuals in their homes, workplaces, and other community settings to help them achieve their goals and improve their quality of life and to prevent institutionalization. Research has shown that the ACT model is effective in reducing hospitalizations, improving housing stability, increasing social functioning, and enhancing overall quality of life for people with severe and persistent mental illness.

One example is the Center for Urban Community Services (CUCS) in New York City. CUCS operates an ACT program that serves adults with serious mental illness, many of whom have experienced homelessness. The program employs a multidisciplinary team of mental health professionals, including psychiatrists, nurses, social workers, and employment specialists, who provide 24/7 support to clients in their homes, at work, and in the community (New York City Department of Homeless Services, Department of Social Services, n.d.). The program also operates at the national level as the CUCS Institute, providing training and assistance to organizations that help mentally ill and homeless individuals across the country.

Care of the Older Adult

The older adult population in the United States is expected to approximately double in size by 2060. In addition to its economic impacts, this growth could also have a significant effect on the treatment of mental health in older adults. Research by SAMHSA (2019) has shown that 1.4 to 4.8 percent of the 49.2 million older adults over age sixty-five in the United States suffer from a serious mental illness. A serious mental illness, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), requires that the client have "a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities" (2023b, para 3). Yet due to the nature of aging, many older adults exhibit impairments in functioning that may or may not be related to mental health issues, making diagnosing and caring for a mental health disorder difficult.

Many people who work in mental health care may not be aware of the signs and symptoms of mental illness in older adults, or how to treat those symptoms (SAMHSA, 2019). Others may consider some signs and symptoms, such as confusion or forgetfulness, as signs of aging, and ignore what is really affecting the client. Caring for the mental health of older adults requires specialized knowledge and an awareness of what is typical and atypical for a particular individual.

Nurses should be aware that older adults are more likely to have co-occurring health conditions, such as diabetes, heart disease, or dementia, which can complicate the treatment of mental health issues. Also, older adults are at a much higher risk for polypharmacy, or taking multiple medications, which, along with differences in drug metabolism, can increase the risk of negative drug interactions or adverse effects. A thorough and accurate medication list must be on hand during every client encounter.

There are many access issues for older adults in community mental health care. Older adults face stigma and ageism related to mental health issues, which can prevent them from seeking help and accessing appropriate care due to fear of being judged. Additionally, numerous older adults live in rural or remote areas, which can make it difficult to access mental health-care services. Older individuals may not have access to technology or transportation or may have mobility issues that make it difficult to travel to appointments. Individuals over age sixty-five are more likely to rely on family members or other caregivers for support, and these caregivers may experience stress and burden related to managing the individual's mental health issues, or may no longer be available.

Some older adults live in institutional types of settings, such as nursing homes or skilled nursing facilities, which are located in the community, but not necessarily community-based services. For those who are diagnosed with a chronic mental illness, they may be living in a behavioral health-specific facility that offers interdisciplinary services for the client. Many older adults, on the other hand, do not live in such facilities and are socially isolated, which can exacerbate mental health issues and make it more difficult to physically access care.

Clients in older age groups may be prone to substance use. Older adults may misuse medications unintentionally through forgetfulness or error. Some older adults may turn to substance use to cope with losses in life, such as changes in employment or living situations, general health, or interpersonal relationships (NIH, 2020). The rate of substance use disorders is 0.2 to 1.9 percent in this population, and while this may seem like a small percentage, the 2016 National Survey of Drug Use and Health data noted that only 240,000 of the 863,000 older adults with a substance use disorder were receiving treatment (SAMHSA, 2019).

Community groups, such as Alcoholics Anonymous or Narcotics Anonymous, are essential for this age group. These meetings may be available in their institutional-based facility, online, or at local community centers or churches.

LIFE-STAGE CONTEXT

Resources for Older Adults

Community-based senior centers can be an excellent resource for older adults. They often offer an array of services to improve the physical and mental well-being of older adults. Services include screenings, such as blood pressure checks, cholesterol tests, and vision and hearing tests. Many places also offer exercise and fitness programs tailored to the needs of older adults, as well as transportation services (https://openstax.org/r/77transport).

Centers often partner with mental health professionals to offer services, such as individual or group therapy, and education sessions to address issues, such as depression, anxiety, grief, or cognitive decline. Additionally, senior centers offer opportunities for recreation and socialization, which are crucial for good mental health in older adults.

Suicide in older age groups is also a risk. Men over the age of fifty are at higher risk for suicide, and attempts by older adults generally result in more deaths (SAMHSA, 2019). A client in an institutional facility may require more frequent supervision than others. Crisis lines and community support groups are significant community resources for care. The 988 Suicide & Crisis Lifeline offers national 24/7 call, text, and chat access to trained counselors who can assist those experiencing emotional distress. Anyone worried about a loved one can also dial 988 for support and information.

LINK TO LEARNING

Mental Health America (https://openstax.org/r/77prevsui) provides information on preventing suicide in older adults.

There are various resources specific to older adults. Aside from senior centers, there are also geriatric mental health clinics that specialize in the diagnosis and treatment of mental health disorders in older adults. Home health services can provide older adults with access to mental health care in their own homes, including in-home assessments, medication management, and psychotherapy. This can be especially helpful for those with limited mobility or transportation issues. Resources vary by location, so it can be helpful to speak with case managers, social workers, and other health-care professionals from the client's community to familiarize yourself with the available resources.

LINK TO LEARNING

The NIH provides information on mental health (https://openstax.org/r/77oldadultmh) in older adults.

The Psychogeriatric Assessment and Treatment in City Housing (PATCH) is an example of a program specifically for older adults that is based on the ACT model. It is a collaborative program between mental health professionals and housing providers, which aims to improve the quality of life of older adults with mental health issues (Robbins et al., 2000). It provides them with access to comprehensive assessments, individualized treatment plans, and ongoing support. The program is focused on addressing the specific needs of older adults, such as age-related health concerns, cognitive impairment, social isolation, and the impact of physical disabilities. Other resources, such as the Health Care Innovations Exchange through the Agency for Healthcare Research and Quality, provide care to this population as well (Agency for Healthcare Research and Quality, 2021).

Determining Appropriate Care for a Client

Determining the appropriate community-based mental health care for a client is important because it can be more cost-effective, motivate client engagement, increase access to care, and improve mental health outcomes.

The first step in determining the appropriate care involves a thorough assessment. This includes gathering information about the client's mental health status, including their symptoms, behaviors, and overall functioning. This may involve using standardized screening tools that can identify a client's risk for suicide, depression, anxiety, and other concerns. The nurse may conduct interviews with the client and their family, perform a mental status exam, and review medical records. Other relevant factors include age, income, medical history, access to health insurance, transportation, and social support. This assessment can help the nurse identify the client's specific needs and preferences, which can guide the selection of appropriate community-based mental health-care services that meet the client's unique needs and goals. The nurse can also collaborate with other members of the health-care team, such as the client's provider and mental health professionals, to develop an effective and coordinated care plan for the client.

REAL RN STORIES

Nurse: B.T., MSN RN
Years in Practice: 24
Clinical Setting: Rural hospital
Geographic Location: Atlanta, Georgia

When I worked as a float nurse in a rural hospital, I was frequently assigned to psychiatry and I became known among other nurses as somewhat of an expert. I had an associate's degree at the time and had not sought a specialty area, though I truly felt an affinity for mental health nursing practice.

One evening when I was working on a med-surg unit, a colleague approached me for advice working with an older adult who was being "stubborn" and refusing home health and other support services as part of the discharge plan. I explored how the discharge teaching was being delivered and heard words such as "told," "pointed out," and "tried to convince."

I offered the nurse a strategy of therapeutic communication, which included empowering the older adult with choice and placing the emphasis on prevention—as opposed to correction. I encouraged the nurse to listen to the older adult's concerns and possibly provide a list of five or six services and have the older adult select two to try, recognizing the importance of the person's autonomy.

A week later, I found a thank-you note and gift card in my mail slot from the nurse I had spoken to; she wrote, "It really worked!" I smiled as I read the message, thinking that it "worked" because the nurse did.

Planning care will involve exploring a range of community-based services suitable to the individual client. When determining a plan of care for a client, the nurse should seek as much of the client's input as possible; when people have input into their own plan, they are much more likely to follow it. After implementing the plan of care, the nurse should periodically check with the client at appropriate intervals to see how they are progressing. If necessary, the nurse can make adjustments to the plan depending on how effective the care is. Ongoing evaluation of the plan's effectiveness will help ensure that the client is receiving the best possible care.

25.2 Community Needs

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Understand the holistic approach to mental health care
- Describe the physical needs of the mental health client in a community environment
- Understand the social-emotional needs of the mental health client in a community environment

The specific needs of mental health clients will vary depending on their diagnosis, treatment plan, and individual circumstances. Nursing is a holistic discipline that treats mental health from a whole person perspective; nurses should consider the physical, emotional, and spiritual aspects of the person when developing a community care treatment plan. Personalized care and ongoing assessment are crucial to meet the unique physical and social-emotional needs of each client in a community setting.

Understanding the Holistic Approach to Mental Health Care in the Community

The holistic approach is person-centered and considers all the determinants of health, such as economic stability, access to health care, education and spiritual expression, safe neighborhoods, and social networks in the community. Holistic care is integrated, combining resources for physical and psychosocial needs, and approaching the whole person, not simply the diagnostic category. Collaboration between the person and the health-care team can address symptom management as well as individualized outcomes of care.

Mental health conditions can impact physical health, manifesting as poor nutrition, increased risk of comorbidities, and medication side effects. Basic physical needs, such as food and housing, must be addressed as part of any effective mental health-care plan. Physical needs also include transportation and work accommodations.

Similarly, physical health issues can affect mental health, causing anxiety, depression, stress, and fear. Additionally, mental health clients may struggle to express their emotions and communicate their needs effectively, which can lead to feelings of frustration and isolation.

Socialization and interpersonal relationships in the community provide a sense of connection, support, and purpose, which can positively impact mental health outcomes. Social support can enhance a sense of belonging, reduce feelings of isolation, improve overall health, and provide opportunities for skill building, engagement, and personal growth.

CLINICAL JUDGMENT MEASUREMENT MODEL

Using the CJMM to Create a Nursing Plan of Care

Davis, BSN RN, is working with Beatrice A., eighty-two years old, who was hospitalized after a fall with no fractures. Her discharge is planned in the next twenty-four hours. Davis reviews the electronic health record (EHR) and learns that Beatrice experiences orthostatic hypotension, consumes approximately one-half of her diet each day, is continent of bowel and bladder. Medications include lisinopril, metformin, omeprazole, simvastatin. Beatrice has health insurance through Medicare with a supplemental policy. She is financially secure with a retirement income.

During interdisciplinary rounds, the physical therapy staff has reported Beatrice remains at risk for falls due to low vision and weakened physical strength and recommends discharge to short-term rehab. The social services representative reports that Beatrice was hospitalized last year after a motor vehicle accident and refused rehab at that time, not wanting to leave her home. Beatrice lives alone in her own apartment, attends weekly church with a neighbor, and has her groceries delivered. She no longer drives a car, has no history of substance use, and watches television programs two to four hours each day.

Davis meets with Beatrice to discuss the discharge plan. Davis knows that the local community has the following services available:

- ambulatory care programs
- support groups, mental health clinics
- home visiting services, medication management
- partial hospitalization or day treatment
- personal-care assistance, case management and services coordination
- transportation services
- telehealth

Davis follows the CJMM steps and involves the client throughout the process.

Step	Nursing Plan of Care
Recognizing Cues	Objective data: wears hearing aids and eyeglasses; seated in a chair by the window; wearing hospital gown, slippers, and a sweater; hair is combed Subjective data: acknowledges the nurse's greeting appropriately and agrees to talk Primary data: client verifies the information the nurse relates about her living situation, medications, and insurance coverage; client states "Yes, I had a fall. I know I get up too fast," "I don't check my blood sugar, I don't have that kind of diabetes," "I have been alone since my sister died two years ago, sometimes I wish I had someone to talk to. I still have her computer, but I don't how to use it." Secondary data: reports from interdisciplinary rounds and nurse's review of electronic health record (EHR)
Analyzing Cues	Objective data: sensory impairment; capable of, or amenable to, hygiene and grooming Subjective data: alert and oriented, social awareness Primary data: orthostasis, diabetes, loneliness, potential learning need Secondary data: identified fall risk, past reluctance for rehab, medication list—any side effects, reduced nutritional intake
Prioritizing Hypotheses	• Consider client's preferences Reluctance for rehab • Airway/Breathing/Circulation Orthostasis • Safety and risk reduction Fall history and risk Vision and hearing Physical strength • Maslow's hierarchy of needs Reduced nutrition Socialization • Least restrictive/Least invasive Community care services
Generating Solutions	Review with client slow position change to prevent orthostatic changes in blood pressure. Review lower extremity exercises taught by physical therapy staff. Share with client available resources in the community, such as transportation services, in-home physical therapy, nursing care, medication monitoring and nutrition services, socialization opportunities and education, specifically computer training, potentially for telehealth.
Taking Actions	Present client with a list of community services and case management/care coordination. Answer questions, set meeting time for tomorrow to discuss client's choices and make arrangements.
Evaluating Outcomes	On discharge day, review plan with client, clarify as needed, share contact information for follow-up.

Physical Needs of Mental Health Clients in the Community

In one sense, the physical needs of the mental health client are the same as those of anyone: to have secure housing, food, transportation, and potential work accommodations. But mental health clients seeking treatment in community or community environments may encounter stigma, and they have specific needs that involve how they

seek and access treatment, and how well they are able to continue their treatment. In essence, this means, for instance, that accessible public transportation is, in part, a mental health issue. There are also a number of comorbidities that can appear alongside many mental health illnesses; depression, for example, often accompanies substance use disorder and physical illnesses like cancer, and is a significant and leading cause of disability in adults of all ethnicities (Khodyakov et al., 2018).

Health and Medical Care

Mental health clients have been shown to have a higher incidence of certain medical issues than the general population. Take cardiovascular disease, for example. Mood disorders, anxiety disorders, post-traumatic stress disorder (PTSD), and chronic stress are among those most studied in relation to cardiovascular disease; however, other behavioral health disorders, including substance misuse, may be related to cardiovascular disease as well (CDC, 2020). This correlation means that a client with a mental illness, such as depression, anxiety, and PTSD, may be more likely to experience a stroke, heart failure, or myocardial infarction. Physical manifestations may be found across the life span and are not necessarily specific to a particular age group. This is especially true of depression. Research has found that clients with depression may experience increased inflammation, changes in heart rate control and blood circulation, stress hormone abnormalities, and metabolic changes. These changes may lead to cardiovascular disease, pain, stroke, diabetes, and even Alzheimer's disease (National Institute on Mental Health [NIMH], 2021). Research has revealed that women, veterans, people with PTSD, and racial or ethnic minorities have higher rates of heart disease that are related to mental health conditions (Gross et al., 2022).

Health-care providers can support these clients by working as multidisciplinary teams, providing resources to mental health clients on risks, or using electronic health records to coordinate the care the client needs. Clients should look for physical signs and symptoms of heart disease, determine any family history or genetic predisposition, and try to keep a healthy lifestyle. This last point is of particular importance; an unhealthy routine, as a result of anxiety or depression, can lead to smoking, being sedentary, or not taking necessary medications as they should be taken. Unfortunately, medications used to treat mental health illnesses may have undesirable side effects such as "obesity, insulin resistance, diabetes, heart attacks (myocardial infarctions), atrial fibrillation, stroke … death," sexual side effects, and hyperglycemia (U.S. Department of Health and Human Services, 2022b), making compliance even more difficult for some mental health clients.

Clients with mental health disorders sometimes experience difficulties with basic physiological and safety needs that increase the challenge to maintain their overall well-being. For example, clients with mental health illnesses may also experience **food insecurity**, which is limited or inconsistent access to the amount of food required to live a healthy lifestyle. Food insecurity has strong physical and emotional effects on an individual and can have serious negative effects on mental health. Those who have a mental health illness are at increased risk for food insecurity and may have to choose between food or treatment for their mental health (NAMI, 2023d). Clients across the life span may qualify for Supplemental Nutrition Assistance Program (SNAP), and those who are pregnant or with children age five or younger may also qualify for the Women, Infants, and Children (WIC) program. NAMI states that "it is critical to address food insecurity and related social determinants of health to allow people with mental health conditions to focus on getting and staying well" (NAMI, 2023d, para 13).

LINK TO LEARNING

The federal government website ChildCare.gov (https://openstax.org/r/77childcare) provides more information on government financial assistance and benefits for families.

Housing

Housing instability or neighborhood violence can affect clients across the life span, and potentially influence the physical health and safety of a client. According to NAMI, a significant barrier to recovery from mental illness is the lack of stable and/or affordable housing; if this need is not met, then the mental health client can end up unhoused, in jail, in a shelter, or back in the hospital (NAMI, 2023d). Therefore, a client may need assistance with housing upon discharge from a hospital. According to the National Alliance to End Homelessness, more than one in ten people who seek substance misuse or mental health treatment in the public health system are homeless (2023). It is important to collaborate with the client to determine the appropriate type of housing that the client may need to

support recovery. One option is **group housing**, a type of small-scale living facility that, in addition to housing, provides support, supervision, and other types of assistance. Group housing can be supervised or partially supervised. Other options in the community can include supportive housing, rental housing, or home ownership. Supervised group housing can provide mental health clients with a higher level of care, but still allow the independence of living in the community. This type of housing may assist the client with meals, medications, activities of daily living, paying bills, transportation, and treatment. Partially supervised group housing allows for more independence, but gives the mental health client access to help if needed; supportive housing combines living space with services.

LINK TO LEARNING

Nurses and clients can find more information on government financial assistance and benefits (https://Openstax.org/r/77govben) at the federal government's benefits site.

The client may also need support in obtaining the finances for housing. Often clients with serious mental illnesses are living on Supplemental Security Income (SSI), and may not be able to afford sufficient housing. A client with a mental health illness may qualify for Section 8, which provides vouchers to low-income individuals and families, or Section 811, the Supportive Housing for People with Disabilities Program, for which a client with a chronic mental health illness may qualify. Be mindful of the fact that many housing options have age and/or income qualifications.

REAL RN STORIES

Nurse: Heather, RN, BSN
Years in Practice: 3
Clinical Setting: Medical-surgical unit
Geographic Location: The inner city of a large metropolitan area in Florida

We serve a diverse client population, but many of our clients are from lower socioeconomic backgrounds and either use Medicaid or have no health insurance. There is a large encampment of people who are homeless staying underneath the freeway overpass three blocks away, and we frequently see these individuals for treatment.

One rainy, cold night, I received report from the emergency department on my new client, Gene S. I was told he was a "frequent flier" who came in "all the time" with the same complaint. He was a fifty-eight-year-old White male with a history of schizophrenia and type 2 diabetes. He had been admitted with a complaint of chest pain, but all testing was negative so far. I went to Gene's room to find him sitting in bed, with his wife at the bedside. They were both disheveled in appearance but very pleasant. Both of them immediately requested juice, crackers, and some sandwiches.

Upon assessment, Gene was alert and oriented, but slow to answer some questions. He and his wife had moved to the area two months ago and were unhoused; they had been staying in the encampment underneath the freeway. I noticed in his chart that he had presented to the emergency room five times in that two-month time period with complaints of "chest pain," but that his test results were always negative and he was always discharged from the emergency room. Gene told me that he was taking metformin and aripiprazole, which he got through his previous doctor in another state. But he had no local doctor, had lost his previous Medicaid card, and only had two weeks' worth of medication left. He and his wife were getting food from a charity that would bring supplies to the encampment, but they had no cell phone and no transportation, and public transportation did not serve the area. Gene stated to me, "It's so nice to come here to the hospital. It's warm and they give me a bed and food for the night, and everyone is so nice to me even though I'm not sick."

I realized that Gene and his wife might be making frequent visits to the hospital because their basic physical needs were not being met outside of the hospital, and this was the only way to access some of them. I notified the on-call case manager of my concerns. Prior to discharge, a social worker helped Gene and his wife complete their Medicaid application and connected them with the local community services office. The community service office would help

Gene and his wife apply for assistance with food (SNAP benefits), housing, and to receive access to low or no-cost medical and mental health care. They arranged for a free transportation service to take Gene and his wife across town to a homeless shelter. Gene was discharged with these resources and no longer made frequent visits to our emergency department.

Work Accommodations and Transportation

Clients with mental health disorders may also need employment or work accommodations. These clients need to be informed of their rights regarding discrimination under the Americans with Disabilities Act and/or the Rehabilitation Act of 1973. Under these laws, clients who qualify may request an extended leave of absence, flexible work/break schedules or start times, work/break environment with reduced distractions or noise, telework, regular feedback, written directions and/or task lists, and/or use of a job coach. While these accommodations can be requested and granted, stigma remains a significant concern in the workplace, and it often prevents employers from considering options and exceptions that assist individuals to maintain employment.

There are several community resources for workers with mental health-related disabilities. Disability-specific nonprofit organizations specialize in supporting individuals with job placement services, support groups, and training programs. Job training programs can provide training in skills that are in demand in the job market, such as computer skills or customer service skills. Disability employment services are often offered through state or local government agencies and can provide job placement services, vocational training, and other types of support for individuals with disabilities. Additionally, there are disability-friendly employers who specifically seek out individuals with disabilities for employment opportunities. These employers are committed to expanding their applicant pool toward a diverse workplace and have accommodations in place for individuals with mental health-related disabilities.

Transportation, or the lack thereof, can be a significant barrier to mental health treatment or services. Clients with mental health illnesses may require the support of another person to drive them to appointments or to pick up medications, while others may be too anxious to drive themselves. Sometimes, a client cannot get to the treatment location or to the pharmacy for medications. Depending on where the client lives, public transportation may or may not be an option. Even when public transportation is an option, the client may not be able to afford the transportation. Being familiar with other options within the community allows the nurse to help clients resolve transportation barriers.

Social and Emotional Needs of Mental Health Clients in the Community

When seeking mental health care in the community, clients will have a range of social and emotional needs. Social and emotional support is a crucial aspect of mental health care, particularly for clients in the community. Mental health-care clients can face stigma, discrimination, and isolation, which contribute to feelings of loneliness, anxiety, and depression. Social and emotional support help to alleviate these negative emotions and improve the client's mental well-being.

The purpose of emotional support is to help clients to feel less isolated and stigmatized, and provide them with a sense of belonging and connectedness (U.S. Department of Health and Human Services, 2022c). Emotional support helps clients to feel valued and appreciated, which can boost their self-esteem and self-confidence. It can also help clients to stay motivated and engaged in their treatment, which can reduce their risk of relapse (SAMHSA, 2013). Local and online peer support groups can offer emotional support to clients, as can public or private counseling services. Family and friends can be an important source of emotional support for individuals with mental health issues. They can provide a listening ear, offer encouragement and support, and help individuals access resources and services that can support their mental health.

Clients may require support in developing coping skills to deal with some of the emotional challenges of their mental health condition. Meditation and mindfulness workshops and seminars can provide clients with techniques to help manage emotional distress. Therapists or support groups can offer other relaxation techniques, problem-solving strategies, or communication skills. Participating in community activities, such as volunteer work, sports, or hobbies, can help clients feel more connected, reduce stress, and provide a sense of purpose.

Some clients may need additional emotional support in the form of developing specific skills to regulate their

emotions. Emotional regulation skills are important for mental health clients because they can help reduce stress and improve overall function in the community. The ability to recognize, understand, and regulate one's emotions in a healthy and adaptive way is considered **emotional regulation**. Good emotional regulation leads to increased self-awareness, improved coping skills, better decision-making, improved relationships, and reduced risk of relapse. In addition to therapy and support groups, clients can also self-educate by finding resources on emotional regulation online or at their local library.

The concept of empowerment is central to good mental health. Empowerment can motivate clients to take an active role in their treatment and recovery. The World Health Organization considers empowerment to refer to "the level of choice, influence and control that users of mental health services can exercise over events in their lives" (Baumann, 2011, para 1). Empowerment means giving individuals the tools, resources, and support they need to make decisions, take action, and create positive change in their lives. Empowerment is essential for mental health clients in the community because it allows them to take control of their lives and regain a sense of agency and self-determination. Here are a few reasons why empowerment is important for mental health clients:

- Increased self-efficacy: This can help them feel more confident and capable of managing their mental health challenges, and can lead to improved mental health outcomes.
- Increased engagement: When people feel empowered, they are more likely to engage in their treatment and take an active role in managing their mental health.
- Increased sense of control: Empowerment can help people regain a sense of control and agency, which can lead to increased feelings of autonomy, independence, and self-esteem.
- Reduced stigma: Empowerment can help reduce the stigma surrounding mental health by encouraging people to speak up and advocate for themselves. This can lead to increased awareness, understanding, and acceptance of mental health issues in the community.

For mental health-care clients, it can also be critical in supporting recovery and wellness for them to feel a sense of **social belonging**, which is the feeling of being connected to and valued by others. This connection can come from a variety of sources, including family, friends, peers, and community groups. When individuals feel like they belong, they are more likely to experience positive emotions, have a sense of purpose, and feel supported in times of stress or challenge. A sense of social belonging can help combat isolation and loneliness, improve self-esteem, and increase motivation. A sense of social belonging can also provide emotional support, practical assistance, and advice or guidance from others in the community who have shared similar experiences (U.S. Department of Health and Human Services, 2021a). Community resources, such as social clubs, art classes, sports teams, or other activities, can provide opportunities for clients to connect with others and engage in activities they enjoy. By providing a supportive, nonjudgmental, and empowering environment, mental health professionals can help clients develop the skills and resources they need to manage their condition and lead fulfilling lives.

LINK TO LEARNING

Mental health clients need to be surrounded by a safety net of support in the community. One such resource is suicide risk assessment standards (https://Openstax.org/r/77lifeline), which connects callers with the National Suicide Prevention Lifeline.

25.3 Programming in Community and Treatment Settings

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Understand the goals of community-based programs
- Understand the goals of programs in treatment settings
- Evaluate the appropriateness of using a community program or a program within a treatment setting

Treatment setting and community-based programs offer different types of benefits for individuals with mental health concerns. Treatment setting programs can be beneficial for clients who need closer monitoring or treatments, while community services allow clients to retain more independence. The goal in mental health treatment is always to offer the most beneficial, least restrictive possible treatment while prioritizing the client's

safety. Whether community or treatment setting, a projected outcome of care for all community-based programs is for clients to maintain that important social bond with others that is so important to good mental health.

Community Services: Community Programs

Community services programs include support groups, home visiting services, and school-based programs. Diagnosis and age of the client can determine which program or programs are right for the client and their family. See 5.3 Community Support Systems for an in-depth discussion of community-based support groups.

Home Visiting Services

A nursing-related **home visiting service** represents a valuable approach to providing mental health care that is personalized, convenient, and tailored to the client's needs within the comfort of their own home environment. Home visiting nurses offer a range of specialized services to individuals with mental health concerns, promoting early intervention, treatment adherence, and overall well-being.

Home visiting nurses play a vital role in assessing clients' mental health status, identifying potential risks, and developing personalized care plans. They collaborate with other health-care professionals to ensure a holistic approach, addressing both the physical and emotional aspects of client care needs. These nurses provide education on coping strategies, medication management, and lifestyle modifications that can positively impact mental health. Importantly, home visiting services offer a level of convenience that traditional clinical settings may not, facilitating consistent engagement and reducing barriers that might stop clients from seeking care.

By providing care in a safe and familiar environment, nurses establish a foundation of trust that can lead to more open and honest discussions about mental health concerns. This approach is particularly valuable for vulnerable populations, such as older adults, new parents, and individuals with chronic illnesses, who may be at greater risk for mental health challenges.

Home visiting nurses also offer vital support for family members and caregivers, providing education and guidance on how to effectively assist and support individuals with mental health conditions. This collaborative approach fosters a comprehensive support network that extends beyond the individual, enhancing their overall quality of life.

Home visiting services can be particularly helpful in identifying and assisting with behavioral health issues in young children (Child Welfare Information Gateway, 2021). Home visiting programs focus on building social and emotional competence in young children and their parents. These programs typically provide early intervention services in family homes and prevention efforts to improve overall mental health outcomes for children and their families.

School-Based Programs

Youth and adolescents receive much of their mental health support in schools. Studies have shown that the availability of comprehensive school mental health programs has a positive effect on students' academic success as well as their social skills, leadership, and self-awareness. By helping to create a favorable learning environment that enables students to be successful in school and in the community, schools with collaborative, community-based partnerships also demonstrate improved attendance and graduation rates (Youth.gov, n.d.-a). Depending on the school, resources can include early interventions, counseling, nursing, educational workshops for students, teacher education, and referrals to outside professionals.

Some students may need an **individualized education program (IEP)** to support their learning. IEPs are created by a multidisciplinary team for any public school student aged three to twenty-one with a qualifying disability, including emotional or behavioral disorders or developmental delays. The team includes the student's parent or legal guardian, general and special education teachers, a school system representative, and often other specialists, such as social workers, nurses, physicians, or others. IEPs are tailored to the individual students' needs and are designed to provide them with the appropriate resources to obtain a free public education. The plan is evaluated and updated regularly and the student usually joins the IEP team at age fourteen to give their own input. Services provided for a student with an IEP include specially designed or modified instruction, supplementary aids and services, parental or professional involvement, or classroom accommodations.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care

Definition: The nurse will recognize the importance of treating clients as partners in their health-care journey, promoting their autonomy, and ensuring their values and needs are at the center of decision-making.

Knowledge: The nurse will be able to utilize evidence-based screening tools to identify adolescents at risk for suicide. The nurse will understand the epidemiology, risk, and protective factors associated with suicide in the adolescent population.

Skill: The nurse will administer a validated suicide screening tool in the school setting to identify adolescents at risk for suicide. The nurse will establish rapport and trust with the adolescents to engage and participate in the screening. The nurse will collaborate with team members to conduct appropriate assessment and interventions for adolescents who screen at risk.

Attitude: The nurse will demonstrate empathy and compassion for adolescents who may be at risk for suicide. The nurse will provide for privacy and maintain confidentiality at all times, respect diversity and support cultural differences in a professional manner, and focus on the adolescent and incorporate them in the decision-making.

(QSEN Institute, n.d.)

Community Services: Treatment Setting Programs

Treatment setting programs in mental health care refer to stays in acute hospital or residential settings where clients receive intensive mental health treatment and support within their community. These programs are designed to provide a safe and supportive environment for individuals experiencing acute mental health symptoms or crises while allowing them to benefit from remaining in their own community. See Therapeutic Settings for additional details.

Identifying the Appropriate Services

There are several factors to consider when determining if community or treatment setting mental health care is more appropriate for a client. Safety is the key determining factor, as is using the least restrictive setting to maintain the client's safety. Clients at risk for self-harm or harm to others would likely be admitted to a hospital treatment setting until stabilized.

As always, the first step is a thorough assessment that will help identify the client's current mood, symptoms, and level of functioning, as well as their goals and preferences for care. Nurses should try to familiarize themselves with the various mental health resources available in the client's community, and encourage the client to research options as well. Consider reaching out to case management, or contact the public health services in the client's community for assistance in locating information on crisis lines, support groups, treatment settings, private therapy, and more. Information should also be available online, or at the local public library.

When developing the plan of care for the client and determining the appropriate services, it is always important to collaborate with the client on their own preferences and advocate for them to receive timely, appropriate care. The focus should be client-family centered and include the interprofessional team to provide the most realistic, attainable, and appropriate treatment plan.

25.4 Workforce Reentry Programs

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe the purposes and different types of workforce reentry programs
- Explain the benefits and challenges to workforce reentry programs related to mental illness and substance use
- Identify ways in which the psychiatric-mental health nurse can support workforce reentry programs to benefit clients

Workforce reentry programs are critical in the realm of rehabilitation and individual empowerment. These programs span the gaps between periods of absence—be it due to mental health treatment, substance misuse recovery, incarceration, or some combination of these—and successful integration back into the workforce. Each type of program, whether focused on vocational training, counseling, education, or other specialized approaches, addresses the unique challenges faced by individuals in their journey toward reentry. By recognizing the diverse needs and circumstances of these clients, these programs offer tailored pathways that lead not only to financial stability but also to personal growth, restored dignity, and a renewed sense of purpose. This intricate network of programs brings reintegration to life, enabling individuals to regain control and contributing to a safer, more supportive community for all.

Workforce Reentry Programs Defined

A **workforce reentry program** is a structured initiative designed to support individuals as they transition back into the workforce after a period of absence, often due to circumstances, such as mental health treatment, substance misuse recovery, or incarceration. These programs aim to address the unique challenges faced by participants during reintegration, which can include gaps in job skills, stigma associated with their absence, and the need for specialized support.

According to NAMI (2024), the incarcerated population in the United States has a significantly higher rate of individuals with a history of mental illness and/or substance use disorders, making this group especially vulnerable after their release. Nearly two in five members of the incarcerated population has a history of mental illness, twice the average rate in the United States (NAMI, 2024). The vast majority of the incarcerated population will be released and face reentry into society, a period that is often stressful and filled with risk for these clients who may experience loss of resources, stigma, and relapse. Most workforce reentry programs are designed with the post-incarceration population in mind.

Workforce reentry programs provide a range of services, including vocational counseling, skills training, job placement assistance, workplace accommodations, and ongoing support. The goal is to empower participants to regain financial independence, build self-esteem, develop job-related skills, and overcome the stigma often associated with mental health conditions. By promoting recovery, improving overall well-being, and fostering a supportive work environment, these programs play a crucial role in enhancing the quality of life for mental health clients while contributing to their successful reentry into the workforce and society.

Purpose of Workforce Reentry Programs

Workforce reentry programs aim to address the complex challenges individuals face as they strive to reintegrate into society, rebuild their lives, and secure stable employment. These programs serve as a crucial bridge to successful reintegration, recognizing that the path to recovery, rehabilitation, and reentry is intertwined with gaining meaningful employment.

The primary purpose of these programs is to break the cycle of recidivism by providing participants with the necessary tools, skills, and support to overcome the unique barriers they encounter. Mental health and substance misuse diagnoses often contribute to a range of challenges, including low self-esteem, lack of employable skills, social stigma, and a history of criminal activity. Workforce reentry programs aim to mitigate these obstacles by offering counseling, therapy, skill-building workshops, vocational training, and more, tailored to the individual needs of participants.

By providing participants with access to education, training, and job placement opportunities, these programs foster a sense of self-worth and dignity, allowing participants to redefine themselves beyond their past mistakes or struggles. Additionally, workforce reentry programs enhance public safety by assisting reintegration into society where gainful employment provides a positive and productive alternative to criminal activity.

Furthermore, employment is not only a means of financial stability, but also a source of purpose, routine, and social connection. By addressing mental health and substance use issues alongside vocational goals, workforce reentry programs aim to holistically heal and empower participants, allowing them to reenter society as productive, capable individuals with the potential to lead fulfilling lives.

The overall purpose of workforce reentry programs for individuals with a mental health or substance misuse diagnosis post-incarceration is to break down barriers, promote rehabilitation, and provide a structured pathway to

sustainable employment. By addressing the complex interplay of factors that contribute to reintegration challenges, these programs play a vital role in fostering personal transformation, reducing recidivism, and supporting the overall well-being of participants.

Types of Workforce Reentry Programs

Workforce reentry programs come in various forms, each tailored to address different needs and challenges individuals may face when reintegrating into the workforce. Here are some common types of workforce reentry programs:

- Vocational rehabilitation programs: These programs provide comprehensive support to individuals with mental health conditions to help them develop job-related skills, identify suitable career paths, and secure employment. Vocational rehabilitation services may include vocational assessments, job training, résumé building, interview coaching, and job placement assistance. Job Corps is an example of this type of program; it is for young people, ages sixteen to twenty-four, who want to participate in no-cost vocational training (U.S. Department of Labor, n.d.-a).
- Supported employment programs: Supported employment programs offer ongoing assistance and guidance for individuals with mental health challenges as they search for and maintain employment. These programs provide job coaches or employment specialists who work closely with participants and employers to ensure a smooth transition and successful integration into the workplace. Examples of such programs include the Mental Health and Addiction Services Supported Employment Project and Division of Substance Abuse and Mental Health Supported Employment Transformation Project (SETP) (SAMHSA, 2022c).
- Transitional employment programs: Transitional employment programs offer temporary work placements with the goal of helping individuals build confidence, work habits, and skills. These placements can serve as stepping stones to more permanent employment and provide valuable experience to enhance participants' résumés.
- Peer support programs: Peer support programs connect individuals with peers who have successfully navigated their own mental health or substance use challenges and returned to the workforce. Peer mentors provide guidance, share their experiences, and offer emotional support, fostering a sense of hope and connection.
- Education and training programs: Some workforce reentry programs focus on education and skill enhancement through workshops, classes, and training sessions. These programs equip participants with the necessary skills for a particular field or trade, increasing their employability and confidence.
- Job placement services: Job placement services assist participants in identifying job opportunities that align with their skills, interests, and limitations. These programs may have established partnerships with employers who are open to hiring individuals with mental health conditions.
- Customized employment programs: Customized employment programs create tailored job positions to match the strengths and preferences of individuals with mental health or substance use challenges. These programs work closely with employers to design roles that accommodate participants' abilities and support their success.
- Entrepreneurship and self-employment programs: Some individuals may choose to explore entrepreneurship or self-employment opportunities. These programs offer training and support for starting and managing small businesses, allowing participants to work at their own pace and on their terms.
- Mental health integration programs: These programs incorporate mental health support into the workplace environment. They provide resources for employees and employers to foster understanding, reduce stigma, and promote a supportive atmosphere for individuals with mental health conditions.
- Continuing education and lifelong learning programs: For individuals who want to further their education or explore new interests, these programs offer access to adult education, higher education, and lifelong learning opportunities to enhance career prospects and personal growth.

The types of programs available can vary in their focus, intensity, and duration, ensuring that individuals can find the support that best suits their needs and goals.

LINK TO LEARNING

Workforce GPS is an online community sponsored by the Employment and Training Administration of the U.S. Department of Labor. The vast array of resources for clients seeking assistance with workforce reentry (https://openstax.org/r/77workreentry) includes access to apprenticeship programs, links to government grant applications, peer community groups, high school and college assistance programs, and more.

Funding and Resources

Funding and resources are essential components for the successful implementation of workforce reentry programs. These programs require a combination of financial support, personnel, and access to specialized services to effectively address the complex needs of this population. Funding and resources for these programs typically come from a combination of government and private sources.

- Government grants: Federal, state, and local government agencies often provide grants to support workforce development initiatives, including those targeting individuals with mental health or substance misuse diagnoses post-incarceration. The U.S. Department of Labor, Bureau of Justice Assistance, Office of Justice Programs, and U.S. Department of Justice are common sources of such grants.
- Nonprofit organizations: Nonprofits that focus on criminal justice reform, mental health advocacy, and substance misuse treatment may offer funding and resources to support workforce reentry programs. These organizations often prioritize initiatives that promote rehabilitation, reduce recidivism, and enhance community reintegration.
- Community foundations: Local community foundations and charitable organizations may allocate funds to support workforce reentry programs that directly benefit the community by providing employment opportunities and addressing mental health or substance use issues. The Salvation Army and Goodwill Industries International are examples of such foundations.
- Corporate partnerships: Some companies are committed to social responsibility and invest in workforce development initiatives. Partnerships with such companies can provide financial support, job placement opportunities, and mentorship programs for program participants.
- Vocational training providers: Vocational schools, community colleges, and training institutions may collaborate with workforce reentry programs to offer discounted or specialized training to program participants, reducing the financial burden and enhancing their job prospects.
- Health-care organizations: Health-care organizations, including mental health clinics and substance misuse treatment centers, may contribute resources, such as counseling services, therapy sessions, and access to medical professionals to support the mental health and well-being of program participants.
- Staff and volunteers: Trained professionals, including social workers, counselors, vocational trainers, and case managers, are essential resources for workforce reentry programs. These individuals provide guidance, support, and expertise to help participants navigate their reintegration journey.
- In-kind donations: Donations of office equipment, training materials, transportation assistance, and other resources can help reduce program costs and improve participants' access to necessary services.
- Advocacy groups: Organizations that advocate for the rights and well-being of individuals with criminal records, mental health conditions, or substance misuse histories may offer support in the form of funding, resources, and expertise.
- Social service agencies: Collaborating with local social service agencies can create access to housing assistance, childcare services, and other resources that support participants' stability and successful reentry.

Benefits and Challenges to Workforce Reentry Programs

Workforce reentry programs offer a range of advantages for individuals seeking to rejoin the workforce after periods of absence. These programs provide valuable skills training, reduce the likelihood of relapse into criminal activities, and contribute to community reintegration. By helping participants secure stable employment, workforce reentry programs promote financial independence and reduce the strain on public assistance programs. Challenges, such as addressing skill gaps, combating stigma, coordinating comprehensive support services, ensuring sustainable funding, and aligning job opportunities with participants' backgrounds and aspirations are important considerations

in ensuring the overall effectiveness and impact of these programs.

Benefits

Workforce reentry programs encompass a spectrum of benefits that profoundly impact individuals navigating their reintegration into the workforce. Beyond the immediate goal of employment, these programs offer a holistic support system that addresses multifaceted challenges. Skill development and educational initiatives equip participants with tangible knowledge, augmenting their employability and cultivating a renewed sense of achievement. Importantly, workforce reentry programs play a pivotal role in bolstering self-esteem and confidence, catalyzing personal empowerment, and enhancing self-worth.

By integrating mental health support services, these programs empower participants with adaptive coping mechanisms, bolstered resilience, and effective strategies for managing underlying mental health challenges. Participants in reentry programs benefit from cognitive behavioral therapy to change antisocial thinking and increase problem-solving ability.

The reentering individual learns to examine attitudes related to previous antisocial behavior and develop respect for the rights of others. The experience of successful workforce reentry fosters a sense of belonging and renewed social connections within their communities. These programs also serve as catalysts for reducing recidivism rates among individuals who are recently released from incarceration. They help provide stability and guidance through a time of stress and transition for these clients.

Challenges

Implementing workforce reentry programs can come with a range of challenges. These hurdles can significantly impact both clients and program administrators and require comprehensive strategies to mitigate their effects. One central challenge involves addressing skill gaps, as participants' time away from the workforce can result in a misalignment of their abilities with contemporary job requirements.

Combating the stigma and discrimination faced by individuals with histories of mental illness, substance misuse, or incarceration is another significant obstacle, demanding strategies to educate employers and reshape perceptions. Integrating mental health and substance misuse support alongside employment objectives requires a well-coordinated and holistic approach. The availability of job opportunities that accommodate participants' unique circumstances can be limited, further highlighting the need for creative solutions to enhance their employability and broaden their career prospects.

Truly comprehensive workforce reentry programs include support services, such as counseling, housing assistance, childcare, and transportation. These support services are essential to clients' overall stability and wellness but are resource intensive. Sustainability remains an ongoing challenge, necessitating continued funding, community engagement, and adaptation to dynamic job market trends. A customized approach to accommodate the individual challenges and goals of each client is best and requires a personalized and flexible program framework. Addressing the practical aspects of reentry, from obtaining identification documents to reconnecting with social networks, poses further complexities. Effectively addressing all of these multifaceted challenges demands a collaborative effort among clients, nurses, governmental bodies, nonprofit organizations, mental health professionals, employers, and community stakeholders to ensure the success and lasting impact of workforce reentry programs.

Engaging employers within the framework of workforce reentry programs presents a particularly complex set of challenges. These challenges stem from a range of factors that influence employers' perceptions, decisions, and willingness to participate in such initiatives. One of the most significant obstacles is the persistent stigma and biases associated with hiring individuals with nontraditional backgrounds.

Additionally, employers often conduct risk assessments, considering potential liabilities and disruptions that individuals with complex histories might bring. This caution can impede their readiness to collaborate with workforce reentry programs (U.S. Department of Labor, n.d.-b). Limited awareness among employers about the benefits and achievements of these programs also contributes to their reluctance. The absence of adequate resources within certain businesses, especially smaller ones, for accommodating unique needs like mental health support or reentry coaching further compounds the challenge.

Communication gaps between workforce reentry programs and employers can create problems with successful placements because misunderstandings about participants' skill sets, strengths, and potential arise. Employers

might question whether the acquired skills align with their industry needs or whether clients will be able to seamlessly integrate into their work environments. Concerns about long-term retention and the stability of individuals with complex histories can also impact employers' decisions, due to preconceived negative ideas about persons with criminal convictions.

Overcoming these challenges requires multifaceted strategies, including ongoing employer education about the benefits of hiring individuals from diverse backgrounds. Highlighting success stories to demonstrate the positive outcomes of workforce reentry programs can further sway employers toward active engagement. Additionally, tailored outreach efforts, incentives for hiring program participants, and consistent support for both employers and participants can foster collaboration. The U.S. Department of Labor offers grants and programs, such as the Federal Bonding Program, to encourage employers to embrace reentry. The Federal Bonding Program assists employers in purchasing liability insurance to help remove the risks of hiring previously incarcerated or other challenged job seekers whose backgrounds may pose significant barriers to securing or retaining employment.

Nursing Involvement with Workforce Reentry Programs

Nursing plays a pivotal role in workforce reentry programs, contributing a unique blend of clinical expertise and compassionate support to individuals navigating the challenges of returning to employment after periods of absence. As advocates for holistic well-being, nurses offer vital contributions to these programs by addressing participants' physical and mental health needs, ensuring seamless coordination of care, and fostering an environment of understanding and encouragement. Through their skills in health assessment, counseling, and collaboration with interdisciplinary teams, nurses play a vital role in enhancing participants' overall success and well-being during their reintegration journey.

Interventions and Needs

Nursing interventions play a pivotal role in the success of workplace reentry programs for individuals with mental health conditions. Here is a list of potential nursing interventions for nurses working with clients involved in these programs:

- Health assessment: Conduct comprehensive health assessments to identify any physical or mental health issues that might impact clients' ability to engage in employment. Address any immediate health concerns, and develop strategies for ongoing health management.
- Medication management: Collaborate with health-care providers to ensure proper medication management, monitor potential side effects, and address any medication-related concerns that might affect participants' work performance.
- Counseling and support: Provide individual and group counseling sessions to address participants' emotional and psychological needs. Offer coping strategies, stress management techniques, and emotional support to enhance their readiness for employment.
- Wellness education: Offer education on various aspects of wellness, including stress reduction, nutrition, exercise, and sleep hygiene, to promote participants' overall well-being. Educate participants on self-care practices to maintain their mental and physical well-being while managing the demands of work and reentry.
- Substance misuse education: Deliver education on substance misuse prevention, relapse prevention strategies, and resources available for clients struggling with substance misuse issues.
- Crisis intervention: Be prepared to provide immediate crisis intervention and support in case participants experience setbacks or relapses during their reentry process.
- Collaboration with mental health professionals: Collaborate with other mental health professionals to ensure a comprehensive approach to clients' mental health needs.
- Stigma reduction: Educate clients and employers about mental health and substance use challenges, working to reduce stigma and misconceptions that might affect clients' employment prospects.
- Referrals and resource navigation: Assist participants in accessing community resources, such as housing assistance, childcare services, and support groups, to address various barriers to reentry.
- Workplace accommodations: Collaborate with employers to recommend workplace accommodations, if necessary, to support participants' mental health needs and ensure a successful work experience.
- Health monitoring and follow-up: Provide ongoing health monitoring and follow-up appointments to assess participants' progress, address any emerging health concerns, and offer continued support.
- Conflict resolution skills: Offer training in conflict resolution and communication skills, helping participants

effectively navigate workplace interactions and challenges.

Community Collaboration

Nursing and community collaboration within the context of workforce reentry programs helps reintegration efforts. Nurses act as liaisons, connecting participants with community-based services, such as mental health counseling, substance misuse support groups, housing assistance, and vocational training opportunities. Their clinical insights enable them to identify participants' unique needs and provide holistic care that addresses both physical and mental health concerns.

Community organizations offer a range of supplementary resources that reinforce the efforts of workforce reentry programs, such as job placement agencies, legal assistance, and financial counseling. This teamwork enables clients to receive a comprehensive support system that extends beyond health care to encompass social, economic, and emotional aspects crucial for successful reintegration. The collaboration also contributes to destigmatizing mental health problems, fostering a more inclusive environment that encourages participation and acceptance. Ultimately, nursing and community collaboration in workforce reentry programs facilitates a holistic approach that empowers individuals to overcome barriers, enhance their well-being, and secure a meaningful place in both the workforce and society.

Summary

25.1 Identifying Varying Types of Care

Community-based mental health services help to improve the overall mental health and well-being of communities. Community mental health offers services that vary according to the needs of the individual client. These needs can be affected by such factors as age, socioeconomic status, or severity of illness and include counseling, therapy, medication management, day programs, residential services, crisis programs, and more. Nurses should assess their clients thoroughly to determine their needs and preferences and develop a treatment plan that best integrates the two.

25.2 Community Needs

The mental health client in a community environment will have both physical and social-emotional needs that have to be addressed in a holistic manner. Physical needs include secure housing, health care, food, transportation, and potential work accommodations. Social-emotional needs are important as well and include emotional support, social belonging, empowerment, and coping and emotional regulation skills. The nurse should help the client develop a care plan that takes into account their own particular physical and social-emotional needs and available community resources in order to achieve the best results possible.

25.3 Programming in Community and Treatment Settings

The goal of community-based programs is to offer a safe, nonjudgmental space for individuals to share their experiences, connect with others who have similar experiences, and receive emotional support within their own communities. The goal of treatment setting programs is to provide a safe and supportive environment for individuals experiencing acute or severe mental health symptoms. Evaluating the appropriateness of using either a community-based program or a more secure treatment setting program entails a thorough nursing assessment and a treatment plan that respects the client's individual needs and preferences and prioritizes safety.

25.4 Workforce Reentry Programs

A workforce reentry program is a structured initiative designed to support individuals as they transition back into the workforce after a period of absence. Some of the challenges faced by workforce reentry programs include overcoming stigma and bias, navigating participants' skill gaps and the fast-changing job market, coordinating comprehensive support services, such as mental health care and housing assistance, securing sustainable funding, and fostering collaboration with employers. Benefits of these programs include providing individuals with the opportunity to acquire new skills, secure stable employment, reduce recidivism rates, and achieve financial independence, ultimately fostering community reintegration and economic growth. The psychiatric-mental health nurse can support workforce reentry programs to benefit clients by conducting thorough mental health assessments, implementing evidence-based interventions, collaborating with community resources to provide holistic support, and offering tailored coping strategies and skills development.

Key Terms

Assertive Community Treatment (ACT) model of care that provides individualized support for clients in the community to help prevent relapse and recidivism and support recovery

community mental health mental health treatment and activities that occur outside of an institution

community mental health center health-care center that targets medically underserved populations in specific communities, also known as Federally Qualified Health Centers

emotional regulation ability to recognize, understand, and regulate one's emotions in a healthy and adaptive way

food insecurity limited or inconsistent access to the amount of food required to live a healthy lifestyle

group housing type of small-scale living facility that, in addition to housing, provides support, supervision, and other types of assistance

home visiting service providing mental health care that is personalized, convenient, and tailored to the client's needs within the comfort of their own home environment, promoting early intervention, treatment adherence, and overall well-being

individualized education program (IEP) student-specific document that outlines the learning plan for public school students who qualify for special education

intensive outpatient program (IOP) type of community care that provides structure and support for clients in a community setting, allowing them to receive intensive treatment without the disruption of hospitalization

social belonging feeling of being connected to and valued by others

workforce reentry program structured initiative designed to support individuals as they transition back into the workforce after a period of absence

Assessments

Review Questions

1. What are examples of types of community care? Select all that apply.
    a. intensive outpatient program (IOP)
    b. family-focused
    c. partial hospitalization program (PHP)
    d. hospital admission

2. Graciela is a sixty-three-year-old woman who recently became the primary caregiver for her husband who had a stroke. She tells her husband's nurse that she has been feeling lonely and sad lately and that none of her friends seem to understand what she is going through. What community resource would best benefit Graciela?
    a. the local food pantry
    b. a rideshare service so the client can get to church
    c. a social worker who can assist with subsidized housing
    d. a support group for adult caregivers

3. What is one of the main mental health challenges currently facing the young adult population?
    a. developmental delays
    b. an increase in comorbidities
    c. polypharmacy
    d. transitional challenges

4. Nurse Tuan worked with a client three weeks ago to get them set up with a community-based mental health-care treatment plan to help with the client's diagnosis of major depressive disorder. Tuan decides to make a follow-up call to the client to ask them how they're doing. What step in the nursing process does Tuan's action represent?
    a. assessment
    b. evaluation
    c. implementation
    d. planning

5. Mr. Jones is a recovering alcoholic with a recent suicide attempt. He has been discharged from the treatment setting after a ten-day stay, and the social worker is setting up housing for him. Which type of housing is most appropriate for Mr. Jones?
    a. detoxification unit
    b. nursing home
    c. group housing
    d. homeless shelter

6. What term refers to the level of choice, influence, and control that users of mental health services can exercise over events in their lives?
    a. Emotional regulation
    b. Empowerment
    c. Mutual negotiation
    d. Self-determination

7. Mrs. Rodriguez, a sixty-year-old female, is struggling with an addiction to alcohol. What community services could support Mrs. Rodriguez?
    a. state hospitalization for suicidal thoughts
    b. family support group
    c. community program for substance use
    d. Narcotics Anonymous

8. Terrell is a thirty-two-year-old male client who was just diagnosed with bipolar disorder and alcohol abuse disorder. He does not meet criteria for hospital admission and is currently able to work and safely care for himself at home. He is also on a new medication regimen that will need frequent lab draws and adjustments for the first several weeks. What is the best setting for treatment for Terrell?
    a. a halfway house
    b. an intensive community (outpatient) program (IOP)
    c. a residential treatment center (RTC)
    d. Narcotics Anonymous (NA)

9. The client asks the nurse about the goal of treatment mental health programs. What would the nurse tell them?
    a. "The goal is to transition someone from treatment setting care to complete independence as quickly as possible."
    b. "The goal is to provide safe, structured, and supportive care for people with mental health symptoms who can benefit from frequent treatment monitoring."
    c. "The goal is to serve as a permanent home for the chronically mentally ill who can't exist out in the community."
    d. "The goal is to provide close monitoring for clients who are a threat to themselves or others."

10. Mr. Dilip is a forty-nine-year-old male who has been out of work for six years due to substance use issues. He wants to rejoin the workforce in his previous career as a woodworker. What type of workforce reentry programs would most directly benefit this client?
    a. peer support program
    b. entrepreneurship program
    c. mental health integration program
    d. vocational rehabilitation program

11. What is one of the main challenges faced by workforce reentry programs?
    a. an excess of employers who are eager to work with clients
    b. a lack of evidence-based practice (EBP) demonstrating their effectiveness
    c. lack of consistent funding
    d. too many resources that can cause confusion for clients

Check Your Understanding Questions

1. Explain how you can determine the most appropriate type of community mental health care for your client.
2. Mrs. Smith has been suffering from chronic depression for the last three years. What types of physical issues might Mrs. Smith be most at risk for?
3. John is a sixteen-year-old student who has been experiencing anxiety and depression. He shares with the school nurse that he has had thoughts of harming himself. What resource is most important for the nurse to provide and why?
4. What are the benefits of community-based support groups?
5. What are the benefits of nursing and community collaboration within the context of workforce reentry programs?

Reflection Questions

1. Why is evaluating childhood developmental milestones so important to mental health care?
2. Mr. Nguyen has a nephew who is struggling with anxiety. How would Mr. Nguyen find a support group specific to his nephew's needs?
3. Why is it so important to assist individuals who have endured a sustained absence from the workforce due to mental illness, substance misuse, and/or incarceration as they attempt to reenter the workforce?

What Should the Nurse Do?

Ryan, a forty-five-year-old male, presents to the community health clinic with complaints of persistent sadness, sleep disturbances, and a decline in social interactions. His medical history reveals a past diagnosis of major depressive disorder, managed with intermittent community therapy. Vital signs are blood pressure of 115/80 mmHg, heart rate of 93 bpm, respiratory rate of 20 breaths per minute, and temperature of 98.4°F (37°C). Ryan reports a recent exacerbation of depressive symptoms, including difficulty concentrating and a sense of hopelessness. He describes challenges in maintaining employment and strained relationships with family and friends. He mentions intermittent suicidal thoughts but denies any current intent. Ryan has a history of limited success with traditional community therapy and expresses openness to exploring alternative mental health-care options.

1. What specific verbal and nonverbal cues did Ryan exhibit that led you to recognize the need for a reassessment of his mental health-care plan?
2. Considering Ryan's openness to alternative mental health-care options, what solutions would you generate to address his current symptoms and treatment challenges?

Grace, a thirty-eight-year-old female, arrives at the mental health community clinic with reported symptoms of anxiety and difficulty coping with stress. Her medical history includes a previous diagnosis of generalized anxiety disorder. Vital signs are blood pressure of 110/82 mmHg, heart rate of 80 bpm, respiratory rate of 16 breaths per minute, and temperature of 98°F (36.9°C).

Grace describes persistent worries, intrusive thoughts, and physical symptoms, such as muscle tension and fatigue. She reports challenges in managing her emotions and maintaining healthy social relationships. Grace expresses a desire for a holistic approach to mental health care that considers both physical and emotional aspects of her well-being.

3. What specific cues in Grace's presentation indicated the need for a holistic approach to mental health care in the community setting?
4. After suggesting solutions that include stress-reduction techniques, exercise plans, nutritional counseling, support group enrollment, and cognitive behavioral therapy, what specific indicators would you monitor to evaluate the effectiveness of the holistic mental health-care plan for Grace, and how frequently would you assess these outcomes?

Calvin, a twenty-eight-year-old male, presents at the community mental health clinic with symptoms of severe depression, isolation, and suicidal ideation. His medical history includes a previous diagnosis of major depressive disorder and a suicide attempt six months ago. Vital signs are blood pressure of 140/80 mmHg, heart rate of 105 bpm, respiratory rate of 20 breaths per minute, and temperature of 98.7°F (37°C). Calvin describes persistent feelings of hopelessness, difficulty concentrating, and a sense of social withdrawal. He reports challenges in maintaining employment and severed connections with family and friends. Calvin is torn between seeking community support groups and considering treatment setting mental health programs due to the severity of his symptoms.

5. How should a nurse analyze the potential impact of Calvin's elevated blood pressure and slightly elevated heart rate on his mental health presentation and the decision-making process between community and treatment setting programs?
6. How would a nurse generate solutions to address both the immediate safety concerns and the long-term mental health support needs of Calvin?

Rita, a forty-two-year-old female, seeks assistance at the community mental health clinic for anxiety, depression,

and a history of substance use disorder. Her medical history includes a previous successful career in marketing, interrupted by a period of substance misuse. Vital signs are blood pressure of 110/75 mmHg, heart rate of 78 bpm, respiratory rate of 15 breaths per minute, and temperature of 99°F (37.2°C). Rita expresses a desire to reenter the workforce but struggles with anxiety related to the stigma associated with her mental health and substance use history. She reports difficulties concentrating and low self-esteem, hindering her ability to pursue new employment opportunities. Rita recognizes the importance of workforce reentry programs and is motivated to rebuild her professional life.

7. What specific actions would you take to connect Rita with appropriate support groups, vocational training, and counseling services, ensuring a comprehensive approach to her workforce reentry?
8. How would you evaluate the outcomes of Rita's participation in workforce reentry programs, and what indicators would suggest success or the need for adjustments to the care plan?

Competency-Based Assessments

1. Use various sources to research community mental health resources in your area. Discuss how these services target specific populations in the area. Identify any populations that are underserved or who might be in need of services that are currently not offered.
2. Develop a ten-minute presentation defining community mental health and how it contributes to better client outcomes.
3. Find three to five sources of evidence-based research on the benefits of empowerment for good mental health. Discuss the purpose of empowerment, how it benefits mental health clients, and ways to promote it at the community mental health level.
4. Research and create a list of local community support groups that might be beneficial for people dealing with mental health issues. Discuss the process of finding the different support groups.

References

Agency for Healthcare Research and Quality. (2021). *Health Care Innovations Exchange*. https://www.ahrq.gov/innovations/index.html

Al-Anon Family Groups Headquarters, Inc. (n.d.-a). *Resources for professionals*. https://al-anon.org/resources-for-professionals/

Al-Anon Family Groups Headquarters, Inc. (n.d.-b). *Who are Al-Anon members?* https://al-anon.org/

Alcoholics Anonymous World Services, Inc. (2023). *Alcoholics anonymous*. https://www.aa.org/

American Hospital Association. (2022, February 2). *AHA house statement: America's mental health crisis February 2, 2022*. Retrieved March 6, 2023, from https://www.aha.org/2022-02-03-aha-house-statement-americas-mental-health-crisis-february-2-2022

American Psychological Association (APA). (2018). *APA dictionary of psychology*. https://dictionary.apa.org/

American Public Health Association (APHA), Public Health Nursing Section. (2013). *The definition and practice of public health nursing*. https://www.apha.org/~/media/files/pdf/membergroups/phn/nursingdefinition.ashx

Association of Public Health Nurses. (2022). *What is a PHN?* Retrieved March 19, 2023, from https://www.phnurse.org/what-is-a-phn-

Baumann, A. (2011). The WHO-EC partnership project on empowerment in mental health. European Psychiatry, 26(S2), 2101–2101. http://doi.org/10.1016/S0924-9338(11)73804-4

Bruckner, T. A., Singh, P., Snowden, L. R., Yoon, J., & Chakravarthy, B. (2019, July). Rapid growth of mental health services at community health centers. *Adm Policy Ment Health*, *46*(5), 670–677. https://doi.org/10.1007/s10488-019-00947-w.

Centers for Disease Control and Prevention (CDC). (2011). *Mental health awareness*. https://archive.cdc.gov/#/details?url=https://www.cdc.gov/genomics/resources/diseases/mental.htm

Centers for Disease Control and Prevention (CDC). (2020, May 06). *Heart disease and mental health*. https://www.cdc.gov/heartdisease/mentalhealth.htm#print

Centers for Disease Control and Prevention (CDC). (2021, June 28). *About mental health*. https://www.cdc.gov/mentalhealth/learn/

Centers for Disease Control and Prevention (CDC). (2022a, April 19). *Anxiety and depression in children*. https://www.cdc.gov/childrensmentalhealth/depression.html#anxiety

Centers for Disease Control and Prevention (CDC). (2022b, November 16). *Children's mental disorders*. https://www.cdc.gov/childrensmentalhealth/symptoms.html

Centers for Disease Control and Prevention. (2022c, September 13). *Mental health*. https://www.cdc.gov/mentalhealth/

Child Welfare Information Gateway. (2021, April). *In-home services to strengthen children and families*. https://www.childwelfare.gov/pubs/issue-briefs/inhome-services/.

Division of Adolescent and School Health, (2023, December 6). *Mental health*. https://www.cdc.gov/healthyyouth/mental-health/index.htm

Gross, G. M., Smith, N., Holliday, R., Rozek, D. C., Hoff, R., & Harpaz-Rotem, I. (2022). Racial disparities in clinical outcomes of veterans affairs residential PTSD treatment between black and white veterans. *Psychiatric Services*, *73*(2), 126–132. https://doi.org/10.1176/appi.ps.202000783

Individuals with Disabilities Education Act, 20 U.S.C. § 300 (2004). https://sites.ed.gov/idea/

Khodyakov, D., Sharif, M. Z., Jones, F., Heller, S. M., Pulido, E., Wells, K. B., & Bromley, E. (2018, September 6). Whole person care in under-resourced communities: Stakeholder priorities at long-term follow-up in community partners in care. *Ethn Dis*, *28*(Suppl 2), 371–380. https://ethndis.org/supplementarchive/files/ethndis-28-371.pdf

McCarty, D., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Substance abuse intensive outpatient programs: assessing the evidence. *Psychiatric Services*, *65*(6), 718–726. https://doi.org/10.1176/appi.ps.201300249

Narcotics Anonymous World Services, Inc. (2023). *About us*. https://www.na.org/

National Alliance on Mental Illness (NAMI). (2022). *NAMI helpline*. https://www.nami.org/help

National Alliance on Mental Illness (NAMI). (2023a). *Finding stable housing*. https://www.nami.org/Your-Journey/Individuals-with-Mental-Illness/Finding-Stable-Housing

National Alliance on Mental Illness (NAMI). (2023b). *NAMI connection*. https://www.nami.org/Support-Education/Support-Groups/NAMI-Connection

National Alliance on Mental Illness (NAMI). (2023c). *NAMI national helpline resource directory*. *https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/2021-Resource-Directory.pdf*

National Alliance on Mental Illness (NAMI). (2023d). *Social determinants of health: Food security*. https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Food-Security

National Alliance on Mental Illness (NAMI). (2023e). *Succeeding at work*. https://www.nami.org/Your-Journey/Individuals-with-Mental-Illness/Succeeding-at-Work

National Alliance on Mental Illness (NAMI). (2023f). *Telehealth*. https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Telehealth

National Alliance on Mental Illness (NAMI). (2024). *Mental health treatment while incarcerated*. https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated

National Alliance on Mental Illness. (n.d.). *Re-entry post incarceration.* https://nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Re-entry-Post-Incarceration

National Alliance to End Homelessness. (2016, October 19). *Mental health reform overview and talking points*. https://endhomelessness.org/resource/mental-health-reform-overview/

National Alliance to End Homelessness. (2023, December). *Health*. https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/

National Institute on Drug Abuse. (2020). *Substance use in older adults drugfacts*. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts

National Institute on Mental Health (NIMH). (2021). *Chronic illness and mental health: Recognizing and treating depression*. https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

National Institutes of Health. (2020). *Substance use in older adults drugfacts*. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts

New York City Department of Homeless Services, Department of Social Services. (n.d.). *Center for urban community services*. Retrieved March 7, 2023, from https://www.nyc.gov/site/dhs/shelter/providers/center-for-urban-community-services.page

New York Office of Mental Health. (2023). *Mental health outpatient treatment and rehabilitative services based intensive outpatient program guidance*. https://omh.ny.gov/omhweb/clinic_restructuring/docs/clinic-iop-guidance.pdf

Project Launch. (2023). *Opportunities in home visiting programs for improving mental health*. Retrieved March 19, 2023, from https://www.caprojlaunch.org/mental-health-and-home-visiting/

QSEN Institute. (n.d.) QSEN Competencies. https://www.qsen.org/competencies-pre-licensure-ksas

Robbins, B., Rye, R., German, P. S., Tlasek-Wolfson, M., Penrod, J., Rabins, P. V., & Black, B. S. (2000). The psychogeriatric assessment and treatment in city housing (PATCH) program for elders with mental illness in public housing: Getting through the crack in the door. *Archives of Psychiatric Nursing*, *14*(4), 163–172. https://doi.org/10.1053/apnu.2000.8653

State of California Board of Registered Nursing (BRN). (2019). *General instructions and application requirements for Public Health Nurse (PHN) certification. https://www.rn.ca.gov/pdfs/applicants/phn-instruct.pdf*

Substance Abuse and Mental Health Services Administration. (2013). *Community conversations about mental health: Information brief*. HHS Publication No. SMA-13-4763. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4763.pdf

Substance Abuse and Mental Health Services Administration. (2019). *Older adults living with serious mental illness*. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf

Substance Abuse and Mental Health Services Administration. (2022a, April 21). *Person- and family-centered care and peer support*. Retrieved March 6, 2023, from https://www.samhsa.gov/section-223/care-coordination/person-family-centered

Substance Abuse and Mental Health Services Administration. (2022b). *Project AWARE*. https://www.samhsa.gov/school-campus-health/project-aware

Substance Abuse and Mental Health Services Administration. (2022c, April 21). *Transforming lives through supported employment (SE) program*. https://www.samhsa.gov/criminal-juvenile-justice/grant-grantees/transforming-lives-through-supported-employment-program

Substance Abuse and Mental Health Services Administration. (2023a, April 24). *Certified community behavioral health clinics (CCBHCs)*. https://www.samhsa.gov/certified-community-behavioral-health-clinics

Substance Abuse and Mental Health Services Administration. (2023b, June 9). *Mental health and substance use disorders*. https://www.samhsa.gov/find-help/disorders

Substance Abuse and Mental Health Services Administration. (n.d.). *The lifeline and 988*. https://988lifeline.org/current-events/the-lifeline-and-988/

Terlizzi, E. P., & Schiller, J. S. (2022, September). *NCHS Data Brief, Number 444: Mental health treatment among adults aged 18–44: United States, 2019–2021*. https://www.cdc.gov/nchs/data/databriefs/db444.pdf

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., Dale, O., Haigh, R., Moran, P., McNicholas, S., Nicholls, V., Foye, U., Simpson, A., Lloyd-Evans, B., Johnson, S., & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: A co-produced qualitative interview study. *BMC Psychiatry*, *22*(1). https://doi.org/10.1186/s12888-021-03605-4

U.S. Department of Health and Human Services. (2021a, August 26). *Social wellness toolkit*. National Institutes of Health. Retrieved March 8, 2023, from https://www.nih.gov/health-information/social-wellness-toolkit

U.S. Department of Health and Human Services. (2021b). *Children and mental health: Is this just a stage?* National Institute of Mental Health. Retrieved March 7, 2023, from https://www.nimh.nih.gov/health/publications/children-and-mental-health

U.S. Department of Health and Human Services. (2022a, January). *Mental illness*. National Institute of Mental Health. Retrieved March 7, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness

U.S. Department of Health and Human Services. (2022b, June). *Mental health medications*. National Institute of Mental Health. https://www.nimh.nih.gov/health/topics/mental-health-medications

U.S. Department of Health and Human Services. (2022c, August 8). *Emotional wellness toolkit*. National Institutes of Health. Retrieved March 8, 2023, from https://www.nih.gov/health-information/emotional-wellness-toolkit

U.S. Department of Health and Human Services. (2022d). *Conversations in your community*. https://www.mentalhealth.gov/talk/community-conversation

U.S. Department of Labor. (n.d.-a). *Job Corps*. https://www.dol.gov/general/topic/training/jobcorps

U.S. Department of Labor. (n.d.-b). *Reentry Employment Opportunities: About*. https://www.dol.gov/agencies/eta/reentry/about

Workforce GPS. (n.d.). *Welcome to WorkforceGPS*. https://www.workforcegps.org/

Youth.gov. (n.d.-a). *School based mental health*. Retrieved March 20, 2023, from https://youth.gov/youth-topics/youth-mental-health/school-based#_ftn

Youth.gov. (n.d.-b). *Mental health promotion and prevention*. Retrieved March 7, 2023, from https://youth.gov/youth-topics/youth-mental-health/mental-health-promotion-prevention

CHAPTER 26
Adjuncts to Treatments

FIGURE 26.1 Community-based programs approach mental health treatment from a cooperative perspective. (credit: "Compassion" by Sonya Revell/flickr, Public Domain)

CHAPTER OUTLINE

INTRODUCTION Recovery from mental illness is often a prolonged and complex journey, significantly challenged by access and adherence to treatment. These obstacles include stigma and discrimination, limited geographic access to services, a shortage of health-care professionals, financial constraints, insufficient support, and nonadherence to treatment protocols. Despite these complications, the integration of adjunctive treatments alongside conventional methods can enhance recovery outcomes and foster greater treatment compliance.

Nurses play a crucial role in this integrative approach to care. Nurses in collaboration with other health-care professionals contribute to the implementation of adjunctive treatments. Their responsibilities in this context encompass a range of activities, including client education, monitoring treatment adherence, providing emotional support, and facilitating access to various therapeutic interventions. Nurses are often the primary point of contact for clients, which positions them uniquely to assess client needs, offer guidance on managing side effects, and advocate for individualized care plans that incorporate adjunctive therapies. These therapies might include psychotherapy, lifestyle modifications, and complementary therapies, all of which can be instrumental in addressing the holistic needs of individuals with mental illness. By actively participating in the delivery of adjunctive treatments, nurses can help reduce the barriers to recovery and promote a more comprehensive, client-centered approach to mental health care that improves overall client outcomes and quality of life (Mongelli et al., 2020).

26.1 Barriers to Recovery

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Recognize barriers to recovery from mental illness
- Discuss adjunctive treatments for recovery
- Explain the nurse's role in adjunctive treatment

Many factors can hinder the recovery process for individuals with mental illness. One significant barrier is stigma, which refers to the negative attitudes, beliefs, and stereotypes associated with mental health conditions. Stigma can lead to discrimination, social isolation, and reduced access to health-care services, impeding individuals from seeking help and adhering to treatment. Lack of access to quality mental health care, including shortages of mental health professionals, particularly in certain geographic regions, limited availability of specialized services, and financial constraints pose additional barriers. Systemic barriers also exist, such as inadequate insurance coverage, fragmented health-care systems, and long waiting periods for treatment that can further slow the recovery journey. Personal factors like low self-esteem, poor self-efficacy, and lack of social support likewise can impede recovery. Nurses must remain aware of the influence of culture and religion on health-care decisions. Recognizing and addressing these barriers and factors is crucial for promoting recovery and improving the overall well-being of individuals with mental illness.

Challenges in Recovery

Primary care is often the initial access to mental health treatment and therefore plays a pivotal role in the provision of mental health services. Several challenges exist that complicate the effective and efficient delivery of these services. One of the main challenges is the underdiagnosis of mental health issues in primary care settings. Primary care practitioners may not have the necessary knowledge and skills to recognize and treat complex mental health issues. Additionally, time constraints and high client load can lead to mental health concerns being overlooked or minimized (Ng et al., 2020).

Another challenge lies within the referral system to secondary mental health services, which means specialist care or hospital admission. Fragmented health-care systems can complicate the process of referring clients, with often long waiting times for specialized services and gaps in communication between primary and secondary care providers (Evans-Lacko et al., 2018). This fragmentation creates access issues for clients in need of the services. It is the responsibility of the primary care practitioner to understand and properly refer the client with mental health concerns to the appropriate provider.

The stigma associated with mental illness also poses a barrier to care and can lead to clients not seeking or adhering to mental health treatments. Despite significant progress, many clients may still feel uncomfortable discussing mental health issues in a primary care setting or may fear the potential implications of a mental health referral (Thornicroft et al., 2016).

Lack of Compliance

Client compliance, also called adherence, is a critical factor in mental health-care treatment success, yet it presents a significant challenge in the management of mental illnesses. Nonadherence to psychiatric treatment has been estimated to be as high as 50 percent (Malik et al., 2020). Various factors can contribute to this issue, including the complexity of treatment regimes, medication side effects, lack of client insight into their illness, and poor therapeutic relationships with care providers (Malik et al., 2020).

The negative impact of nonadherence on treatment outcomes, including relapses and hospitalizations, adds to the complexity and costs of managing mental health conditions (Velligan et al., 2017). Strategies to improve adherence can be multifaceted, encompassing client education, treatment simplification, side effects management, therapeutic collaboration enhancement, and stigma reduction programs (Velligan et al., 2017).

Residual Symptoms, Side Effects, and Stigma

Psychiatric medications are pivotal in managing mental illnesses but may not entirely alleviate symptoms. Some individuals may experience residual symptoms while adhering to their medication regimen. Such **residual symptoms**, including persistent depressive mood, anxiety, cognitive deficits, and insomnia, can severely affect an

individual's quality of life and functionality (Semahegn et al., 2020) and can lead to clients discontinuing treatment.

Medication side effects are another significant concern in psychiatric treatment, often contributing to residual symptomatology. These side effects may include metabolic changes, sexual dysfunction, or neurological effects, which can compound individuals' challenges with mental health conditions (Montejo et al., 2018).

The stigma associated with taking psychiatric medications can exacerbate these challenges. Many individuals feel societal pressure and self-stigma associated with the need for psychiatric medication, which can lead to feelings of inadequacy, shame, and isolation. This stigma can have far-reaching consequences, impacting adherence to medication, social relationships, self-esteem, and overall treatment outcomes (Malik et al., 2020). Stigma associated with mental illness is a pervasive issue that has manifested in various ways across societies. Historically, mental illness has been misunderstood, leading to fear, misconceptions, and negative attitudes toward those experiencing mental health challenges. This stigma manifests in society through discrimination, social exclusion, and harmful stereotypes, which can impede individuals' willingness to seek help and receive appropriate care. Stigma exists due to a combination of factors, including lack of education, cultural beliefs, and media portrayals that often depict mental illness inaccurately or negatively (Subu et al., 2021).

In a cultural context, the perception and impact of stigma vary widely. Different cultures have unique beliefs and attitudes toward mental health, which influence how individuals perceive and respond to mental illness. Understanding these cultural considerations is essential for health-care providers, particularly nurses, who are often at the forefront of client care and advocacy. Nurses must be aware of the cultural nuances that influence their clients' experiences of stigma and tailor their approach to care accordingly. Culturally sensitive care involves acknowledging and respecting clients' beliefs, values, and experiences, and engaging in open, nonjudgmental communication to build trust and rapport (Ahad et al., 2023).

A more holistic approach to mental health care can help mitigate symptoms and stigma. Such an approach includes medication management, psychoeducation, psychotherapy, addressing lifestyle factors, and reducing perceived shame in securing treatment for mental health conditions. It also involves close collaboration between clients, health-care providers, and caregivers in shared decision-making processes (Laranjeira et al., 2023).

CULTURAL CONTEXT

Cultural Considerations in Mental Health Recovery and Adjunct Treatment

Cultural factors play a significant role in shaping the experiences and perceptions of individuals in mental health recovery and receiving adjunct treatments. Understanding these cultural nuances is crucial for health-care providers to deliver effective and compassionate care:

- Beliefs and attitudes toward mental illness: Different cultures have distinct beliefs about mental illness, influencing how individuals perceive and respond to mental health challenges. For example, some cultures may view mental illness as a spiritual or moral issue, while others might see it as a medical condition. Recognizing and respecting these beliefs is essential in providing culturally sensitive care.
- Stigma and discrimination: Stigma surrounding mental illness varies across cultures and can significantly impact a person's willingness to seek help and adhere to treatment. In some cultures, mental illness may be heavily stigmatized, leading to social exclusion and discrimination. Health-care providers need to be aware of these cultural dynamics and work to reduce stigma in their interactions with clients.
- Communication styles: Cultural differences in communication styles can affect how clients express their symptoms and concerns. Providers should be attentive to nonverbal cues and understand the cultural context of verbal communication. Open, empathetic, and nonjudgmental communication is crucial in building trust with clients from diverse cultural backgrounds.
- Family and community involvement: In many cultures, family and community play a central role in supporting individuals with mental illness. Understanding the client's family dynamics and community resources can enhance treatment plans and recovery outcomes. Involving family members in care planning and education can also improve treatment adherence and support.
- Holistic and integrative approaches: Different cultures may have unique approaches to health and healing that

can complement conventional mental health treatments. Traditional healing practices, herbal remedies, and spiritual interventions may be integral to the client's belief system and can be considered in adjunctive treatment plans, where appropriate.
- Language and interpretation services: Language barriers can impede effective communication and understanding between health-care providers and clients. Providing access to interpretation services and culturally appropriate educational materials is crucial for ensuring that clients fully comprehend their treatment options and can make informed decisions.

Health-care providers must continually strive to develop culturally sensitive care, which involves understanding and respecting cultural differences, engaging in continuous learning about diverse cultures, and applying this knowledge in clinical practice (Stubbe, 2020).

Access to Care and Need for Support

Despite the high prevalence and profound impact of mental health disorders, access to mental health care remains a significant challenge globally. Barriers to accessing care can be multifaceted, encompassing systemic issues, such as insufficient mental health resources, geographical distance from services, long wait times, and high costs, especially in regions with limited public health coverage (Werlen et al., 2020). Marginalized groups, including racial and ethnic minorities, low-income populations, and individuals in rural areas, face additional challenges in accessing mental health care due to systemic disparities (Subu et al., 2021).

Client support is integral to overcoming these barriers and improving mental health outcomes. Support can take many forms, such as providing client education, promoting mental health literacy, fostering a supportive therapeutic alliance, and engaging in shared decision-making (Aoki et al., 2022). Peer support groups can also be beneficial, cost-effective, and accessible, providing an environment of mutual understanding and empathy, sharing personal experiences and coping strategies, and reducing feelings of isolation (Bellamy et al., 2020).

Nurses play a crucial role in addressing systemic barriers to mental health care by advocating for policy reform, access to affordable services, and the reduction of stigma and discrimination associated with mental illness (Thornicroft et al., 2016). Nurses can influence mental health policy by participating in professional organizations, engaging with policymakers, and contributing to public discourse on mental health issues. For example, they can advocate for increased funding for mental health services, integration of mental health care into primary care settings, and policies that support evidence-based practices (Anders, 2021). Nurses can advocate for policies that ensure access to affordable mental health care for all individuals, regardless of their socioeconomic status. This includes supporting the expansion of insurance coverage for mental health services and advocating for enhanced mental health services in health-care coverage (Flaubert et al., 2021). Nurses can also help combat stigma associated with mental illness through education, community outreach, and by modeling compassionate, nonjudgmental care. They can also participate in public awareness campaigns and collaborate with advocacy groups to challenge myths and misconceptions about mental illness (Borenstein, 2020).

Ease of access to mental health care is a crucial factor in ensuring effective treatment and recovery. Several services and resources have been developed to address physical barriers to accessing mental health care. Telehealth services have emerged as a vital tool in providing mental health care, especially in areas with limited access to mental health professionals. Telehealth involves the use of telecommunications technologies to deliver health-related services and information. It allows clients to receive therapy, counseling, and psychiatric services remotely, which can be particularly beneficial for those living in rural or underserved areas (Gajarawala & Pelkowski, 2021). Moreover, community-based mental health services are designed to be more accessible and less stigmatizing than traditional psychiatric settings. These services often include community clinics, day treatment programs, peer support groups, and crisis intervention teams. Community-based services focus on providing comprehensive care tailored to the individual's needs within their community, promoting recovery and integration into society (Singh et al., 2022). The internet also offers a wealth of online resources for mental health support, including informational websites, online support groups, and mental health apps. These resources can provide education, self-help tools, and peer support, making mental health information and support more accessible to a broader audience. Online resources can be particularly useful for individuals who are hesitant to seek face-to-face therapy or who prefer anonymity (Wong et al., 2018).

Adjunctive Modalities

Traditional treatment modalities for mental health conditions include psychotherapy and medication. Psychotherapy is a cornerstone in the treatment of mental illness, often used in conjunction with pharmacological interventions for optimal outcomes (Cook et al., 2017). This therapeutic approach involves talking with a mental health professional to understand and manage mental health conditions, with various types of psychotherapy suited to different mental disorders (American Psychological Association [APA], 2021). In mental health care, **adjunctive treatments** comprise a range of alternative treatments designed to enhance the impact of primary treatments, improving overall mental health outcomes (Lake, 2022). Some of these modalities include mindfulness-based therapies, biofeedback, art therapy, music therapy, animal-assisted therapy, and yoga (de Bruin et al., 2016).

For instance, mindfulness-based therapies have been shown to reduce symptoms of depression and anxiety and improve quality of life (Bhattacharya & Hofmann, 2023). Similarly, studies have found biofeedback to be effective in managing stress and anxiety disorders by giving clients a greater awareness of their physiological functions (Yu et al., 2018). Biofeedback is a therapeutic technique used in mental health care that involves training individuals to improve their health by controlling certain physiological processes that are typically involuntary, such as heart rate, muscle tension, blood pressure, skin temperature, and brain wave activity. In mental health care, biofeedback is used to help clients learn how to regulate their body's responses to stress, anxiety, and other emotional states. By becoming aware of their physiological responses and learning techniques to control them, clients can develop better coping mechanisms for managing symptoms of various mental health conditions (Mayo Clinic, 2019).

Creative therapies, such as art and music therapy, can offer a nonverbal outlet for emotions and aid in expressing and exploring feelings. Engaging in music and art therapy can provide emotional expression, stress relief, and cognitive benefits. These therapies are used to help individuals cope with trauma and improve mental health (Shukla et al., 2022). Research has demonstrated that combining these adjunctive modalities with standard treatment approaches can result in more effective and holistic care, potentially leading to better client satisfaction, increased compliance, and improved therapeutic outcomes (Lake, 2022).

Nutrition and Activity

Nutrition and physical activity play significant roles in the treatment of mental illnesses and are often incorporated into comprehensive treatment plans. Certain nutritional supplements, including omega-3 fatty acids, vitamin D, and B vitamins, have been found to have positive effects on mood and cognitive function. A balanced diet rich in fruits, vegetables, whole grains, and lean proteins can also contribute to better mental health (Firth et al., 2020).

Physical activity likewise is a well-established adjunctive treatment for mental illnesses. Regular exercise has been shown to reduce symptoms of depression, anxiety, and stress and improve cognitive function (Mahindru et al., 2023). For instance, aerobic exercises, such as jogging, cycling, or swimming, have been found to stimulate the release of endorphins, serotonin, and norepinephrine, which can enhance mood and overall well-being (Basso & Suzuki, 2017). Yoga, which combines physical postures, breathing exercises, and meditation, has been shown to reduce symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD). It promotes relaxation, mindfulness, and overall well-being (Laplaud et al., 2023).

Integrating nutritional counseling and physical activity interventions into mental health treatment plans can benefit clients and improve outcomes. These approaches should be personalized to each individual's needs and abilities and should be used as additions to standard mental health treatments (Grajek et al., 2022). Quality sleep is also essential for mental health. Poor sleep can exacerbate mental health conditions, while good sleep hygiene can improve mood and cognitive function (Scott et al., 2021).

Behavioral, Peer, and Group Therapy

Behavioral therapy is a general term for treatment wherein the client partners with helping others to raise personal awareness of problematic behaviors. The goal of behavioral therapy, such as CBT, is to work toward further understanding and, ultimately, to modify the thoughts and feelings that drive the unwanted actions. Overall, the use of behavioral therapy in mental health treatment can be highly effective, but the specific modality and approach should be tailored to the individual's needs and specific mental health condition (APA, 2021).

Peer therapy is a valuable adjunct treatment for mental illness, offering unique benefits that complement individual therapy and medication. Peer therapy involves support from individuals who have lived experience with mental

illness, providing empathy, understanding, and practical advice based on personal experience. Peer therapy has been shown to enhance self-efficacy, empowerment, and engagement in the recovery process. It provides an opportunity for individuals to share coping strategies and learn from others' experiences in a nonjudgmental setting (Shalaby & Agyapong, 2020).

Group therapy, on the other hand, typically involves a trained therapist leading a group of individuals who share similar mental health challenges. Group therapy offers the benefits of shared experiences, peer support, and the opportunity to develop social skills in a safe environment. It can be particularly effective for conditions such as depression, anxiety disorders, and substance misuse because it allows individuals to see how others deal with similar challenges and to receive feedback on their own experiences. Both forms of therapy foster a sense of community and support, helping individuals feel less isolated in their experiences (Malhotra & Baker, 2022).

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN in Adjunctive Treatments for Mental Illness

Quality and Safety Education for Nurses (QSEN) underscores the importance of providing safe, effective, client-centered, timely, efficient, and equitable care. In the context of adjunctive treatments for mental illness, the following considerations should be taken into account:

- Client-centered care: It is crucial to respect the clients' unique experiences, values, and preferences. Collaborate with clients in developing their treatment plans, including adjunctive therapies, such as psychoeducation, cognitive behavioral techniques, or nutritional and physical interventions.
- Teamwork and collaboration: Nurses should actively communicate and collaborate with the multidisciplinary team. This collaboration ensures comprehensive care, incorporating the perspectives of psychiatrists, psychologists, occupational therapists, social workers, and dietitians.
- Evidence-based practice: Decisions about adjunctive treatments should be based on the best available evidence, clinical expertise, and client preferences. Stay informed about the latest research on the efficacy and safety of adjunctive therapies.
- Quality improvement: Regularly evaluate client outcomes and processes to identify areas of improvement. Use this information to refine treatment plans and protocols, aiming to enhance the safety and effectiveness of adjunctive treatments.
- Safety: Regularly assess clients for any risks or adverse effects related to adjunctive treatments. Monitor for any worsening symptoms, suicidal ideations, or adverse reactions to treatments. Maintain a safe and therapeutic environment.
- Informatics: Leverage health information technology to support client care, decision-making, and communication among the health-care team. Electronic health records can provide timely access to comprehensive client information, enhance coordination of care, and support monitoring client progress.

The Nurse's Role in Adjunctive Treatments

The nurse's role in mental health treatment, particularly adjunctive modalities, is multifaceted and integral to comprehensive care. As trained health professionals, with respect to adjunctive treatments, nurses can provide psychosocial interventions, client education, and care coordination (Hurley et al., 2022). For instance, nurses can facilitate treatment delivery during CBT by reinforcing the skills taught in therapy sessions, providing support, and encouraging adherence to homework assignments (Tanoue et al., 2018). Nurses may also lead psychoeducational sessions, providing clients and families with crucial information about the nature of mental illness, medication management, and coping strategies (Matsuda & Kohno, 2021). Additionally, nurses may teach about the risks associated with nonadherence to treatments, and how to manage crises.

Nurses assist with complementary interventions, such as mindfulness-based therapies, physical activity programs, and nutritional counseling. They may guide clients through relaxation exercises, assist in developing an exercise regimen, or provide dietary advice to improve overall wellness. Through these roles, nurses enhance the effectiveness of adjunctive treatments for mental illness, contributing to better client outcomes (Ee et al., 2020). Nurses also play a critical role in risk avoidance during adjunctive treatments for mental illness, ensuring that clients

are safe and well cared for. One of the key responsibilities of nurses is the ongoing assessment and monitoring of clients. Nurses must be vigilant in detecting any signs of adverse reactions to adjunctive treatments or changes in a client's mental status and promptly reporting these to the treating physician. They also monitor for suicidal or self-harm ideations, which could be exacerbated by certain mental health conditions, ensuring that preventive measures are taken, and the treatment team is promptly notified (Nawaz et al., 2021).

26.2 The Anti-psychiatry Movement

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss controversy about the practice of psychiatry and the *DSM*
- Identify calls for treatment/medical diagnostic framework reform
- Explain the nursing implications of the anti-psychiatry movement

The **anti-psychiatry movement** is a political/social movement and intellectual phenomenon that emerged in the 1960s as a public response to perceived injustices and inadequacies within the traditional psychiatric system. The movement, heavily influenced by figures such as R.D. Laing, Thomas Szasz, Franco Basaglia, Theodore Lidz, and Michel Foucault, questions the legitimacy of psychiatric diagnoses, the effectiveness of psychiatric medications and treatments, and the overall influence of psychiatry on society (Desai, 2005). It raises ethical concerns around involuntary commitment, restraints, and forced medication, asserting that these practices can infringe upon individuals' basic human rights (Benning, 2016). While the anti-psychiatry movement has faced criticism for its radical perspectives, it has also inspired meaningful changes, such as enhanced client rights and the shift toward more humane, client-centered care in psychiatric practice (Kritsotaki, 2021).

Controversy Over Standard Psychiatry/*Diagnostic and Statistical Manual* (*DSM*)

The anti-psychiatry movement has been a significant critic of standard psychiatry, particularly as embodied in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). The *DSM*, the authoritative guide for diagnosing mental disorders used by clinicians and researchers, has faced extensive criticism and calls for reform. Critics argue that the manual's categorical approach, which classifies mental disorders based on symptom clusters, inadequately represents the complexities and nuances of mental health. There are concerns about the reliability of diagnoses, the validity of diagnostic categories, and the potential for overdiagnosis and pathologizing of normal human behaviors (Fritscher, 2023). The movement has leveled criticism regarding the influence of the pharmaceutical industry on the development of the manual. In light of these concerns, there is a growing advocacy for a multidimensional model of mental disorders. This model proposes viewing mental health conditions on a continuum, rather than as distinct categories, to capture the range and severity of symptoms better. Additionally, proponents of this model suggest greater transparency in the *DSM* development process, ensuring that diagnoses are based more on empirical evidence and less on external influences (Bredström, 2017).

Critique of Standard Psychiatry from the Anti-Psychiatry Movement

Anti-psychiatry critics like Thomas Szasz argue that the medical model of mental illness, which conceptualizes these conditions as diseases to be diagnosed and treated, is fundamentally flawed (Benning, 2016). The movement asserts that this perspective oversimplifies complex human experiences and emotions by categorizing them into symptom-based diagnoses. Further, critics like R.D. Laing suggest that such an approach can invalidate clients' experiences and may neglect the sociocultural contexts contributing to mental distress (Cooper, 2017). Anti-psychiatry also critiques the emphasis on pharmacological treatments, arguing that they can potentially result in overmedication and neglect alternative therapeutic options (Desai, 2005). Critics express concerns over the potential for coercive practices in psychiatry, such as forced medication or involuntary commitment, which they perceive as infringing on individual freedoms (Chieze et al., 2021).

LINK TO LEARNING

Read this article that critiques the traditional medical model (https://openstax.org/r/77tradmedmodel) of institutional care.

Consumer/Social Scientist Perspective

The critique of traditional psychiatry has also been taken on by a consumer/social scientist perspective. These groups advocate for increased client rights, consideration of sociocultural factors, and individualized, holistic treatment approaches (Murray, 2014). Consumers often emphasize lived experience as a vital aspect of understanding and treating mental illness, something that the anti-psychiatry movement champions (Sunkel & Sartor, 2022). Social scientists, particularly sociologists, view the movement as highlighting the sociocultural construction of mental illness, underscoring the importance of understanding mental health within the context of social norms, power dynamics, and societal structures. They argue that constructing behaviors as illness emphasizes the potential negative impacts of labeling and stigmatization (Borelle, 2017). Although these perspectives affirm the importance of the issues raised by the anti-psychiatry movement, they also recognize the need for a balanced approach that appreciates the value of medical interventions when appropriate (Desai, 2005).

Social Control/Cultural Aspects

Mental health diagnoses and treatments are deeply intertwined with societal norms, cultural beliefs, and power dynamics in a given context (Ahad et al., 2023). The process of psychiatric diagnosis can act as a form of social control by medicalizing behaviors and experiences that deviate from societal norms, thereby reinforcing those norms (Telles-Correia et al., 2018). This is especially apparent in the historical inclusion of certain behaviors and identities as diseases. For example, homosexuality was once classified as a mental disorder in the *DSM*; it was removed in 1973 in response to evolving societal norms and scientific understanding (Drescher, 2015).

Cultural factors shape perception, diagnosis, and treatment of mental illnesses as well. Different cultures and societal groups have varying concepts of mental illness and how it should be treated. The Church of Scientology, for instance, has been a prominent and controversial force in the anti-psychiatry movement. The Church's founder, L. Ron Hubbard, was a vocal critic of psychiatry, viewing it as a corrupt, coercive, and harmful institution (Kent & Manca, 2014). The Church developed initiatives like the Citizens Commission on Human Rights (CCHR), a Scientology-affiliated organization that campaigns against perceived abuses in psychiatric practice (CCHR, 2023). The Church's criticisms echo broader anti-psychiatry sentiments about the medicalization of human distress, coercive treatments, and the dehumanization of clients (Kent & Manca, 2014). Nevertheless, the Church's involvement in the anti-psychiatry movement is contentious. Some argue that it reflects the Church's self-interest, given that Hubbard also founded Dianetics, a system that presents an alternative to psychiatry (Kent & Manca, 2014). The Church's role in the anti-psychiatry movement illustrates how diverse groups can take up the critique of psychiatry for various motives (Benning, 2016).

Relationship with the Pharmaceutical Industry

The relationship between the anti-psychiatry movement and the pharmaceutical industry is characterized by deep tension. A significant concern within the anti-psychiatry movement is the **medicalization**—the process by which mental health issues are framed and treated primarily as medical conditions—of mental health and the consequent emphasis on pharmacological treatments. Many critics argue that medicalization benefits the pharmaceutical industry at the expense of client rights and freedoms (Ivanov & Schwartz, 2021). This perspective emphasizes biological and physiological explanations for mental disorders and often prioritizes pharmacological treatments over other forms of therapy. Medicalization can include categorizing various behaviors, emotions, and psychological states as medical problems that require treatment, often with medication (Fergusson et al., 2023).

Critics point to the close ties between the pharmaceutical industry and psychiatry, including financial relationships, which they argue may lead to conflicts of interest and potentially biased research outcomes. The anti-psychiatry movement also emphasizes the potential harms of psychiatric medications, such as side effects and withdrawal symptoms, arguing that the industry, with its pharmaceutical-focus approach, downplays or overlooks them (Cosgrove et al., 2014).

While the anti-psychiatry movement raises important critiques, it is important to note that pharmacological treatment can be beneficial and even lifesaving for many individuals. Balancing these critiques with the real needs of clients represents a critical challenge within mental health care (Stein et al., 2022).

PSYCHOSOCIAL CONSIDERATIONS

Key Positions Embraced by the Anti-psychiatry Movement

The anti-psychiatry movement follows several specific beliefs regarding mental health treatment:

- Individual autonomy: The anti-psychiatry movement places great importance on respecting the autonomy of individuals diagnosed with mental health disorders. It critiques the paternalistic tendencies of some psychiatric approaches, where the clinician's authority may overshadow the client's voice and self-determination.
- De-medicalization of human experiences: Advocates point out that some experiences labeled as pathological by psychiatry may instead be natural responses to stressors or social injustices. They question the boundary between normal and pathological, suggesting that psychiatry can medicalize human experiences and emotions.
- Stigma and identity: Anti-psychiatry proponents assert that psychiatric labels can contribute to stigma, affecting a person's self-perception and societal identity. They argue that these labels may lead to internalized shame and societal discrimination.
- Role of societal power dynamics: The movement often underscores how prevailing societal norms and power structures can influence psychiatry. For instance, it has critiqued how certain behaviors are pathologized due to cultural bias or social control rather than evidence of dysfunction.
- Trauma-informed perspectives: Anti-psychiatry advocates emphasize the importance of acknowledging and addressing trauma's impact on mental health, often overlooked in traditional psychiatric models.

Potential impacts of the movement:

- Clinical practice and policies: The anti-psychiatry critique has led to a shift in some areas of mental health practice and policy, promoting greater client involvement, a focus on recovery-oriented models, and increased trauma-informed care.
- Consumer/survivor movement: Anti-psychiatry has inspired a broader consumer/survivor/ex-client movement, advocating for the rights and voices of people diagnosed with mental health conditions.
- Paradigm shift: Some professionals advocate for a paradigm shift in mental health care from the disease model to a psychosocial model that recognizes the complex interplay of biological, psychological, and social factors in mental health.

Challenges of the movement:

- Potential neglect of biological factors: Some argue that the anti-psychiatry movement's emphasis on social and psychological factors might lead to an underappreciation of biological aspects of mental health disorders.
- Risk of discrediting psychiatry: Some worry that anti-psychiatry sentiments may discourage individuals from seeking necessary psychiatric care or erode public trust in mental health professionals.
- Absolutism: There is a risk of adopting an overly dogmatic stance. The medical and psychosocial models can provide valuable insights into mental health, and a balance of perspectives may be necessary.

Calls for Treatment/Medical Diagnostic Framework Reform

The *DSM-5*-TR is the latest edition of what has been the primary diagnostic guide for mental health professionals since its first edition in 1952. Criticisms of the manual have prompted significant calls for reform in the medical diagnostic framework for mental illness. Critics assert that the manual's approach is too categorical, neglecting the often complex and nuanced presentation of mental illness (Stein et al., 2022).

The National Institute of Mental Health (NIMH) introduced the Research Domain Criteria (RDoC) framework, marking a shift toward a multidimensional approach in understanding mental health. This framework recognizes the complex interaction of genetic, neurobiological, and environmental factors in the development of mental disorders. Unlike traditional diagnostic systems that categorize mental illnesses, RDoC focuses on identifying disrupted brain processes and behaviors as the basis for understanding mental illness. According to Böttger et al. (2023), this approach is considered by some to provide a more accurate representation of the underlying pathophysiology of

mental health conditions, offering a more nuanced and comprehensive understanding of these disorders.

Nonetheless, this model also faces criticism. This highlights the need for a balanced, biopsychosocial approach in the future development of the medical diagnostic framework. It is clear from the critics, however, that the time has arrived for treatment reform in mental health care. Implementation of a more comprehensive and inclusive diagnostic model could lead to improved client outcomes, increased understanding of mental illnesses, and reduced stigma (Stein et al., 2022).

Nursing Implications of the Anti-Psychiatry Movement

The anti-psychiatry movement has influenced nursing practice considerably, particularly in the mental health field. This movement fundamentally questions the legitimacy of psychiatric diagnosis and treatment, advocating instead for understanding mental health issues as human experiences rather than pathological disorders (Benning, 2016). This perspective has significantly influenced the nursing profession in several ways. It has promoted a more holistic and client-centered approach to care. Instead of solely focusing on symptoms and diagnoses, nurses are now encouraged to consider their clients' lived experiences, personal narratives, and sociocultural contexts (Flaubert et al., 2021). This shift has been instrumental in developing therapeutic communication skills and fostering empathy in nurse-client relationships.

The anti-psychiatry movement also promoted a shift toward deinstitutionalization and community-based care. This impacts nursing practice as nurses increasingly deliver care in outpatient settings and in the community, requiring them to adapt their skills to diverse environments and work more closely with clients' social networks (Fulone et al., 2021).

While the movement has contributed to positive changes, it also presents challenges. Nurses must grapple with the tension between medical models of mental illness, which emphasize biological factors and medication, and anti-psychiatry perspectives, which reject these models. This balancing act requires continual professional development and reflection on practice. The anti-psychiatry movement encourages a holistic, empathetic, and community-focused approach to care, but it also presents ongoing challenges as nurses collaborate with other professionals and navigate the complexities of mental health care.

The anti-psychiatry movement emphasizes the importance of addressing the holistic needs of clients, including their psychological, social, and spiritual well-being. Nurses should be aware of the broader context of clients' lives and the various factors that contribute to their mental health.

REAL RN STORIES

Nurse: Zander, RN
Years in Practice: Eight years
Clinical Setting: Private psychiatric hospital
Geographic Location: New York City

When I first started working as a psych nurse, I was assigned to a great unit with a strong educational focus. I became good friends with Ruth, a nurse many years my senior, and some of her stories made me laugh, and some almost made me cry. One time in particular, we had just admitted a young adult from the streets who was fiercely opposed to being hospitalized and definitely opposed to taking any of the medication ordered for schizophrenia. I was annoyed when the client refused the meds especially after I did such a good job teaching. Ruth invited me to lunch, and we had a conversation about the differences between Ruth's time and mine. Ruth told me that in "her day" the nurses were never told the client's diagnosis and were just expected to keep them occupied and attend to their needs on the unit. She said that even though the nurses never knew what was "wrong" with the clients, nursing care was focused on the relationship, which Ruth looks back on as a good thing. This was one of those times when Ruth's story almost made me cry.

Validation as an Approach in Nursing Care

An empathetic and holistic approach to care, **validation therapy** emphasizes understanding and respect for the client's subjective experiences, particularly effective when working with individuals with neurocognitive disorders.

This client-centered therapy uses validation, empathy, and active listening to connect with people in the late stages of life, often those living with cognitive impairments, to enhance their well-being and dignity (Fertalova & Ondriova, 2019).

In nursing practice, validation therapy guides nurses to view behaviors not as symptoms to be controlled, but rather as a form of communication. A client experiencing a mental health issue may be trying to communicate an unmet need or express discomfort. Instead of correcting or reorienting the client to reality, the validation approach suggests understanding the person's perspective and validating their feelings (Scales et al., 2018).

The impact of this approach is twofold: it can help reduce stress and anxiety in the client and it builds stronger connections between the client and the nurse. It encourages nurses to become less judgmental, to listen deeply, and to respond to context and emotions rather than the literal statements made by the client (Hartley et al., 2020). Research indicates that validation therapy can improve the quality of life for people with dementia, decreasing negative behaviors and increasing positive emotions (Scales et al., 2018).

Safety and Crisis Intervention

The anti-psychiatry movement has led to a reevaluation of crisis intervention strategies, emphasizing the need for consent and autonomy in care. Proponents argue for the reduction of involuntary treatments and the implementation of alternatives, such as peer support, community-based services, and crisis intervention teams that prioritize de-escalation and voluntary cooperation (Bazelon Center for Mental Health Law, 2024). These approaches align with the principles of trauma-informed care, which acknowledge the impact of trauma on mental health and strive to create services that are compassionate and non-retraumatizing (Center for Substance Abuse Treatment, 2019).

The movement has underscored the importance of considering the social determinants of mental health, such as poverty, discrimination, and social isolation, in crisis intervention. This broader perspective encourages interventions that not only address immediate mental health crises, but also work toward systemic changes to prevent such crises from occurring (Kirkbride et al., 2024). The anti-psychiatry movement has significantly influenced safety and crisis intervention strategies in mental health care. By advocating for client autonomy, less coercive practices, and a holistic view of mental health, it has contributed to the development of more ethical and effective approaches to crisis intervention. It also presents challenges in balancing client rights with the need for safety in situations of acute risk, however. Future research and policy development must continue to navigate these complexities to improve mental health-care outcomes (Johnson et al., 2022).

Client Education and Advocacy

The anti-psychiatry movement has played a significant role in advancing client education and advocacy within mental health care. Central to the movement is the belief in the autonomy and rights of individuals experiencing mental health challenges. This perspective has led to an emphasis on informed consent, the democratization of the therapeutic relationship, and the empowerment of clients through education and self-advocacy (Dalal, 2020). Education is essential for dispelling the myths and stereotypes about mental health disorders that often fuel stigma and discrimination (Ahad et al., 2023). Client education, from the anti-psychiatry viewpoint, involves providing individuals with comprehensive information about their diagnoses, treatment options (including potential risks and benefits), and the sociopolitical context of mental health care. This approach supports individuals in making informed decisions about their care, fostering a sense of agency and participation in their treatment process. The movement advocates for transparency and honesty in the psychiatric system, encouraging practices that inform clients about the nonmedical aspects of their conditions, such as the impact of social determinants on mental health and the potential for recovery outside traditional psychiatric interventions (Paterick et al., 2017).

Advocacy involves championing the rights and interests of individuals with mental health conditions. It seeks to foster societal change, ensuring fair treatment and equal opportunities for this group. Both education and advocacy facilitate the transformation of mental health care toward a more holistic, compassionate approach that respects the autonomy and dignity of individuals. As integral parts of the anti-psychiatry movement, they empower individuals to actively participate in mental health care, understanding all their options, rather than be passive treatment recipients (Saha, 2021).

Staff Education on the Perspective of the Client

Educating staff on the perspective of mentally ill clients is crucial to enhancing the quality of care provided. This

involves adopting a client-centered approach that focuses on understanding individuals' lived experiences and perspectives (Flaubert et al., 2021). Understanding the client's perspective is vital in promoting empathy and reducing stigma among mental health professionals. Such understanding can also help professionals better comprehend clients' needs and preferences, thus guiding the development of individualized treatment plans (Phelan et al., 2023).

Self-examination of bias by staff in mental health care is a critical aspect of providing equitable and effective treatment to diverse client populations. Bias, whether conscious or unconscious, can significantly impact the quality of care provided, affecting diagnosis, treatment decisions, client interaction, and overall client outcomes. Recognizing and addressing these biases is essential for improving mental health services and ensuring that all individuals receive compassionate and appropriate care, regardless of their background, identity, or circumstances (Gopal et al., 2021).

CLINICAL JUDGMENT MEASUREMENT MODEL

Generating Solutions: Understanding the Client's Perspective

The client is reluctant to attend groups on the unit or accept any medications. The client's background and culture are very different from those of the nurse.

Nursing knowledge is required to appreciate the client's perspective and generate a solution. The nurse takes a client-centered approach, focused on empathy. The nurse engages in self-reflection to identify personal bias that may influence the nurse-client relationship. The nurse uses these approaches to contextualize the client's avoidance of treatments and to consider interventions that may align more with the client's belief system.

Training programs like Mental Health First Aid (MHFA) and peer-support models aim to create a more compassionate and empathetic approach toward mental illness by fostering an understanding of the client's perspective (Edgar & Connaughton, 2021). Educating staff on the perspective of the mentally ill client through programs such as MHFA is a cornerstone of effective, compassionate, and person-centered care in mental health services. Other areas of education opportunities may be during annual skills training sessions and in-service opportunities within health-care facilities.

26.3 Users Groups

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Explain the development of user groups
- List online communities and support groups for clients and families
- Select credible databases from nursing forums and professional organizations
- Understand the use of informatics and technology innovation in nursing practice

In mental health care, **user groups** refer to structured gatherings of individuals who share common experiences related to mental health issues. Such groups are often organized around specific conditions, such as depression, anxiety, bipolar disorder, or schizophrenia. These groups commonly include people living with mental health conditions, their families, and sometimes mental health professionals.

User groups are vital in providing peer support, a critical component of comprehensive mental health care. They offer an environment where individuals can share personal experiences and coping strategies and offer mutual encouragement. The peer-led approach can help destigmatize mental health and empower individuals to participate in their care actively. Moreover, users can contribute to service design and policy formulation within each given group. Including user perspectives helps ensure that mental health services are responsive to the needs of the people they serve (Fortuna et al., 2022).

The Development of User Groups

The development of user groups in mental health care has evolved over several decades, with roots in the broader mental health recovery movement. Beginning in the 1970s and 1980s, a time of deinstitutionalization, those with lived experience of mental illness began to challenge the dominant medical model of mental health care, advocating

for greater control and participation in their treatment (Davidson, 2016). By the 1990s, these advocacy efforts crystallized into the formation of organized user groups. These groups, typically composed of individuals living with mental health conditions, began to play a more active role in care and in development of mental health policy. They demanded a shift from paternalistic models of care to more collaborative, person-centered approaches (Davidson, 2016).

Over time, user groups have significantly influenced the shape and content of mental health-care services. Their advocacy has led to increased recognition of the value of peer support and the incorporation of recovery-oriented practices into mainstream mental health care. These practices emphasize individual strengths, self-determination, and the potential for recovery, even in serious mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021).

Anti-psychiatry sentiment has likely been instrumental in the development and proliferation of advocacy groups and peer support networks. These organizations work to protect the rights of mental health clients, challenge stigma, and promote alternatives to conventional psychiatric treatments. They provide platforms for individuals to share their experiences, offer mutual support, and collectively advocate for changes in mental health policy and practice (Castillo et al., 2019). An example of a platform is the Hearing Voices Network, which emphasizes self-determination and critiques the overreliance on medication and involuntary treatments in mental health care (Higgs, 2020).

In the twenty-first century, user groups have significantly evolved, adapting to the digital age with innovative approaches to gathering, sharing, and utilizing health information. This transformation is largely attributed to advancements in technology, which have expanded the reach of these groups and enhanced their ability to access digital health information. User groups, including clients, health-care professionals, and students, now rely on a wide array of digital tools, such as health apps, online forums, social media platforms, and electronic health records (EHRs), to facilitate communication, support, education, and the management of health information (Vos et al., 2020). These digital platforms have fostered an environment of collaboration and peer support, enabling individuals to share experiences, seek advice, and gain insights into various health issues. Online platforms and forms of social media have further facilitated the creation of virtual user groups, allowing individuals from diverse locations to share experiences, provide mutual support, and advocate for change in mental health care (Naslund et al., 2016). The rapid adoption of digital health information technologies does, however, raise concerns regarding data privacy, security, quality and reliability, and the digital divide, indicating a need for ongoing evaluation and regulation to ensure equitable access and protection of user data (Mumtaz et al., 2023).

The Need for User Groups

User groups in mental health care play a crucial role in supporting individuals experiencing mental health issues and shaping the direction of mental health services. These groups are important from various perspectives. From an individual perspective, user groups provide an essential platform for peer support, allowing individuals to share personal experiences, coping strategies, and receive mutual and empathetic understanding from others who have similar experiences (Naslund et al., 2016). Studies have shown that participation in user groups can lead to improved self-esteem, enhanced coping skills, and reduced symptoms of mental distress (Shalaby & Agyapong, 2020).

From a community perspective, user groups can play a crucial role in reducing the stigma associated with mental health disorders by promoting awareness and understanding. They offer a collective voice that can challenge misconceptions and discriminatory practices (Naslund et al., 2016).

From a systems perspective, user groups can contribute to service design and policy development. They provide invaluable insights based on lived experiences that can help tailor services better to meet the needs of those with mental health conditions. User groups have driven a more recovery-oriented approach to mental health care, prioritizing individual strengths and self-determination (Fortuna et al., 2022).

The International Dimension of Users Groups

The importance and impact of user groups in mental health care extends beyond national borders. Globally, the recovery and peer support movements have influenced mental health-care systems, emphasizing the importance of lived experience in developing effective treatments and policies (Sunkel & Sartor, 2022). These groups contribute to mental health policy development, often supported by international organizations, such as the World Health

Organization (WHO) (Semrau et al., 2019). The World Federation for Mental Health (https://openstax.org/r/77WrldFedMtlHlt) has advocated for and facilitated the formation of user groups, emphasizing their importance in achieving human rights-based approaches to mental health.

The advent of digital technology has further internationalized user groups, enabling the formation of online communities that cross geographic boundaries. This development has been particularly valuable for individuals in regions where mental health services are limited or stigmatized (Naslund et al., 2017). In many low- and middle-income countries, user groups have played a crucial role in filling these mental health service provision gaps, offering peer support and advocacy in environments often plagued by limited resources and stigma.

Despite this progress, challenges remain. Ensuring that diverse voices within user groups are heard, combating stigma, and securing sustainable funding are ongoing international concerns (Semrau et al., 2019).

Online Resources for Users

Digital technology has facilitated the emergence of many online resources for user groups in mental health care. These platforms provide virtual spaces for individuals to connect with others, share experiences, and access support, often overcoming geographical boundaries and time constraints inherent in traditional, face-to-face groups (Strand et al., 2020). For example, the National Alliance on Mental Illness (NAMI) offers numerous online community resources, including discussion groups and educational programs, catering to individuals with mental health conditions and their families (NAMI, 2023). Similarly, Mental Health America (MHA) has developed online resources, including screening tools, information about mental health conditions, and a platform connecting individuals to peer communities and professional assistance (MHA, 2023).

Local support groups can also be found on these sites:

- Mental Health America (https://openstax.org/r/77MentalHlthAm)
- Anxiety and Depression Association of America (https://openstax.org/r/77AnxDepAssoc)
- Depression and Bipolar Support Alliance (https://openstax.org/r/77DepBipolSupp)

Online therapy platforms allow users to connect with licensed mental health professionals and provide the option to join group therapy sessions online (Markowitz et al., 2020). Mobile applications facilitate peer support and may provide self-help guides on various mental health topics (Alqahtani et al., 2021). The application of chatbots, or artificial intelligence (AI)-powered conversational agents in mental health care, has rapidly increased in recent years. These digital tools have the potential to provide widespread, cost-effective, and personalized mental health support. Chatbots can be programmed to deliver CBT techniques, which are recognized as effective for treating various mental health conditions, including anxiety and depression (Haque & Rubya, 2023). For example, a chatbot developed by researchers at Stanford University utilizes CBT strategies to help users manage their mental health (Fitzpatrick et al., 2017). Chatbots can be available 24/7, reducing barriers related to therapists' availability, wait times, and cost. This makes mental health care more accessible to those who may not otherwise seek or be able to afford traditional therapy services (Vaidyam et al., 2019). It is essential to recognize the limitations and potential risks of using chatbots in mental health care though. For instance, they may lack the ability to understand complex human emotions fully, fail to detect a crisis, or misinterpret the user's input. Therefore, these services should be viewed as a supplement to, not a replacement for, professional mental health services (Haque & Rubya, 2023). And while all of these online resources increase accessibility, it is important to be mindful of their challenges, such as concerns about privacy, variable quality of treatment and information, and the lack of in-person interaction (Naslund et al., 2017).

LIFE-STAGE CONTEXT

Digital Resources for Mental Health Care

Different life stages can significantly differ in their use and effectiveness of digital resources for mental health care:

- Children and adolescents: Younger individuals may be more comfortable with technology, given their digital nativity. Resources for this group should be designed with age-appropriate language and features. Parental consent, monitoring, and adherence to child data protection regulations are crucial considerations (Hollis et

al., 2017).
- Adults: Adults may have varying degrees of comfort with technology depending on their exposure and experience. Digital resources providing **internet interventions** (therapies delivered via web-based services) can be flexible and adapted to suit their lifestyles and responsibilities (Andersson et al., 2019).
- Older adults: Seniors may face challenges using digital resources due to less familiarity with technology or physical limitations (e.g., visual impairment). Extra support in learning to use digital resources or adaptations to make them more accessible can help (Dong et al., 2023).

Credible Databases

Several credible databases offer valuable information for clinicians, researchers, clients, and caregivers concerning mental illness:

- PubMed (https://openstax.org/r/77PubMed), a U.S. National Library of Medicine service, contains more than thirty million citations for biomedical literature from MEDLINE, life science journals, and online books. It is a crucial resource for clinical research in all areas of medicine, including mental health (National Library of Medicine, 2021).
- The Cochrane Library (https://openstax.org/r/77CochraneLibry) is a reputable database that provides high-quality, independent evidence for health-care decision-making. It includes the Cochrane Database of Systematic Reviews, which offers systematic reviews on various health-related topics, including mental health interventions (The Cochrane Collaboration, 2021).
- The American Psychological Association (APA) (https://openstax.org/r/77APA) is a definitive source for psychology and mental health topics. The database contains access to articles, podcasts, books, and more.
- The National Institute of Mental Health (NIMH) (https://openstax.org/r/77NIMH2) and National Alliance on Mental Illness (NAMI) (https://openstax.org/r/77NAMI) websites provide a wealth of information on various mental health conditions and ongoing research, making them valuable resources for professionals and the general public.

CULTURAL CONTEXT

Cultural Considerations in Digital Resources

Cultural considerations are essential to ensure digital mental health resources are accessible, relevant, and effective across diverse populations.

- Language: Digital resources should be available in the languages spoken by the target population. Additionally, the content should be sensitive to cultural nuances in language use (Maar et al., 2017).
- Cultural relevance: Consider cultural beliefs and practices regarding mental health when designing, recommending, and delivering digital resources. This might involve integrating culturally specific coping strategies or acknowledging cultural stigma around mental health.
- Socioeconomic factors: The availability of reliable internet and technological devices can vary across cultures and economic contexts. Digital resource strategies must consider these disparities to avoid exacerbating health inequities (Maar et al., 2017).

Nursing Informatics

The integration of nursing science, computer science, and information science to manage and communicate data, or **nursing informatics**, has an increasing role in mental health care. Digital tools can streamline client information, track treatment outcomes, enhance communication among health-care professionals, and improve client care (Edgcomb et al., 2022). Electronic health records (EHRs) are a prime example, enabling more coordinated and client-centered care by making comprehensive health information available to all health-care professionals involved in a client's care. For mental health nursing, EHRs can facilitate monitoring symptom progression and treatment response over time, helping to tailor interventions to individual client needs (Kariotis et al., 2022).

Health informatics is a professional specialty in nursing (American Nurses Association [ANA], 2022) and in medicine (Edgcomb, 2021). Use of health informatics can support analysis of population health and health risks and, due to

capture of real-time data along with reimbursement information, can assist development of practice guidelines (Edgcomb, 2021). From a psychiatric-mental health (PMH) nursing perspective, health informatics can reduce communication errors, systematize nursing tasks to free nurses for more client contact, and provide ready access to research evidence for best practice. Equally relevant to PMH nursing, informatics can help create learning systems for clients and communities, and optimize technology for all users (ANA, 2022).

The nursing profession must adapt to the digital future through a multifaceted approach that encompasses education, practice, and policy to effectively meet the evolving demands of health-care delivery and client care. Nursing education should integrate digital literacy and informatics competencies into curricula to prepare nurses for the proficient use of EHRs, telehealth technologies, and digital health applications. This includes training in data management, cybersecurity, and the ethical implications of digital health to ensure that nurses are equipped to protect client privacy and data integrity (Booth et al., 2021).

In clinical practice, nurses should embrace and advocate for the use of digital tools that enhance client care, such as remote monitoring devices, mobile health apps, and virtual care platforms, to improve access to care, client engagement, and health outcomes. Mobile health (mHealth) applications offer the potential for remote client monitoring, facilitating medication adherence, and providing psychoeducational materials (Firth et al., 2017). Furthermore, nurses should play an active role in the development and evaluation of digital health technologies to ensure they meet clinical needs and enhance the quality of care (Booth et al., 2021).

Nursing leadership should advocate for policies that support the integration of digital health technologies in health-care settings, address the digital divide, and ensure equitable access to digital health resources for all clients (Booth et al., 2021). Additionally, ongoing professional development opportunities in digital health should be made available to nurses to keep pace with technological advancements and evolving health-care practices (Altmiller & Pepe, 2022).

Integrating nursing informatics in mental health care comes with challenges despite its potential. Data privacy, the need for training among health-care professionals, and the digital divide among clients need focus in order to effectively leverage the benefits of nursing informatics in mental health care (Kariotis et al., 2022). The digital divide in health care refers to the gap between individuals who have access to digital health technologies and the internet, and those who do not, due to various socioeconomic, geographic, demographic, or cultural factors. This divide not only encompasses access to hardware, such as computers and smartphones, but also includes differences in the ability to use these technologies effectively to manage health information, communicate with health-care providers, and make informed health decisions (Saeed & Masters, 2021).

Several factors contribute to the digital divide in health care. Economic disparities play a significant role, as individuals from lower socioeconomic backgrounds may not be able to afford the cost of digital devices or internet services. Geographic location is another critical factor, with rural and remote areas often facing limited access to high-speed internet and digital health services. Age and education also influence digital literacy, with older adults and those with lower levels of education less likely to engage with digital health technologies (Saeed & Masters, 2021).

The digital divide has significant implications for health equity, as it can exacerbate disparities in health access and outcomes. Individuals who are digitally disenfranchised may have less access to timely health information, online appointment scheduling, telehealth services, and electronic health records, potentially leading to delays in care, reduced client engagement, and poorer health outcomes (Turcios, 2023).

Efforts to bridge the digital divide in health care focus on improving access to affordable high-speed internet and digital devices, enhancing digital literacy through education and training programs, and developing inclusive technologies and services that are accessible and usable by diverse populations. The introduction of the Affordable Connectivity Program (ACP) reflects a growing recognition of the internet as a vital utility, akin to water and electricity, and an essential step toward digital equity. ACP is a federal initiative designed to help ensure that households can afford the broadband they need for work, school, health care, and other essential services. It represents a continuation and expansion of the temporary Emergency Broadband Benefit (EBB) program that was established to provide internet access to low-income families during the COVID-19 pandemic. Under ACP, eligible households can receive a discount on broadband service and connected devices. This includes a monthly discount on broadband service and a one-time discount for the purchase of a laptop, desktop computer, or tablet from

participating providers. Eligibility for the program is based on household income or participation in other government assistance programs such as the Supplemental Nutrition Assistance Program (SNAP), Medicaid, Federal Public Housing Assistance, SSI, WIC, or Lifeline, among others (Federal Communications Commission [FCC], 2021). The ACP aims to not only provide immediate financial relief to help cover the cost of broadband services, but to also foster long-term solutions for bridging the digital divide. By making internet access more affordable, the program seeks to enhance opportunities for education, health-care access, employment, and social inclusion for underserved and marginalized communities (FCC, 2021).

PSYCHOSOCIAL CONSIDERATIONS

Telehealth in Mental Health Care

Telehealth has emerged as a pivotal modality in delivering mental health care, offering an accessible, cost-effective, and flexible solution for both providers and clients. The integration of telehealth into mental health services facilitates timely access to care, reduces barriers related to geographical distance, and enhances client privacy and comfort by allowing care to be received in the client's own environment (SAMHSA, 2021).

Telehealth applications in mental health care include synchronous videoconferencing for therapy sessions, asynchronous communication for client monitoring and follow-up, and mobile health apps for self-management of mental health conditions. These technologies support a wide range of psychiatric services, from diagnosis and treatment to crisis intervention and long-term care management, addressing the needs of diverse client populations including those in rural or underserved areas (Witteveen et al., 2022).

Evidence suggests that telehealth interventions can be as effective as traditional in-person therapy for many mental health conditions, including depression, anxiety, and post-traumatic stress disorder (PTSD), thereby underscoring its potential to significantly enhance mental health-care delivery (Morland et al., 2023). Successful implementation requires addressing challenges, such as ensuring digital literacy among clients and providers, maintaining privacy and security of health information, and navigating varying state regulations and reimbursement policies for telehealth services (Saeed & Masters, 2021).

Assisting clients in accessing user groups and digital resources for mental health care can significantly enhance their care and recovery. Health-care providers, including mental health professionals and nurses, are key in this process. Nurses can identify and recommend relevant user groups and digital resources tailored to clients' needs. By regularly compiling and updating information on local and online user groups, professionals can provide current and relevant resources to clients (Naslund et al., 2017).

In addition, clinicians can support clients in using these resources. For instance, they can provide guidance on how to navigate online platforms, discern reliable information, and engage safely and effectively with online communities. Clinicians can also help clients integrate the support and strategies they gain from these resources into their overall treatment plan (Firth et al., 2017). Health-care systems can also facilitate access by offering clients digital literacy training and integrating user groups and digital resources into standard care. This could involve workshops, individual training sessions, or regularly providing clients with informational materials, such as brochures or website tutorials (Campanozzi et al., 2023). Collaboration with user groups can further enhance access. Regular communication between mental health professionals and user groups can help maintain a reciprocal relationship where both parties learn from each other, ultimately benefiting the client's care (Kwame & Petrucka, 2021).

LINK TO LEARNING

Mental Health America offers support groups (https://openstax.org/r/77MentlHlthAmer) through an online community to assist individuals, families, and health-care consumers.

Summary

26.1 Barriers to Recovery

Recovery from mental illness is often hindered by several barriers, including stigma and discrimination, lack of access to care, financial constraints, and limited social support. Stigma can lead to shame and reluctance to seek help, while financial and geographical barriers can prevent access to necessary treatments. Additionally, a lack of understanding and support from family and community can impede recovery efforts. Adjunctive treatments are complementary therapies used alongside traditional mental health treatments to enhance recovery outcomes. These include lifestyle interventions (e.g., exercise, diet), holistic approaches (e.g., yoga), and peer support programs. These treatments address various aspects of mental health and contribute to a more comprehensive approach to recovery.

Nurses play a vital role in the implementation of adjunctive treatments for mental illness. Their responsibilities include assessing client needs, providing education about treatment options, monitoring treatment adherence, and offering emotional support. Nurses also act as advocates for clients, ensuring they receive comprehensive, personalized care. By integrating adjunctive treatments into care plans, nurses can address the holistic needs of individuals with mental illness and promote better health outcomes (Kealeboga et al., 2023).

26.2 The Anti-psychiatry Movement

The anti-psychiatry movement emerged in the 1960s as a radical critique of mainstream psychiatric practice. Its proponents argue against the medical model of mental illness, critiquing the validity of psychiatric diagnoses, the effectiveness and ethics of treatments, and the role of societal power dynamics in defining and treating mental health issues. While views within the movement vary widely, common concerns involve medicalizing normal human experiences, coercion, stigma, and dehumanization within psychiatric practice. While the anti-psychiatry movement has sparked crucial conversations and reforms, its relationship with mainstream psychiatry remains complex. Nurses, as frontline providers of care, play a critical role in the mental health treatment process and are therefore uniquely positioned to integrate some of the values and perspectives of the anti-psychiatry movement into their practice. This integration can enhance client care, promote recovery-oriented approaches, and contribute to the transformation of mental health services to be more person-centered and less coercive. Understanding the psychosocial considerations associated with the movement can support more nuanced conversations about mental health, emphasizing the necessity for a comprehensive, client-centered approach (Kwame & Petrucka, 2021).

26.3 Users Groups

User groups and digital resources have become integral components of mental health care, offering numerous benefits and potential for improving the mental health landscape. User groups can provide invaluable peer support for individuals with mental health issues. These groups can be conducted in-person or online and offer a sense of community, mutual understanding, and practical advice based on lived experiences. Furthermore, they can help combat the feelings of isolation and stigma often associated with mental illness. User groups can be broadly categorized or focused on specific mental health conditions, allowing individuals to find communities that align with their needs.

Digital resources for mental health care include various tools and platforms, such as online databases, therapy apps, teletherapy services, and mental health chatbots. These resources allow for greater accessibility and flexibility in accessing mental health care and information. They can be particularly beneficial for those who face barriers to traditional mental health services, such as geographical distance, physical disabilities, cultural stigma, or time constraints.

User groups and digital resources provide valuable avenues of support and treatment for individuals with mental illness. It is essential, however, that clinicians ensure that these resources are reliable, safe, and tailored to the specific needs of the individuals using them. Integrating these resources into mental health care can complement traditional therapy methods, promote self-management strategies, and contribute significantly to comprehensive mental health care.

Key Terms

adjunctive treatments range of alternative treatments designed to enhance the impact of primary treatments, improving overall mental health outcomes

anti-psychiatry movement political/social and intellectual phenomenon that emerged in the 1960s as a response to perceived injustices and inadequacies within the traditional psychiatric system

internet interventions therapies delivered via web-based services, flexible and adapted to suit adult lifestyles and responsibilities

medicalization process by which mental health issues are framed and treated primarily as medical conditions

nursing informatics integration of nursing science, computer science, and information science to manage and communicate data

residual symptoms such as fatigue, anxiety, and sleep disturbances that are commonly left over after treatment and are associated with relapse and disability

user group structured gatherings of individuals who share common experiences, in this case related to mental health issues

validation therapy empathetic and holistic approach to care that emphasizes understanding and respect for the client's subjective experiences

Assessments

Review Questions

1. What is a common barrier to recovery from mental illness?
   a. increased social interaction
   b. stigma and discrimination
   c. availability of multiple treatment options
   d. high levels of self-esteem

2. What is an example of an adjunctive treatment in mental health care?
   a. antipsychotic medication
   b. hospitalization
   c. psychotherapy
   d. yoga

3. What is a key role of nurses in the provision of adjunctive treatments for mental illness?
   a. prescribing medication
   b. conducting psychotherapy sessions
   c. monitoring client treatment adherence
   d. performing surgical procedures

4. What statement describes a controversy associated with the practice of psychiatry?
   a. the universal agreement on the efficacy of psychiatric medications across all populations
   b. the use of involuntary treatment and the potential infringement on personal freedoms
   c. the absence of any ethical dilemmas in psychiatric practices
   d. the complete alignment of psychiatric diagnoses with physical health conditions

5. What does the anti-psychiatry movement want to reform in psychiatric practices?
   a. increasing the use of involuntary treatments to improve client outcomes
   b. enhancing the transparency and client involvement in treatment decisions
   c. reducing the emphasis on social determinants of mental health
   d. eliminating the use of all medications in psychiatric treatment

6. What is a nursing implication derived from the anti-psychiatry movement?
   a. Nurses should solely rely on psychiatrists' decisions without involving clients in the care process.
   b. Nurses should disregard clients' personal experiences and narratives about their mental health.

c. Nurses should adopt a client-centered approach that respects individuals' rights and preferences in care.
d. Nurses should exclusively use involuntary treatment methods for managing all psychiatric clients.

7. What statement *best* describes the development of user groups in the digital age?
   a. User groups have decreased in number due to the advent of technology.
   b. User groups are exclusively for professional networking and cannot be used for health-care purposes.
   c. User groups have evolved to utilize digital platforms for broader reach and acquiring digital health information.
   d. User groups are less important in the digital age as individuals prefer to seek information independently.

8. What platform is commonly used for hosting online communities and support groups for clients and families?
   a. video game forums
   b. social media platforms
   c. encrypted email services
   d. corporate intranets

9. What is a key resource for finding databases and evidence-based practice resources in nursing?
   a. popular search engines like Google
   b. nursing forums and professional organizations' websites
   c. personal blogs of health-care professionals
   d. entertainment websites

10. How can nurses use informatics and technology innovation in their practice?
    a. by avoiding the use of electronic health records to protect client privacy
    b. by utilizing telehealth services to provide care and consultation remotely
    c. by relying solely on traditional paper records for client documentation
    d. by ignoring new technology trends as they are often temporary and not useful

Check Your Understanding Questions

1. How do nurses contribute to risk avoidance during adjunctive treatments for mental illness?
2. How can nurses support clients in managing medication side effects during adjunctive treatment for mental illness?
3. How does a nurse contribute to providing psychoeducation in adjunctive treatments for mental illness?
4. How might you respond to a client's interest in the anti-psychiatry movement as a nursing professional?
5. A client expresses interest in using a mental health app, but the nurse is unsure of its credibility. How should the nurse respond?
6. An older adult client with depression is having difficulty navigating an online mental health resource. How can the nurse help the client?
7. A client with social anxiety wants to join an online support group but is nervous about sharing personal information. How can the nurse help the client feel more comfortable joining the support group?
8. A client shows signs of severe depression but insists that using a mental health chatbot is sufficient for their needs. What should the nurse do?

Reflection Questions

1. How do the various factors contributing to nonadherence in mental health care intersect, and what strategies can nurses employ to address these challenges and enhance client compliance with psychiatric treatment?
2. How can nursing professionals actively contribute to reform initiatives in psychiatry, ensuring that client-

centered care and equitable access are prioritized?

3. As a mental health nurse, how would you integrate information obtained from professional databases into your practice to ensure evidence-based care for your clients?

What Should the Nurse Do?

Amira is a thirty-two-year-old female who has been diagnosed with bipolar disorder. Despite receiving medication and therapy, Amira still experiences significant challenges in managing her symptoms and achieving stability in her daily life. She expresses frustration and hopelessness about her ongoing struggles and feels discouraged about her prospects for recovery.

1. What potential barriers to recovery might Amira be facing in managing her bipolar disorder?
2. What adjunctive treatments or interventions could be beneficial for Amira's recovery from bipolar disorder?
3. What specific roles and interventions should the nurse prioritize in supporting Amira's participation in adjunctive treatments?

Ezra, a forty-five-year-old male, has a history of schizophrenia and has been receiving psychiatric treatment for several years. Recently, he has become increasingly skeptical about the effectiveness of psychiatric medications and therapy in managing his symptoms. Ezra expresses frustration with the psychiatric system and believes that it does not adequately address his needs. He has started researching alternative approaches to mental health treatment and has become interested in the anti-psychiatry movement.

4. What aspects of the psychiatric system might Ezra find controversial, leading him to question its practices?
5. What specific calls for reform might Ezra be responding to within the psychiatric system?
6. How might the anti-psychiatry movement influence nursing practice and care delivery for individuals like Ezra?

Zaria is a psychiatric nurse working in a community mental health center. She is exploring ways to enhance her practice and provide better support for her clients and their families. Zaria is interested in leveraging technology and online resources to connect with user groups, access support networks, and stay updated on the latest advancements in psychiatric nursing.

7. How can Zaria explain the development of user groups in the context of mental health support?
8. How can Zaria utilize databases from nursing forums and professional organizations to enhance her nursing practice?
9. In what ways can Zaria incorporate informatics and technology innovation into her nursing practice?

Competency-Based Assessments

1. Do some research on the underdiagnosis of mental illness in primary care settings and how it affects overall client outcomes. Brainstorm what strategies you as a nurse can employ to enhance identification of mental health concerns during routine primary care visits.

2. Imagine a scenario in which a client expresses concerns aligned with the anti-psychiatry movement. As a nurse, how can you engage in a therapeutic conversation to address these concerns while respecting the client's autonomy?

3. In what ways can technology and informatics contribute to the promotion of mental health awareness in the community, beyond individual client care?

References

Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus, 15*(5), e39549. https://doi.org/10.7759/cureus.39549

Alqahtani, F., Winn, A., & Orji, R. (2021). Co-designing a mobile app to improve mental health and well-being: Focus group study. *JMIR Formative Research, 5*(2), e18172. https://doi.org/10.2196/18172

Altmiller, G., & Pepe, L. H. (2022). Influence of technology in supporting quality and safety in nursing education. *The Nursing Clinics of North America, 57*(4), 551–562. https://doi.org/10.1016/j.cnur.2022.06.005

American Nurses Association. (2022). *The scope of nursing informatics practice*. https://www.nursingworld.org/~49c602/globalassets/catalog/book-toc/nursing-informatics-3e-sample-chapter.pdf

American Psychological Association. (2021). *Understanding psychotherapy and how it works*. https://www.apa.org/topics/psychotherapy/understanding

American Psychological Association. (2022). *Mental health*. https://www.apa.org/topics/mental-health

Anders, R. L. (2021). Engaging nurses in health policy in the era of COVID-19. *Nursing Forum, 56*(1), 89–94. https://doi.org/10.1111/nuf.12514

Andersson, G., Carlbring, P., Titov, N., & Lindefors, N. (2019). Internet interventions for adults with anxiety and mood disorders: A narrative umbrella review of recent meta-analyses. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 64*(7), 465–470. https://doi.org/10.1177/0706743719839381

Aoki, Y., Yaju, Y., Utsumi, T., Sanyaolu, L., Storm, M., Takaesu, Y., Watanabe, K., Watanabe, N., Duncan, E., & Edwards, A. G. (2022). Shared decision-making interventions for people with mental health conditions. *The Cochrane Database of Systematic Reviews, 11*(11), CD007297.

Basso, J. C., & Suzuki, W. A. (2017). The effects of acute exercise on mood, cognition, neurophysiology, and neurochemical pathways: A review. *Brain Plasticity, 2*(2), 127–152. https://doi.org/10.3233/BPL-160040

Bazelon Center for Mental Health Law. (2024). *When there's a crisis, call a peer: How people with lived experience make mental health crisis services more effective*. https://www.bazelon.org/wp-content/uploads/2024/01/Bazelon-When-Theres-a-Crisis-Call-A-Peer-full-01-03-24.pdf

Bellamy, C. D., Klee, A. S., Cornejo, X., Guy, K., Costa, M., & Davidson, L. (2020). Peer support for people with psychiatric illness. *Psychotic Disorders*, 538–546. https://doi.org/10.1093/med/9780190653279.003.0060

Benning, T. B. (2016). No such thing as mental illness? Critical reflections on the major ideas and legacy of Thomas Szasz. *BJPsych Bulletin, 40*(6), 292–295. https://doi.org/10.1192/pb.bp.115.053249

Bhattacharya, S., & Hofmann, S. G. (2023). Mindfulness-based interventions for anxiety and depression. *Clinics in Integrated Care, 16*, 100138. https://doi.org/10.1016/j.intcar.2023.100138

Booth, R. G., Strudwick, G., McBride, S., O'Connor, S., & Solano López, A. L. (2021). How the nursing profession should adapt for a digital future. *The BMJ*, 373, n1190. https://doi.org/10.1136/bmj.n1190

Borelle, C. (2017). « C'est uniquement social ». Sur la production d'un dualisme social/psychiatrique en sciences sociales et dans le travail ordinaire de la psychiatrie. *Politix, 117*, 201–222. https://doi.org/10.3917/pox.117.0201

Borenstein, J. (2020, August). Stigma, prejudice and discrimination against people with mental illness. American Psychiatric Association. https://www.psychiatry.org/clients-families/stigma-and-discrimination

Böttger, S. J., Förstner, B. R., Szalek, L., Koller-Schlaud, K., Rapp, M. A., & Tschorn, M. (2023). Mood and anxiety disorders within the Research Domain Criteria framework of Positive and Negative Valence Systems: A scoping review. *Front. Hum. Neurosci.*, 17. https://doi.org/10.3389/fnhum.2023.1184978

Bredström, A. (2017). Culture and context in mental health diagnosing: Scrutinizing the *DSM-5* revision. *Journal of Medical Humanities, 40*(3), 347–363. https://doi.org/10.1007/s10912-017-9501-1

Butcher, C. J., & Hussain, W. (2022). Digital healthcare: The future. *Future Healthcare Journal, 9*(2), 113–117. https://doi.org/10.7861/fhj.2022-0046

Campanozzi, L. L., Gibelli, F., Bailo, P., Nittari, G., Sirignano, A., & Ricci, G. (2023). The role of digital literacy in achieving health equity in the third millennium society: A literature review. *Frontiers in Public Health, 11*. https://doi.org/10.3389/fpubh.2023.1109323

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., III, Docherty, M., Aguilera Nunez, M. G., Barcelo, N., Goodsmith, N., Halpin, L. E., Morton, I., Mango, J., Montero, A. E., Rahmanian Koushkaki, S., Bromley,

E., Chung, B., Jones, F., Gabrielian, S., Gelberg, L., Greenberg, J. M., ... Wells, K. B. (2019). Community interventions to promote mental health and social equity. *Current Psychiatry Reports, 21*(5), 35. https://doi.org/10.1007/s11920-019-1017-0

Center for Substance Abuse Treatment. (2019). Trauma-informed care: A sociocultural perspective. *Trauma-Informed Care in Behavioral Health Sciences.* Substance Abuse and Mental Health Services Administration (US). https://www.ncbi.nlm.nih.gov/books/NBK207195/

Chieze, M., Clavien, C., Kaiser, S., & Hurst, S. (2021). Coercive measures in psychiatry: A review of ethical arguments. *Frontiers in Psychiatry, 12*, 790886. https://doi.org/10.3389/fpsyt.2021.790886

Citizens Commission on Human Rights Nonprofit Mental Health Watchdog. (2023). https://www.cchr.org/

Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-based psychotherapy: Advantages and challenges. *Neurotherapeutics: The Journal of the American Society for Experimental NeuroTherapeutics, 14*(3), 537–545. https://doi.org/10.1007/s13311-017-0549-4

Cooper, R. (2017). Where's the problem? Considering Laing and Esterson's account of schizophrenia, social models of disability, and extended mental disorder. *Theoretical Medicine and Bioethics, 38*(4), 295–305. https://doi.org/10.1007/s11017-017-9413-0

Cosgrove, L., Krimsky, S., Wheeler, E. E., Kaitz, J., Greenspan, S. B., & DiPentima, N. L. (2014). Tripartite conflicts of interest and high stakes patent extensions in the *DSM-5*. *Psychotherapy and Psychosomatics, 83*(2), 106–113. https://doi.org/10.1159/000357499

Dalal, P. K. (2020). Consent in psychiatry—concept, application & implications. *The Indian Journal of Medical Research, 151*(1), 6–9. https://doi.org/10.4103/ijmr.IJMR_1518_19

Davidson, L. (2016). The recovery movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs, 35*(6), 1091–1097. https://doi.org/10.1377/hlthaff.2016.0153

de Bruin, E. I., van der Zwan, J. E., & Bögels, S. M. (2016). A RCT comparing daily mindfulness meditations, biofeedback exercises, and daily physical exercise on attention control, executive functioning, mindful awareness, self-compassion, and worrying in stressed young adults. *Mindfulness, 7*(5), 1182–1192. https://doi.org/10.1007/s12671-016-0561-5

Desai, N. G. (2005). Antipsychiatry: Meeting the challenge. *Indian Journal of Psychiatry, 47*(4), 185–187. https://doi.org/10.4103/0019-5545.43048

Dong, Q., Liu, T., Liu, R., Yang, H., & Liu, C. (2023). Effectiveness of digital health literacy interventions in older adults: Single-arm meta-analysis. *Journal of Medical Internet Research, 25*, e48166. https://doi.org/10.2196/48166

Drescher, J. (2015). Out of *DSM*: Depathologizing homosexuality. *Behavioral Sciences, 5*(4), 565–575. https://doi.org/10.3390/bs5040565

Edgar, S., & Connaughton, J. (2021). Using mental health first aid training to improve the mental health literacy of physiotherapy students. *Physiotherapy Canada. Physiotherapie Canada, 73*(2), 188–193. https://doi.org/10.3138/ptc-2019-0036

Edgcomb, J. B. (2021). *Leveraging clinical informatics to improve mental health care*. Yale School of Medicine. https://medicine.yale.edu/psychiatry/education/map/support/edgecomb/

Edgcomb, J., Coverdale, J., Aggarwal, R., Guerrero, A. P. S., & Brenner, A. M. (2022). Applications of clinical informatics to child mental health care: A call to action to bridge practice and training. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 46*(1), 11–17. https://doi.org/10.1007/s40596-022-01595-3

Ee, C., Lake, J., Firth, J., Hargraves, F., de Manincor, M., Meade, T., Marx, W., & Sarris, J. (2020). An integrative collaborative care model for people with mental illness and physical comorbidities. *International Journal of Mental Health Systems, 14*(1). https://doi.org/10.1186/s13033-020-00410-6

Evans-Lacko, S., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Benjet, C., Bruffaerts, R., Chiu, W. T., Florescu, S., de Girolamo, G., Gureje, O., Haro, J. M., He, Y., Karam, E. G., Kawakami, N., Lee, S., Lund, C., Kovess-Masfety, V., Levinson, D., . . . Thornicroft, G. (2018). Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: Results from the WHO World Mental Health (WMH) surveys. *Psychological Medicine, 48*(9), 1560–1571. https://doi.org/10.1017/S0033291717003336

Federal Communications Commission. (2021, December 15). *Affordable Connectivity Program*. Federal Communications Commission. https://www.fcc.gov/acp

Fergusson, E., Reed-Purvis, S., & Foulkes, L. (2023). Overmedicalization of young people's distress is undermining and disempowering families. *Nature Mental Health, 1*(6), 381–382. https://doi.org/10.1038/s44220-023-00071-7

Fertalova, T., & Ondriova, I. (2019). Non-pharmacological treatment of Alzheimer's. IntechOpen. https://doi.org/10.5772/intechopen.84893

Firth, J., Gangwisch, J. E., Borisini, A., Wootton, R. E., & Mayer, E. A. (2020). Food and mood: How do diet and nutrition affect mental wellbeing? *BMJ (Clinical research ed.),* 369, m2382. https://doi.org/10.1136/bmj.m2382

Firth, J., Torous, J., Nicholas, J., Carney, R., Pratap, A., Rosenbaum, S., & Sarris, J. (2017). The efficacy of smartphone-based mental health interventions for depressive symptoms: A meta-analysis of randomized controlled trials. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 16*(3), 287–298. https://doi.org/10.1002/wps.20472

Fitzpatrick, K. K., Darcy, A., & Vierhile, M. (2017). Delivering cognitive behavior therapy to young adults with symptoms of depression and anxiety using a fully automated conversational agent (woebot): A randomized controlled trial. *JMIR Mental Health, 4*(2), e19. https://doi.org/10.2196/mental.7785

Flaubert, J. L., Menestrel, S. L., Williams, D. R., & Wakefield, M. K. (2021). The role of nurses in improving health care access and quality. *The future of nursing 2020–2030: Charting a path to achieve health equity*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK573910/

Fortuna, K. L., Solomon, P., & Rivera, J. (2022). An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Quarterly*. https://doi.org/10.1007/s11126-022-09971-w

Fritscher, L. (2023, January 17). *Advantages and disadvantages of the diagnostic statistical manual*. Verywell Mind. https://www.verywellmind.com/dsm-friend-or-foe-2671930

Fulone, I., Barreto, J. O. M., Barberato-Filho, S., Bergamaschi, C. C., Silva, M. T., & Lopes, L. C. (2021). Improving care for deinstitutionalized people with mental disorders: Experiences of the use of knowledge translation tools. *Frontiers in Psychiatry, 12*, 575108. https://doi.org/10.3389/fpsyt.2021.575108

Gajarawala, S. N., & Pelkowski, J. N. (2021). Telehealth benefits and barriers. *The Journal for Nurse Practitioners: JNP, 17*(2), 218–221. https://doi.org/10.1016/j.nurpra.2020.09.013

Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: Clinical practice, research and decision making. *Future Healthcare Journal, 8*(1), 40–48. https://doi.org/10.7861/fhj.2020-0233

Grajek, M., Krupa-Kotara, K., Białek-Dratwa, A., Sobczyk, K., Grot, M., Kowalski, O., & Staśkiewicz, W. (2022). Nutrition and mental health: A review of current knowledge about the impact of diet on mental health. *Frontiers in Nutrition, 9*, 943998. https://doi.org/10.3389/fnut.2022.943998

Haque, M. D. R., & Rubya, S. (2023). An overview of chatbot-based mobile mental health apps: Insights from app description and user reviews. *JMIR mHealth and uHealth, 11*, e44838. https://doi.org/10.2196/44838

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse-client relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies, 102*, 103490. https://doi.org/10.1016/j.ijnurstu.2019.103490

Higgs, R. N. (2020). Reconceptualizing psychosis: The hearing voices movement and social approaches to health. *Health and Human Rights, 22*(1), 133–144.

Hollis, C., Falconer, C. J., Martin, J. L., Whittington, C., Stockton, S., Glazebrook, C., & Davies, E. B. (2017). Annual research review: Digital health interventions for children and young people with mental health problems - A systematic and meta-review. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 58*(4), 474–503. https://doi.org/10.1111/jcpp.12663

Hurley, J., Lakeman, R., Linsley, P., Ramsay, M., & Mckenna-Lawson, S. (2022). Utilizing the mental health nursing workforce: A scoping review of mental health nursing clinical roles and identities. *International Journal of Mental Health Nursing, 31*(4), 796–822. https://doi.org/10.1111/inm.12983

Ivanov, I., & Schwartz, J. M. (2021). Why psychotropic drugs don't cure mental illness-But should they? *Frontiers in Psychiatry, 12*, 579566. https://doi.org/10.3389/fpsyt.2021.579566

Johnson, S., Dalton-Locke, C., Baker, J., Hanlon, C., Salisbury, T. T., Fossey, M., Newbigging, K., Carr, S. E., Hensel, J., Carrà, G., Hepp, U., Caneo, C., Needle, J. J., & Lloyd-Evans, B. (2022). Acute psychiatric care: Approaches to increasing the range of services and improving access and quality of care. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 21*(2), 220–236. https://doi.org/10.1002/wps.20962

Kariotis, T. C., Prictor, M., Chang, S., & Gray, K. (2022). Impact of electronic health records on information practices in mental health contexts: Scoping review. *Journal of Medical Internet Research, 24*(5), e30405. https://doi.org/10.2196/30405

Kealeboga, K. M., Manyedi, M. E., & Moloko-Phiri, S. (2023). Nurses' perceptions on how recovery-oriented mental health care can be developed and implemented. *Nursing Research and Practice, 2023*, 4504420. https://doi.org/10.1155/2023/4504420

Kent, S. A., & Manca, T. A. (2014). A war over mental health professionalism: Scientology versus psychiatry. *Mental Health, Religion & Culture, 17*(1), 1–23. https://doi.org/10.1080/13674676.2012.737552

Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P., Pitman, A., Soneson, E., Steare, T., Wright, T., & Griffiths, S. L. (2024). The social determinants of mental health and disorder: Evidence, prevention and recommendations. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 23*(1), 58–90. https://doi.org/10.1002/wps.21160

Kritsotaki, D. (2021). Changing psychiatry or changing society? The motion for the rights of the "mentally ill" in Greece, 1980–1990. *Journal of the History of Medicine and Allied Sciences, 76*(4), 440–461. https://doi.org/10.1093/jhmas/jrab020

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of client-centered care and communication in nurse-client interactions: Barriers, facilitators, and the way forward. *BMC Nursing, 20*(1), 1–10. https://doi.org/10.1186/s12912-021-00684-2

Lake, J. (2022). *Complementary, alternative, & integrative approaches in mental health care*. www.psychiatrictimes.com. https://www.psychiatrictimes.com/view/complementary-alternative-integrative-approaches-in-mental-health-care

Laplaud, N., Perrochon, A., Gallou-Guyot, M., Moens, M., Goudman, L., David, R., Rigoard, P., & Billot, M. (2023). Management of post-traumatic stress disorder symptoms by yoga: An overview. *BMC Complementary Medicine and Therapies, 23*(1), 258. https://doi.org/10.1186/s12906-023-04074-w

Laranjeira, C., Carvalho, D., Valentim, O., Moutinho, L., Morgado, T., Tomás, C., Gomes, J., & Querido, A. (2023). Therapeutic adherence of people with mental disorders: An evolutionary concept analysis. *International Journal of Environmental Research and Public Health, 20*(5), 3869. https://doi.org/10.3390/ijerph20053869

Maar, M. A., Yeates, K., Perkins, N., Boesch, L., Hua-Stewart, D., Liu, P., Sleeth, J., & Tobe, S. W. (2017). A framework for the study of complex mHealth interventions in diverse cultural settings. *JMIR mHealth and uHealth, 5*(4), e47. https://doi.org/10.2196/mhealth.7044

Mahindru, A., Patil, P., & Agrawal, V. (2023). Role of physical activity on mental health and well-being: A review.

Cureus, 15(1), e33475. https://doi.org/10.7759/cureus.33475

Malhotra, A., & Baker, J. (2022, December 13). Group therapy. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK549812/

Malik, M., Kumari, S., & Manalai, P. (2020). Treatment nonadherence: An epidemic hidden in plain sight. *Psychiatric Times, 37*(3), 25–26. https://www.psychiatrictimes.com/view/treatment-nonadherence-epidemic-hidden-plain-sight

Markowitz, J. C., Milrod, B., Heckman, T. G., Bergman, M., Amsalem, D., Zalman, H., Ballas, T., & Neria, Y. (2020). Psychotherapy at a distance. *American Journal of Psychiatry, 178*(3), appi.ajp.2020.2. https://doi.org/10.1176/appi.ajp.2020.20050557

Matsuda, M., & Kohno, A. (2021). Development of a blended learning system for nurses to learn the basics of psychoeducation for clients with mental disorders. *BMC Nursing, 20*(1), 1–10. https://doi.org/10.1186/s12912-021-00677-1

Mayo Clinic. (2019). *Biofeedback*. https://www.mayoclinic.org/tests-procedures/biofeedback/about/pac-20384664

Mental Health America. (2023). *Mental Health America's online communities*. www.mhanational.org

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus (American Psychiatric Publishing), 18*(1), 16–24. https://doi.org/10.1176/appi.focus.20190028

Montejo, A. L., Montejo, L., & Baldwin, D. S. (2018). The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 17*(1), 3–11. https://doi.org/10.1002/wps.20509

Morland, L., Wells, S., & Rosen, C. (2023). *PTSD and telemental health*. U.S. Department of Veteran Affairs. https://www.ptsd.va.gov/professional/treat/txessentials/telemental_health.asp

Mumtaz, H., Riaz, M. H., Wajid, H., Saqib, M., Zeeshan, M. H., Khan, S. E., Chauhan, Y. R., Sohail, H., & Vohra, L. I. (2023). Current challenges and potential solutions to the use of digital health technologies in evidence generation: a narrative review. *Frontiers in Digital Health, 5*. https://doi.org/10.3389/fdgth.2023.1203945

Murray, H. (2014). "My place was set at the terrible feast": The meanings of the "anti-psychiatry" movement and responses in the United States, 1970s–1990s. *The Journal of American Culture, 37*(1), 37–51. https://doi.org/10.1111/jacc.12105

Naslund, J. A., Aschbrenner, K. A., Araya, R., Marsch, L. A., Unützer, J., Patel, V., & Bartels, S. J. (2017). Digital technology for treating and preventing mental disorders in low-income and middle-income countries: A narrative review of the literature. *The Lancet Psychiatry, 4*(6), 486–500. https://doi.org/10.1016/S2215-0366(17)30096-2

Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: Peer-to-peer support and social media. *Epidemiology and Psychiatric Sciences, 25*(2), 113–122. https://doi.org/10.1017/S2045796015001067

National Alliance on Mental Illness. (2023). *NAMI HelpLine*. https://www.nami.org/help

Nawaz, R. F., Reen, G., Bloodworth, N., Maughan, D., & Vincent, C. (2021). Interventions to reduce self-harm on in-client wards: Systematic review. *BJPsych Open, 7*(3), e80. https://doi.org/10.1192/bjo.2021.41

Ng, T. P., Nyunt, M. S. Z., Feng, L., Kumar, R., Fones, C. S. L., & Ko, S. M. (2020). Collaborative care for primary care treatment of late-life depression in Singapore: Randomized controlled trial. *International Journal of Geriatric Psychiatry, 35*(10), 1171–1180. https://doi.org/10.1002/gps.5353

Nuri, N., Sarker, M., Ahmed, H., Hossain, M., Beiersmann, C., & Jahn, A. (2018). Pathways to care of clients with mental health problems in Bangladesh. *Int J Ment Health Syst, 12*, 39. https://doi.org/10.1186/s13033-018-0218-y

Paterick, T. E., Patel, N., Tajik, A. J., & Chandrasekaran, K. (2017). Improving health outcomes through client

education and partnerships with clients. *Proceedings (Baylor University. Medical Center), 30*(1), 112–113. https://doi.org/10.1080/08998280.2017.11929552

Phelan, S. M., Salinas, M., Pankey, T., Cummings, G., Allen, J. P., Waniger, A., Miller, N. E., Lebow, J., Dovidio, J. F., van Ryn, M., & Doubeni, C. A. (2023). Client and health care professional perspectives on stigma in integrated behavioral health: Barriers and recommendations. *Annals of Family Medicine, 21*(Suppl 2), S56–S60. https://doi.org/10.1370/afm.2924

Saeed, S. A., & Masters, R. M. (2021). Disparities in health care and the digital divide. *Current Psychiatry Reports, 23*(9), 61. https://doi.org/10.1007/s11920-021-01274-4

Saha, G. (2021). Advocacy in mental health. *Indian Journal of Psychiatry, 63*(6), 523–526. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_901_21

Scales, K., Zimmerman, S., & Miller, S. J. (2018). Evidence-based nonpharmacological practices to address behavioral and psychological symptoms of dementia. *The Gerontologist, 58*(suppl_1), S88–S102. https://doi.org/10.1093/geront/gnx167

Scott, A. J., Webb, T. L., Martyn-St James, M., Rowse, G., & Weich, S. (2021). Improving sleep quality leads to better mental health: A meta-analysis of randomised controlled trials. *Sleep Medicine Reviews, 60*, 101556. https://doi.org/10.1016/j.smrv.2021.101556

Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G., & Ankomah, A. (2020). Psychotropic medication non-adherence and its associated factors among clients with major psychiatric disorders: A systematic review and meta-analysis. *Systematic Reviews, 9*(1), 17. https://doi.org/10.1186/s13643-020-1274-3

Semrau, M., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., Hanlon, C., Jordans, M., Kigozi, F., Lund, C., Petersen, I., Shidhaye, R., & Thornicroft, G. (2019). Strengthening mental health systems in low- and middle-income countries: Recommendations from the Emerald programme. *BJPsych Open, 5*(5), e73. https://doi.org/10.1192/bjo.2018.90

Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer support in mental health: Literature review. *JMIR Mental Health, 7*(6), e15572. https://doi.org/10.2196/15572

Shukla, A., Choudhari, S. G., Gaidhane, A. M., & Quazi Syed, Z. (2022). Role of art therapy in the promotion of mental health: A critical review. *Cureus, 14*(8), e28026. https://doi.org/10.7759/cureus.28026

Singh, V., Kumar, A., & Gupta, S. (2022). Mental health prevention and promotion-A narrative review. *Frontiers in Psychiatry, 13*, 898009. https://doi.org/10.3389/fpsyt.2022.898009

Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry, 24*(4), e12199. https://doi.org/10.1111/nin.12199

Stein, D. J., Shoptaw, S. J., Vigo, D. V., Lund, C., Cuijpers, P., Bantjes, J., Sartorius, N., & Maj, M. (2022). Psychiatric diagnosis and treatment in the 21st century: Paradigm shifts versus incremental integration. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 21*(3), 393–414. https://doi.org/10.1002/wps.20998

Strand, M., Eng, L. S., & Gammon, D. (2020). Combining online and offline peer support groups in community mental health care settings: A qualitative study of service users' experiences. *International Journal of Mental Health Systems, 14*(1). https://doi.org/10.1186/s13033-020-00370-x

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse clients. *Focus (American Psychiatric Publishing), 18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Substance Abuse and Mental Health Services Administration. (2021). *Evidence-based resource guide series: Telehealth for the treatment of serious mental illness and substance use disorders.* https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf

Subu, M. A., Wati, D. F., Netrida, N., Priscilla, V., Dias, J. M., Abraham, M. S., Slewa-Younan, S., & Al-Yateem, N. (2021). Types of stigma experienced by clients with mental illness and mental health nurses in Indonesia: A qualitative content analysis. *International Journal of Mental Health Systems, 15*(1), 1–12. https://doi.org/

10.1186/s13033-021-00502-x

Sunkel, C., & Sartor, C. (2022). Perspectives: Involving persons with lived experience of mental health conditions in service delivery, development and leadership. *BJPsych Bulletin, 46*(3), 160–164. https://doi.org/10.1192/bjb.2021.51

Tanoue, H., Yoshinaga, N., Kato, S., Naono-Nagatomo, K., Ishida, Y., & Shiraishi, Y. (2018). Nurse-led group cognitive behavioral therapy for major depressive disorder among adults in Japan: A preliminary single-group study. *International Journal of Nursing Sciences, 5*(3), 218–222. https://doi.org/10.1016/j.ijnss.2018.06.005

Telles-Correia, D., Saraiva, S., & Gonçalves, J. (2018). Mental disorder-The need for an accurate definition. *Frontiers in Psychiatry, 9*, 64. https://doi.org/10.3389/fpsyt.2018.00064

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet, 387*(10023), 1123–1132. https://doi.org/10.1016/s0140-6736(15)00298-6

Turcios, Y. (2023, March 20). *Digital access: A super determinant of health*. www.samhsa.gov. https://www.samhsa.gov/blog/digital-access-super-determinant-health

Vaidyam, A. N., Wisniewski, H., Halamka, J. D., Kashavan, M. S., & Torous, J. B. (2019). Chatbots and conversational agents in mental health: A review of the psychiatric landscape. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 64*(7), 456–464. https://doi.org/10.1177/0706743719828977

Velligan, D. I., Sajatovic, M., Hatch, A., Kramata, P., & Docherty, J. P. (2017). Why do psychiatric clients stop antipsychotic medication? A systematic review of reasons for nonadherence to medication in clients with serious mental illness. *Patient Preference and Adherence, 11*, 449–468. https://doi.org/10.2147/PPA.S124658

Vos, J. F. J., Boonstra, A., Kooistra, A., Seelen, M., & van Offenbeek, M. (2020). The influence of electronic health record use on collaboration among medical specialties. *BMC Health Services Research, 20*(1), 676. https://doi.org/10.1186/s12913-020-05542-6

Werlen, L., Puhan, M. A., Landolt, M. A., & Mohler-Kuo, M. (2020). Mind the treatment gap: The prevalence of common mental disorder symptoms, risky substance use and service utilization among young Swiss adults. *BMC Public Health, 20*(1). https://doi.org/10.1186/s12889-020-09577-6

Witteveen, A. B., Young, S., Cuijpers, P., Ayuso-Mateos, J. L., Barbui, C., Bertolini, F., Cabello, M., Cadorin, C., Downes, N., Franzoi, D., Gasior, M., John, A., Melchior, M., McDaid, D., Palantza, C., Purgato, M., Van der Waerden, J., Wang, S., & Sijbrandij, M. (2022). Remote mental health care interventions during the COVID-19 pandemic: An umbrella review. *Behaviour Research and Therapy, 159*, 104226. https://doi.org/10.1016/j.brat.2022.104226

Wong, K. P., Bonn, G., Tam, C. L., & Wong, C. P. (2018). Preferences for online and/or face-to-face counseling among university students in Malaysia. *Frontiers in Psychology, 9*, 64. https://doi.org/10.3389/fpsyg.2018.00064

Yu, B., Funk, M., Hu, J., Wang, Q., & Feijs, L. (2018). Biofeedback for everyday stress management: A systematic review. *Frontiers in ICT, 5*. https://doi.org/10.3389/fict.2018.00023

CHAPTER 27
Current Trends and Growing Needs

FIGURE 27.1 Community-based programs approach mental health treatment from a cooperative perspective. (credit: "Compassion" by Sonya Revell/flickr, Public Domain)

CHAPTER OUTLINE

INTRODUCTION The field of psychiatric-mental health nursing is ever-evolving because of the dynamic interplay of societal changes and emerging health-care demands. From the far-reaching impact of the COVID-19 pandemic on mental health to the imperative of diversity, equity, and inclusion in care, mental health nurses navigate a complex terrain that demands adaptability and dedication. Current trends and growing needs underscore the vital role of psychiatric-mental health nurses in addressing the mental well-being of individuals and communities. Their role in fostering mental well-being and advocating for equitable access to quality mental health care remains central in an ever-changing health-care landscape. This includes a renewed focus on vulnerable groups, such as victims of human trafficking, veterans, LGBTQIA+ individuals, and the homeless population.

27.1 Effects of the COVID-19 Pandemic

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the impact of the stress of the COVID-19 pandemic on mental health-care services and innovation
- Describe nursing strategies for client care in a postpandemic context
- Review nurses' mental health and self-care postpandemic

The COVID-19 pandemic has had a profound impact on the landscape of mental health care, ushering in a surge of mental health challenges, such as heightened anxiety, depression, and trauma-related symptoms. It has underscored the vital role of mental health practitioners, including psychiatric-mental health nurses, in providing essential support and interventions to individuals grappling with pandemic-induced mental health tribulations. Moreover, the pandemic has prompted a rapid transformation in mental health service delivery, with the widespread adoption of telehealth and innovative technological approaches to therapy. This section explores the multifaceted ways in which the pandemic has reshaped mental health care and highlights the resilience and adaptability of nurses in responding to the evolving needs of their clients amidst a global health crisis.

Stressors and Innovation

According to the World Health Organization (WHO), as of January 21, 2024, more than 770 million COVID-19 cases had been reported worldwide, with more than 7 million deaths (WHO, 2024).

As of September 2023, COVID-19 had resulted in more than 6 million hospitalizations and more than a million deaths in the United States (Centers for Disease Control and Prevention [CDC], 2023a). It has exacerbated preexisting mental health issues and introduced new ones. The isolation, fear, uncertainty, and grief associated with the pandemic have led to a surge in anxiety, depression, and post-traumatic stress disorder (PTSD) in individuals of all ages (Mortazavi et al, 2020).

Fighting the COVID-19 pandemic required a strategy known as **flattening the curve**, which refers to a public health strategy aimed at slowing the spread of a contagious disease, like COVID-19, to ensure that the health-care system can manage the capacity of clients. By implementing measures, such as social distancing, mask-wearing, and lockdowns, the goal was to reduce the peak number of cases that intensified in a short period of time to spread cases out in order to protect vulnerable populations and provide appropriate health-care access. This helped keep hospitals from being overwhelmed and allowed them to provide adequate care to those in need, ultimately saving lives. Social distancing and lockdowns took a toll on the mental health of millions of people, however. In fact, the COVID-19 pandemic intensified feelings of fear and isolation in many people. Fear has been a pervasive emotion; fear of the virus itself and fear of the vaccine when it was introduced affected huge portions of the American population. Social isolation stemming from lockdowns, social distancing measures, and limited in-person interactions exacerbated feelings of loneliness and depression among mental health clients who rely on social support networks for their well-being.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) called attention to the potential for increased domestic violence due to stay-at-home orders.

Access to care became a significant challenge as many mental health services were disrupted or shifted to virtual platforms, creating barriers for those without reliable internet access or suitable privacy for telehealth sessions (SAMHSA, 2020). SAMHSA called for health care, schools, businesses, and law enforcement to work together to help families and communities (2020).

Nurses and other frontline health-care workers likewise experienced stress and burnout due to the demands of caring for COVID-19 clients, often witnessing high mortality rates. The COVID-19 pandemic placed immense pressure on nurse staffing, resulting in a surge in demand for health-care services and a shortage of qualified nurses. This led to extended work hours and a need for innovative strategies to recruit and retain nursing staff in health-care facilities (Chan et al., 2021). Access to mental health services became more critical than ever, with many people struggling to cope with the emotional toll of the pandemic. This prompted the rapid shift toward telehealth and virtual mental health services, which have played a crucial role in ensuring continued access to care while reducing the risk of virus transmission.

The pandemic highlighted the importance of addressing mental health as an integral part of public health. Governments and health-care systems worldwide have recognized the significance of mental well-being during crises and have begun to allocate more resources and funding to mental health services. Additionally, the pandemic brought discussions surrounding mental health out of the shadows and reduced stigma. People have become more open about their struggles, which may lead to lasting changes in how society views and supports mental health. The pandemic has also accelerated research and innovation in mental health care, with a focus on developing new treatments, interventions, and support systems to meet the growing demand for mental health services. While the negative impact of COVID-19 on mental health has been significant and challenging, the pandemic has also spurred positive changes and increased awareness about the importance of mental health care in communities.

The COVID-19 pandemic compelled psychiatric-mental health nurses to expand their skill set and adapt to new realities in health-care delivery. The pandemic accelerated the adoption of telehealth and digital mental health services and highlighted the need for the mental health-care providers to be prepared with alternative ways of providing care to their clients in case of widespread emergencies. Preparedness now encompasses a broader range of competencies, including telehealth proficiency, crisis management in a virtual context, technological literacy, and a heightened focus on client education and support.

Since the pandemic, psychiatric-mental health nurses have increasingly utilized videoconferencing, phone calls, and online platforms to provide remote care to clients. This innovation has expanded access to mental health services, reaching individuals who may have previously faced barriers to in-person care, such as those in remote areas or with transportation challenges. It has also enabled nurses to conduct assessments, provide therapy, and offer support in a safe and socially distanced manner. Additionally, some nurses have integrated digital tools and apps into their practice to monitor client progress, provide psychoeducation, and engage in therapeutic interventions. These technological advancements represent a lasting transformation in mental health service delivery, but also require certain skills in order to implement and deliver effectively.

Preparedness now includes a greater emphasis on technological literacy. Nurses became more comfortable with digital mental health tools, apps, and online resources, and they incorporated these into their practice to support client self-management. Nurses also played a pivotal role in educating clients about the availability and benefits of telehealth services, helping them navigate digital platforms, and ensuring they had the necessary resources to participate in remote sessions.

Nurses have developed new protocols for remote crisis intervention and assessing clients for signs of distress during telehealth sessions. They have adapted their crisis management strategies to the virtual environment, ensuring that clients in crisis continued to receive timely support. Nurses also incorporated preparedness for public health emergencies into their practice. They learned to adapt quickly to changing circumstances, including potential lockdowns and quarantine measures, and to ensure continuity of care for clients under challenging conditions.

PSYCHOSOCIAL CONSIDERATIONS

National Suicide Hotline

The creation of 988 as the National Suicide Hotline of the United States officially began with The National Suicide Hotline Designation Act of 2020. The decision to create a three-digit hotline, similar to 911 for emergencies, was driven by the need to improve access to mental health services and crisis intervention. In July 2022, 988 was established as the dialing code for the National Suicide Prevention Lifeline.

By having a dedicated and easily accessible number, the hope is to reduce the stigma associated with mental health issues and encourage people to seek help when needed. Additionally, a dedicated number can help streamline the process of connecting individuals in crisis with appropriate mental health professionals, improving response times.

(National Association of State Mental Health Program Directors, 2021)

Nursing Actions and Strategies for Client Care

Amid the challenges posed by the COVID-19 pandemic, psychiatric-mental health nursing has to ensure effective client care while promoting self-help and community services and supporting recovery. One crucial strategy involves

emphasizing self-help resources and techniques tailored to the unique circumstances of the pandemic. Psychiatric-mental health nurses have been at the forefront of providing clients with tools to manage their mental health independently. Encouraging clients to tap into available community resources and support networks is another aspect of this approach, fostering resilience and reducing feelings of isolation.

In addition to promoting self-help and community resources, psychiatric-mental health nurses played a central role in supporting the recovery journey of clients during the pandemic. They ensured continuity of care through telehealth platforms, offering regular check-ins and therapy sessions to maintain therapeutic relationships and monitor progress. Nurses also adapted treatment plans to address pandemic-related stressors and traumas, fostering a recovery-oriented approach that acknowledges the unique challenges of these times. By implementing trauma-informed care and tailoring interventions to individual needs, psychiatric-mental health nurses strive to facilitate not only symptom management but also the broader process of healing and recovery.

LINK TO LEARNING

Some people experience a post-acute sequelae, known as "long COVID." See this report (https://openstax.org/r/77longCovid) from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2023) describing this lingering public health and mental health crisis

Promote Self-Help and Community Services

Psychiatric-mental health nurses played a vital role in promoting self-help and community services for clients during the COVID-19 pandemic, recognizing the importance of resilience, coping, and access to support systems. Here are some ways in which they have contributed and continue to contribute to these efforts:

- Empowering clients with self-help strategies: Psychiatric nurses can actively educate their clients about self-help strategies for managing stress, anxiety, and other mental health challenges related to the pandemic. They can provide guidance on techniques, such as mindfulness, deep breathing exercises, and grounding exercises that clients can practice on their own to alleviate symptoms.
- Promoting psychoeducation: Nurses can be instrumental in providing psychoeducation about the psychological impact of the pandemic, emphasizing that feelings of fear, isolation, and uncertainty are normal responses. By helping clients understand the link between their emotions and the pandemic, nurses empower them to take control of their mental health.
- Referring to community resources: Psychiatric-mental health nurses connect clients to community resources and services that provide additional support. They facilitate referrals to local mental health agencies, crisis helplines, support groups, and teletherapy services, ensuring that clients have access to a broader network of assistance.
- Supporting telehealth and online communities: Recognizing the importance of virtual support during lockdowns and social distancing measures, nurses have encouraged clients to engage in online mental health communities, peer support groups, and virtual therapy sessions. They help clients navigate these resources, ensuring they can access assistance even when in-person options are limited.
- Strengthening coping skills: Nurses have worked with clients to enhance their coping skills, including problem-solving, goal-setting, and building resilience. They assist clients in developing personalized coping plans tailored to their unique circumstances.
- Providing a listening ear: Perhaps one of the most critical roles of psychiatric-mental health nurses has been providing a compassionate and empathetic listening ear. They create a safe and nonjudgmental space for clients to express their fears and concerns, offering emotional support and validation.
- Advocating for client needs: Psychiatric nurses often advocate for their clients' mental health needs within the health-care system and the community, helping to reduce stigma and improve access to care.

LIFE-STAGE CONTEXT

Social Media and Adolescents during the Pandemic

Adolescents increasingly belong to a media culture. A survey of ninety-three teen girls was conducted during the COVID-19 lockdown on their connections between peer relationships, social media use, and emotional well-being. The survey found that social technologies created acceptable contact and provided emotional benefit when actual face-to-face interactions were restricted.

Limitations of the study included a high percentage of girls in socioeconomically secure groups and data collection through self-report. Most study participants identified as White, non-Hispanic. The researchers acknowledge that the pandemic had disproportionate effect on families in minoritized communities, and that their study may not be generalizable to broader, more diverse samples.

(James et al., 2023)

Support Recovery

Psychiatric-mental health nurses have assumed a pivotal role in supporting clients' recovery in the wake of the COVID-19 pandemic. Anxiety and depression increased in the adult population during the pandemic, as did the rates of substance misuse and drug overdose deaths (Panchal et al., 2023). With a specialized focus on the mental health challenges stemming from the pandemic, nursing responsibilities encompass a range of functions.

Nurses assess the unique psychological impacts of COVID-19 on individual clients, considering factors such as isolation, grief, anxiety, and trauma. Based on these assessments, nurses collaboratively develop tailored care plans to address specific pandemic-related stressors and mental health symptoms. Medication management remains a crucial aspect of their role, ensuring that clients who require psychiatric medications for mental health challenges receive appropriate treatment and monitoring. Additionally, nurses play an active role in educating clients about the importance of mental well-being during trying times, focusing on strategies to manage stress, sleep, and overall health. Monitoring and follow-up care are integral, allowing nurses to track progress and adjust interventions as necessary, while stigma reduction efforts work to encourage clients to seek help without fear or judgment.

Nurses' Mental Health and Self-Care

The COVID-19 pandemic has exerted a profound impact on the mental health of psychiatric-mental health nurses themselves, exacerbating existing challenges in their profession. Psychiatric nurses have faced increased stress and emotional strain while providing care during the pandemic. The isolation and social distancing measures have disrupted the therapeutic relationships they build with their clients, and the restrictions on visitations heightened the feelings of loneliness and despair among those receiving psychiatric care. Policy changes and uncertainty surrounding the pandemic response added to the stress, making it challenging for nurses to plan and provide consistent care. Additionally, controversy surrounding COVID-19 vaccines became a source of tension and stress among health-care workers, including nurses (Peterson et al., 2022). While vaccines have proven effective in preventing severe illness, some nurses expressed vaccine hesitancy, leading to concerns about workplace safety and potential conflicts with colleagues who hold differing views. This has contributed to the overall emotional burden experienced by psychiatric-mental health nurses during the pandemic.

The mental health toll on psychiatric nurses has been substantial, with many reporting higher rates of depression, anxiety, and sleep disturbances (Aloweni et al., 2022). The constant exposure to the emotional distress of their clients and the additional anxieties related to COVID-19 transmission took a toll. Moreover, changing personal priorities emerged as a significant issue. The pandemic forced many nurses to grapple with difficult decisions about their own health and the health of their families, leading to internal conflicts and guilt. Balancing the demands of work with their personal lives, including caring for children or vulnerable family members, became increasingly challenging. In sum, the COVID-19 pandemic highlighted the need for comprehensive mental health support for psychiatric-mental health nurses, addressing not only the unique stressors of their profession, but also the broader societal challenges that emerged during this global crisis.

LINK TO LEARNING

Review this Self-Care Tip Sheet for Nurses (https://openstax.org/r/77nursetipsheet) from the American Psychiatric Nurses Organization. It contains helpful, healthy suggestions that encourage nurses to care for their own mind, body, and spirit.

Frontline Experience

During the COVID-19 pandemic, psychiatric-mental health nurses faced a myriad of challenges that significantly affected their mental health (Kameg et al., 2021). Issues related to the supply of personal protective equipment (PPE) added an extra layer of stress and anxiety, as they often worked in environments requiring adequate protection. The intensity of their workloads also skyrocketed as they faced the emotional burden of caring for clients who were grappling with the mental health effects of the pandemic, all while adapting to new safety protocols and an influx of COVID-19 cases. The work led to burnout among many nurses. The integration of new nurses, while essential to meet the surging demand for health-care professionals, added to the pressure of the experienced psychiatric-mental health nurses who had to train and supervise them.

Tragically, the pandemic also brought an increase in client deaths, further contributing to the psychological toll on these nurses. Witnessing the loss of clients, particularly when in-person support from families was limited or prohibited due to COVID-19 restrictions, added to their grief and emotional distress. Many nurses developed compassion fatigue, the emotional and physical exhaustion that results from providing empathetic care to those experiencing trauma or suffering. The cumulative effect of these challenges led some nurses to leave the profession, worsening staffing shortages in an already strained mental health-care system.

REAL RN STORIES

Nurse: Janis, BSN
Geographic Location: Missouri

Working as a behavioral health nurse during the pandemic was both challenging and eye-opening. While the world was dealing with the physical health crisis, my clients were fighting their own silent battles against the pandemic's toll on mental health. The isolation, fear, and uncertainty magnified their struggles, and it was heart-wrenching to witness. The loneliness was one of the worst things for most people, I think. We had to stop allowing visitors for our clients and that was really hard for them. Our staff had to adapt quickly to using PPE and educated all of the clients on hygiene and distancing. Yet, there were moments of triumph, too, as I saw the resilience in my clients and the incredible strength they possessed. The pandemic taught me the vital importance of mental health support and solidified my dedication to this field, knowing that my role in helping others navigate their darkest moments during an especially stressful time was more crucial than ever.

Sustaining Nursing Workforce

Sustaining the psychiatric-mental health nursing workforce during and after the COVID-19 pandemic has been crucial, given the increased demand for mental health services and the unique challenges faced by these professionals. Several key strategies and considerations have come into play:

- Practice environment: Ensuring a supportive and safe practice environment is paramount. Adequate staffing levels, access to personal protective equipment (PPE), and infection control measures are crucial for nurses' physical safety and well-being. Additionally, promoting a culture of respect, support, and recognition within health-care settings can help lessen the emotional toll of the pandemic on psychiatric-mental health nurses.
- Academy Health Interdisciplinary Research Group on Nursing Issues (IRGNI): Organizations like IRGNI have played a vital role in fostering research collaboration and knowledge dissemination within the field of nursing. During the pandemic, these groups facilitated sharing best practices, evidence-based interventions, and research findings to inform psychiatric-mental health nursing care (AcademyHealth, n.d.).
- Nurse-led initiatives and policy: Psychiatric-mental health nurses have been at the forefront of developing innovative care delivery models and advocating for policy changes to address the pandemic's mental health

impact. Nurse-led initiatives have been instrumental in expanding access to mental health services, particularly through telehealth, and promoting policies that support mental health parity.
- Diversity, equity, and inclusion (DEI): Efforts to promote diversity, equity, and inclusion in psychiatric-mental health nursing education and employment have gained momentum. Ensuring a diverse workforce that reflects the communities it serves is essential for providing culturally sensitive and responsive care, especially during a public health crisis.
- Retention and recruitment: Retaining current nurses has been a priority, with health-care organizations offering mental health support, flexible work arrangements, and career development opportunities. Simultaneously, organizations have been recruiting new psychiatric-mental health nurses through targeted outreach, educational incentives, and by highlighting the importance of mental health nursing in addressing pandemic-related mental health challenges.

27.2 Human and Sex Trafficking

LEARNING OBJECTIVES

By the end of this section, you will be able to:
- Define human trafficking
- Identify resources for prevention and awareness
- Discuss nursing responsibilities related to human trafficking

Human trafficking is a serious public health emergency affecting an estimated twelve to thirty million people every year in the United States, including more than five million children (Byrne, Parsh, & Parsh, 2019). It is a grave and disturbing global crisis, transcending borders and affecting countless lives. For nurses and clients, understanding and addressing human trafficking is of paramount importance.

This section will explore the facets of human trafficking, from its underlying causes to the psychological and physical trauma it inflicts on its victims. It will also offer insights into how psychiatric-mental health nurses can actively engage in preventing and combating this crime. By delving into the interconnectedness of mental health and human trafficking, future nurses will be able to recognize signs, provide compassionate care, and collaborate with multidisciplinary teams to support survivors on their path to recovery. Understanding this issue is not only essential for delivering holistic health care, but also for advocating for the vulnerable and marginalized individuals who often bear the brunt of human trafficking's devastating consequences.

Human Trafficking Defined: Force, Exploitation, and Vulnerability

Human trafficking involves the illegal trade of people, typically for forced labor or commercial sexual exploitation, using coercion, fraud, or force. This grave violation of human rights involves the recruitment, transportation, harboring, or receipt of victims for the purpose of exploitation. It is a global criminal enterprise that thrives on the vulnerability of its victims, exploiting their socioeconomic, personal, or psychological vulnerabilities to maintain control and profit from their suffering. Human trafficking is a complex and multifaceted issue that demands attention from health-care workers, law enforcement, policymakers, and organizations dedicated to combating this form of exploitation.

Force, exploitation, and vulnerability are interconnected elements that characterize **human trafficking**. The physical or psychological violence used to control victims, including threats, abuse, or confinement is called **force**. Perpetrators employ force to instill fear and compliance, making it difficult for victims to escape their situations. The numerous different ways in which traffickers financially benefit from their victims' labor or sexual services is called **exploitation**. For example, this can involve coercing victims into prostitution, pornography, or other forms of commercial sex work and then taking the majority of their earnings. A person's **vulnerability**, or ability to be harmed or influenced, plays a critical role in the recruitment and control of victims. Those who are vulnerable due to poverty, homelessness, substance addiction, or a history of abuse are often targeted by traffickers who exploit these vulnerabilities to manipulate and control their victims.

Table 27.1 provides examples of different types of human trafficking.

Type	Definition
Child soldiering	Child soldiering refers to the practice of recruiting and using children, typically under the age of eighteen, for armed conflict or warfare. These children are often forcibly abducted or coerced into joining armed groups, where they are subjected to combat roles, including fighting, spying, or serving as support personnel.
Debt bondage	Debt bondage is a form of forced labor in which individuals are trapped in a cycle of debt, often due to borrowing money or receiving advances from employers, and are subsequently compelled to work for low or no wages to repay the debt. Victims of debt bondage are often subjected to exploitative working conditions and find it challenging to escape the cycle of debt and exploitation.
Labor trafficking	Labor trafficking refers to the illegal practice of recruiting, harboring, transporting, or obtaining individuals through force, fraud, or coercion to engage in various forms of labor, often in degrading or exploitative conditions. Victims of labor trafficking are typically subjected to involuntary servitude, forced labor, or other forms of labor exploitation, and they may be trapped in situations where their freedom and basic rights are severely restricted.
Sex trafficking	Sex trafficking is the illegal act of recruiting, harboring, transporting, or obtaining individuals through force, fraud, or coercion for the purpose of engaging them in commercial sexual exploitation, including prostitution or pornography. Victims of sex trafficking are often subjected to violence, manipulation, and severe exploitation, and they are denied their basic human rights and autonomy.

TABLE 27.1 Types of Human Trafficking

Educating Those Affected

Providing education to survivors of human trafficking is a crucial component of holistic recovery and empowerment. Survivors often face physical and psychological health challenges resulting from their traumatic experiences, and nursing education can play a pivotal role in helping them regain control over their lives.

First and foremost, nursing education for survivors involves a trauma-informed approach. Understanding the impact of trauma on survivors' mental and physical health is essential. Nurses should create a safe and nonjudgmental environment that fosters trust, allowing survivors to disclose their experiences at their own pace. Education should encompass knowledge about common health issues associated with trafficking, including sexually transmitted infections, substance misuse, and mental health disorders.

Empowering survivors with health-care knowledge is also crucial. This includes teaching basic self-care skills, recognizing signs of illness, and accessing health-care services. Many survivors have limited access to health care during their exploitation, and providing them with the tools to navigate the health-care system empowers them to seek care when needed. Additionally, addressing the long-term effects of trauma and promoting self-care strategies, such as mindfulness and stress management, can aid in their emotional healing.

Nursing education should extend beyond just health care. It should also encompass life skills, such as financial literacy, job readiness, and social support networks, to help survivors reintegrate into society successfully. By equipping survivors with education and resources, nurses play a vital role in helping them reclaim their lives, regain independence, and break the cycle of exploitation. Ultimately, nursing education for survivors of human trafficking is a step toward restoring their dignity and enabling them to lead healthier, more fulfilling lives.

LINK TO LEARNING

The U.S. Department of State has compiled a list of twenty ways (https://openstax.org/r/77fighthumtraff) to help fight human trafficking. It contains resources, tools, and tips for helping victims of human trafficking.

Available Resources for Prevention and Awareness

For human trafficking victims and the nurses who assist them, a range of essential resources are available to provide support and aid in recovery. Government agencies, such as the U.S. Department of Health and Human Services (HHS) and the Office for Victims of Crime (OVC), offer comprehensive information, grants, and programs aimed at addressing the needs of trafficking survivors as well as professional development opportunities. Social services, including local shelters and nonprofit organizations like Polaris and the National Human Trafficking Hotline, offer emergency housing, legal assistance, counseling, and other vital services tailored to the unique needs of victims. Additionally, specialized training and resources for health-care professionals, including nurses, are available through organizations like HEAL Trafficking, equipping them with the knowledge and skills to recognize, assist, and advocate for trafficking survivors within the health-care system.

Government Agencies

Several government agencies in the United States provide resources and support for human sex trafficking victims and work to combat trafficking. Some of the key agencies include:

- Office on Trafficking in Persons (OTIP): Part of the U.S. Department of Health and Human Services, OTIP is responsible for providing comprehensive services to trafficking victims, including shelter, legal assistance, and social services. It also offers grants to organizations working to combat human trafficking.
- The Department of Justice (DOJ): DOJ's Civil Rights Division houses the Human Trafficking Prosecution Unit, which focuses on prosecuting traffickers and assisting victims. It also provides grant funding to local law enforcement agencies and service providers through the Office for Victims of Crime (OVC).
- The Federal Bureau of Investigation (FBI): The FBI investigates and combats human trafficking as part of its mission. It works on both domestic and international cases, targeting traffickers and networks involved in the trade.
- U.S. Immigration and Customs Enforcement (ICE): ICE has a Homeland Security Investigations (HSI) unit dedicated to investigating transnational human trafficking cases. It also provides victim assistance through the Victim Assistance Program.
- Department of State - Office to Monitor and Combat Trafficking in Persons (TIP Office): This office produces the annual Trafficking in Persons Report, which assesses global efforts to combat trafficking and ranks countries on their antitrafficking efforts.
- U.S. Department of Labor (DOL): DOL's Wage and Hour Division investigates labor trafficking cases, ensuring that workers are protected and paid appropriately. It also provides support and resources to victims of labor trafficking.
- U.S. Customs and Border Protection (CBP): CBP plays a role in preventing trafficking at the borders, identifying victims, and working to dismantle trafficking networks involved in illegal border crossings.
- Child Exploitation and Obscenity Section (CEOS): Part of the DOJ's Criminal Division, CEOS focuses on prosecuting child exploitation cases, including child sex trafficking.
- The National Human Trafficking Hotline: While not a government agency, this hotline is funded by the Department of Health and Human Services and is a critical resource. It provides assistance, referrals, and information to victims of trafficking and concerned individuals. The hotline can be reached at 1-888-373-7888.

These agencies work together to combat human trafficking, provide support to victims, prosecute traffickers, and raise awareness about the issue. They often collaborate with nongovernmental organizations (NGOs) and local service providers to deliver comprehensive assistance to survivors.

Social Services

There are many private agencies that also aid victims and survivors of human trafficking. Many receive either federal or state funding to assist their operations.

- Polaris Project: Polaris operates the National Human Trafficking Hotline, 888-373-7888 (National Human Trafficking Hotline, 2023). This hotline provides assistance, resources, and referrals to trafficking victims and concerned individuals. Polaris Project also engages in advocacy efforts to combat trafficking.
- ECPAT-USA (End Child Prostitution and Trafficking): ECPAT-USA focuses on preventing the sexual exploitation of children and advocating for their rights. It offers educational resources, conducts research, and works to

shape policies that protect children from trafficking.

- Covenant House: Covenant House provides shelter, food, and support services to homeless and trafficked youth in several U.S. cities. It offers a comprehensive range of services, including mental health support, job training, and legal assistance.
- CAST (Coalition to Abolish Slavery and Trafficking): CAST offers comprehensive services to survivors of trafficking, including shelter, legal assistance, and case management. It also engages in policy advocacy and community outreach.
- GEMS (Girls Educational and Mentoring Services): GEMS is dedicated to empowering young women and girls who have experienced commercial sexual exploitation and domestic trafficking. It provides counseling, educational support, and opportunities for personal growth.
- Dignity Health's Human Trafficking Response Program: Dignity Health offers a comprehensive program aimed at identifying and providing care to trafficking victims in health-care settings. It trains health-care professionals to recognize signs of trafficking and connects victims with support services.
- The Salvation Army: The Salvation Army operates several programs and shelters across the country that provide support to trafficking victims. It offers emergency shelter, counseling, and case management services.
- Safe Horizon: Safe Horizon offers a range of services to victims of crime and abuse, including trafficking. It provides legal assistance, counseling, and advocacy for survivors in the New York City area.

Nursing Care: Assessment and Intervention

The identification of and intervention for potential victims of human trafficking represent critical aspects of a nurse's role. Table 27.2 serves as a comprehensive guide for nurses engaged in the assessment and intervention process when encountering clients suspected of being victims of human trafficking. Acknowledging the complex nature of this issue, the table outlines key indicators for identification, such as physical and behavioral signs, and provides information that is crucial for initiating a trauma-informed conversation. Furthermore, it offers insights that are helpful with collaborating with multidisciplinary teams, reporting mechanisms, and culturally sensitive approaches. By equipping nurses with signs and evidence of trafficking, the aim is to enhance their ability to recognize, respond, and advocate for the well-being of individuals subjected to this form of abuse.

Signs of Trafficking	Evidence of Trafficking
Physical signs	• Evidence of physical abuse, including bruises, burns, or other injuries • Signs of malnourishment or untreated medical conditions • Tattooing or branding, which traffickers sometimes use to mark their victims
Behavioral signs	• Fear, anxiety, depression, or other emotional distress • A sudden change in demeanor or behavior, such as becoming withdrawn or submissive • An inability to speak freely or make eye contact • Displaying a lack of control over their own finances, identification documents, or personal belongings
Controlled communication	• A third party who appears to be exerting control over the individual, speaking for them, or monitoring their interactions • Inconsistent or scripted responses when asked about their situation
Working conditions	• Being unable to leave their job or working excessively long hours with no breaks • Living at their workplace or in overcrowded, unsanitary conditions

TABLE 27.2 Identifying Victims

Signs of Trafficking	Evidence of Trafficking
Lack of identification	• Not possessing identification documents, such as a driver's license or passport • Having false identification documents
Restricted movement	• Being closely monitored or accompanied at all times • An inability to come and go freely
Sexual exploitation	• Having a history of engagement in commercial sex work when they are underage or showing signs of being controlled by a third party
Age and vulnerability	• Appearing significantly younger than their stated age • Having a history of child abuse or neglect, making them more vulnerable to exploitation
Fear and independence	• Expressing a profound fear of authorities or retaliation from traffickers • Demonstrating a strong emotional attachment to their trafficker or controller, often due to Stockholm syndrome or coercive tactics
Online presence	• Evidence of advertisements for commercial sex services on online platforms or social media accounts that suggest control by a third party

TABLE 27.2 Identifying Victims

Registered nurses with two or more years of clinical experience (especially in emergency nursing, maternal/child health, or critical care) may become certified as a Sexual Assault Nurse Examiner (SANE). The International Association of Forensic Nurses (https://openstax.org/r/77forensicnurse) provides more information on this certification.

CLINICAL JUDGMENT MEASUREMENT MODEL

Recognize Cues: Possible Signs of Human Trafficking

Recognizing cues involves identifying that which is abnormal with the client. For example, the nurse might notice that their client is fearful in the presence of their partner, has multiple bruises, and seems reluctant to answer questions. These abnormal findings require action. To learn more, the nurse may ask the client questions such as:

- Have you experienced harm or received threats when attempting to leave your current situation?
- Have threats been made against your family members?
- Is your place of residence the same as your workplace?
- Could you please describe your living and dining arrangements?
- Are you indebted to your employer in any way?
- Do you possess your passport or identification, and if not, who is in possession of it?

The client's responses can guide the nurse on what actions to take next. For urgent cases, the nurse should contact emergency services at 911. The National Human Trafficking Hotline is 1-888-373-7888 and can be contacted to report a tip, connect with antitrafficking services, for training, general information, or antitrafficking resources.

Mandated Reporting and Trauma-Informed Care

Mandated reporting and trauma-informed care are two crucial aspects of nursing practice when it comes to

addressing human trafficking. These concepts are intertwined and play a significant role in identifying and assisting trafficking victims while minimizing further trauma.

Nurses, like many other health-care professionals, are mandated reporters. This means they are legally obligated to report suspected cases of abuse, neglect, or exploitation of children or vulnerable adults, which includes human trafficking. When a nurse encounters a client who exhibits signs or discloses information suggesting involvement in trafficking, they have a legal and ethical duty to report their suspicions to the appropriate authorities, such as Child Protective Services or law enforcement. The agency to which the professional must report the suspected abuse differs by state; nurses must be familiar with the law where they are practicing. Mandated reporting is essential for several reasons:

- It helps protect vulnerable individuals, especially minors, from further harm.
- It allows law enforcement and social services agencies to investigate and intervene in trafficking cases.
- It holds traffickers accountable for their actions.
- It contributes to a broader effort to combat human trafficking and bring perpetrators to justice.

Recognizing the trauma that survivors of human trafficking have experienced is essential for health-care professionals, including nurses. The approach that acknowledges the prevalence of trauma and its effects on an individual's mental, emotional, and physical well-being is trauma-informed care. Key principles of trauma-informed care include:

- understanding the potential triggers and emotional responses that trauma survivors may exhibit
- creating a safe and nonjudgmental environment that fosters trust and open communication
- prioritizing the survivor's autonomy and choice in their care and treatment
- being aware of the potential retraumatization that can occur if care is not delivered with sensitivity to a survivor's history
- collaborating with trauma-informed mental health professionals to provide appropriate psychological support

When working with victims of human sex trafficking, trauma-informed care is essential because many survivors have experienced severe physical and psychological abuse. When nurses provide care that is sensitive to the trauma, they can better establish rapport, gain the survivor's trust, and facilitate disclosure of their experiences. Additionally, this approach helps survivors feel more comfortable accessing health-care services, which is often their first step toward recovery.

Client Referral and Support

Client referral and support are fundamental aspects of nursing care when addressing human trafficking. Nurses play a crucial role in connecting trafficking survivors with the necessary resources and services while providing ongoing support to facilitate their healing and recovery.

In the realm of client referral, nurses play a pivotal role in ensuring that survivors of human trafficking receive the comprehensive care they need. This includes immediate attention to their physical well-being, where nurses may provide referrals to medical specialists, facilitate forensic examinations when necessary, and address sexual and reproductive health concerns. Given the often-profound mental health challenges faced by survivors, nurses also connect them with mental health professionals and therapists specializing in trauma-informed care. Moreover, nurses collaborate with social workers to provide referrals to social services agencies, enabling survivors to access housing assistance, financial support, food, and other resources. Nurses can also guide survivors toward legal aid organizations or attorneys specializing in human trafficking cases, offering assistance with restraining orders, immigration matters, or pursuing restitution from traffickers. Lastly, for survivors grappling with substance misuse issues, nurses facilitate referrals to addiction treatment programs and support groups to address these specific challenges comprehensively.

Client support requires a multifaceted approach in nursing care for trafficking survivors, encompassing trauma-informed care to establish trust, emotional support involving active listening and empathy, safety planning to prevent revictimization, education about rights and resources, crisis intervention for acute distress, advocacy within the health-care system, and empowerment to regain control over their lives, participate in their recovery decisions, and promote autonomy and self-efficacy.

Nurses' Reactions and Care for the Caregiver

Nurses who care for survivors of human trafficking often face unique challenges and emotional reactions due to the nature of the work. Providing care for survivors of such traumatic experiences can take a toll on the mental and emotional well-being of health-care professionals. Nurses who care for survivors of human trafficking may experience compassion fatigue or vicarious trauma. Compassion fatigue occurs when nurses become emotionally exhausted due to their empathetic responses to survivors' suffering, and **vicarious trauma** refers to the emotional toll that exposure to the trauma of others can have on health-care providers. These reactions can lead to symptoms, such as anxiety, depression, and burnout. Likewise, nurses may experience a range of emotional responses when caring for trafficking survivors, including sadness, anger, frustration, and helplessness. It is crucial for nurses to acknowledge and manage these emotions effectively to prevent them from negatively impacting their care. Nurses also may have preconceived notions or biases about human trafficking, which can affect the care they provide. Recognizing and addressing these biases are essential to ensure that survivors receive nonjudgmental and compassionate care. Caring for survivors can also lead to **secondary trauma**, where health-care providers experience symptoms similar to those of trauma survivors. This can include intrusive thoughts, nightmares, and hypervigilance. Recognizing these symptoms and seeking support is essential for nurses' well-being. To address these challenges and ensure that nurses are equipped to provide the best care possible, "care for the caregiver" is crucial:

- Self-care: Nurses must prioritize self-care, which includes practices like exercise, mindfulness, seeking support from colleagues or therapists, and setting boundaries to prevent burnout.
- Supervision and support: Health-care organizations should provide supervision and support for nurses caring for trafficking survivors. Regular debriefing sessions and access to mental health professionals can help nurses process their emotions and manage vicarious trauma.
- Education and training: Ongoing education and training on trauma-informed care and the unique needs of trafficking survivors can help nurses feel more prepared and confident in their roles.
- Peer support: Encouraging peer support and creating a culture where nurses can openly discuss their experiences and challenges can be highly beneficial.
- Supervision and team collaboration: Nurses should collaborate with other health-care professionals, social workers, and organizations specializing in trafficking to provide holistic care to survivors and share the emotional burden of their work.

27.3 PTSD and Veteran Trauma

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define post-traumatic stress disorder (PTSD)
- Identify referrals and resources for a client with PTSD
- Describe the nurse's role in assisting trauma clients

Post-traumatic stress disorder (PTSD) is a pervasive and challenging mental health condition that affects not only the general population but also presents as a particularly serious issue within the military veteran population. Characterized by debilitating symptoms stemming from exposure to trauma, PTSD poses complex clinical challenges. In the realm of psychiatric-mental health nursing, there is an urgency to address the unique psychological and emotional burdens faced by military veterans, who often grapple with the enduring effects of combat-related traumas. Psychiatric-mental health nurses, as frontline health-care providers, are tasked with the mission of delivering specialized care, employing trauma-informed approaches, and advocating for evidence-based treatments to foster recovery and improve the overall mental well-being of veterans.

PTSD Defined

Post-traumatic stress disorder (PTSD) can develop after a person experiences or witnesses a traumatic event. These events can include military combat exposure, natural disasters, accidents, physical or sexual assault, and other life-threatening incidents. PTSD can manifest through a range of symptoms, such as flashbacks, nightmares, intrusive thoughts, avoidance of triggers, emotional numbness, and heightened anxiety. It can significantly impact an individual's daily life, relationships, and overall well-being. Treatment options, including therapy and medication, are available to help individuals manage and overcome PTSD, enabling them to regain a sense of control and improve

their quality of life. PTSD is a complex and deeply distressing condition, but with appropriate support and care, many individuals can make significant progress in their recovery.

According to the U.S. Department of Veterans Affairs (2023b), PTSD is a particularly prevalent and complex issue within the military community, where service members often face intense and traumatic experiences during their deployments. Combat exposure, witnessing injuries or death, and the constant threat of danger can lead to the development of PTSD symptoms. These symptoms may include recurrent flashbacks, hypervigilance, nightmares, irritability, and emotional numbness. PTSD in the military can be especially challenging due to the stigma associated with seeking mental health support and the fear of potential career consequences. There is a growing recognition of the importance of addressing PTSD within the military, however, and various support mechanisms, including specialized therapy programs and peer support networks, have developed to assist service members in their journey toward healing and recovery.

The *DSM-5-TR* (American Psychiatric Association, 2022) outlines the criteria for diagnosing PTSD, which includes exposure to trauma, intrusive symptoms, avoidance of triggers, negative changes to cognitions and mood, arousal and activity, duration of more than a month, and functional impairment.

Treatment for PTSD typically involves a combination of therapies and, in some cases, medication (Hoeft et al., 2019; American Psychological Association, 2020). The choice of treatment depends on the individual's specific symptoms, preferences, and the recommendations of their health-care provider. It can include CBT, exposure therapy, or EMDR. Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based therapy specifically designed for children and adolescents with PTSD. It incorporates CBT techniques to address trauma-related symptoms.

Potential medications used to treat PTSD include antidepressants and, off-label, Prazosin. The only medications that are FDA-approved for the specific treatment of PTSD are the SSRIs sertraline (Zoloft) and paroxetine (Paxil) (American Psychological Association, 2017). SNRIs, such as venlafaxine (Effexor), are also frequently used to manage symptoms of depression and anxiety in PTSD. The U.S. Department of Veterans Affairs (2023a) recommends that, of the antidepressants available, the SSRIs sertraline and paroxetine and the SNRI venlafaxine are found to be most effective for PTSD. Prazosin may be used off-label to alleviate nightmares and sleep disturbances associated with PTSD. Some other techniques used with PTSD clients include:

- Group therapy: Group therapy sessions provide a supportive and nonjudgmental environment where individuals with PTSD can share their experiences, learn coping strategies, and receive validation from peers who have faced similar challenges.
- Family therapy: Involving family members in therapy can help improve communication and relationships.
- Mindfulness and relaxation techniques: Techniques, such as mindfulness meditation, deep breathing exercises, and progressive muscle relaxation, can help individuals manage stress and anxiety.
- Complementary therapies: Some individuals find relief through adjunctive, complementary therapies like acupuncture, yoga, or art therapy.
- Self-help strategies: Encouraging individuals to engage in self-help strategies like journaling and maintaining a healthy lifestyle can complement formal treatment.

Referrals and Resources

Referrals and resources for clients with PTSD, including military veterans with PTSD, are crucial in ensuring that individuals receive comprehensive care and support. Here are specific examples of organizations and resources that provide assistance:

- Veterans Affairs (VA): The U.S. Department of Veterans Affairs is a primary resource for veterans with PTSD. VA medical centers and clinics across the country offer specialized PTSD treatment programs, including evidence-based therapies, such as CBT and EMDR. Veterans can access mental health services, medication management, and peer support through the VA.
- Wounded Warrior Project (WWP): WWP is a nonprofit organization that provides a wide range of programs and services to support veterans and service members who have experienced physical or mental health challenges, including PTSD.
- Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA offers a Behavioral Health Treatment Services Locator to help individuals find treatment facilities that offer services for PTSD.

- National Center for PTSD: This center, affiliated with the VA, offers a wealth of information and resources on PTSD. It also conducts research and provides training for health-care professionals.
- Give an Hour: This nonprofit organization connects veterans, service members, and their families with mental health professionals who offer free counseling and support.
- Veterans Crisis Line: Operated by the VA, the Veterans Crisis Line provides immediate assistance to veterans in crisis. Veterans, their families, or concerned individuals can call, text, or chat online for confidential support.
- National Alliance on Mental Illness (NAMI): NAMI offers education, advocacy, and support for individuals and families affected by mental health conditions, including PTSD. It has local chapters and support groups that can provide information and referrals.
- Local community mental health centers: Many communities have mental health centers or clinics that provide services for PTSD.
- Online resources: There are various online resources, including websites, forums, and mobile apps, that provide information, self-help tools, and community support for individuals with PTSD. Examples include the PTSD Coach app and the Military OneSource website.

Nurse's Role

The nursing process in care of clients with post-traumatic stress conditions includes specific assessment items to help focus the interventions. The therapeutic relationship, specifically the working phase, builds trust, assures safety, and establishes boundaries. The nurse functions as educator regarding medication, if indicated, coach for coping skills, and advocate for the client's self-management.

Assessment

Assessment is a critical component of nursing care for clients with PTSD. It involves gathering comprehensive information about the client's condition, including their physical and mental health, trauma history, and the impact of PTSD on their daily life. Key aspects of the assessment process for clients with PTSD include:

- Trauma history: Ask about the type of traumatic event(s) the client experienced, the timing and duration of the trauma, and any past or ongoing exposure to traumatic stressors.
- Symptom assessment: Assess the symptoms the client experiences, such as intrusion symptoms like recurrent distressing memories, nightmares, flashbacks, and intense psychological or physiological reactions that represent triggers to the trauma; avoidance symptoms, such as thoughts, feelings, conversations, places, people, or activities that remind them of the trauma; and arousal/reactivity symptoms, such as irritability, anger outbursts, reckless behavior, hypervigilance, exaggerated startle response, sleep disturbances, and problems with concentration.
- Functional ability assessment: Assess how PTSD symptoms impact the client's daily functioning, including their ability to work, maintain relationships, engage in self-care, and participate in activities of daily living.
- Safety assessment: Evaluate any potential self-harm, harm to others, or suicidal thoughts and ensure the client has a safe environment.
- Co-occurring conditions: Assess for co-occurring mental health conditions, such as depression, anxiety disorders, or substance use disorders, as these often accompany PTSD and may require integrated treatment.
- Cultural sensitivity: Recognize that cultural factors can influence how individuals experience and express their PTSD symptoms (Health Care Toolbox, n.d.).
- Client preferences and goals: Ask about the client's treatment preferences, goals, and concerns, because this information can guide care planning.

CLINICAL SAFETY AND PROCEDURES (QSEN)

QSEN Competency: Client-Centered Care, Trauma-Informed Care

Definition: Recognize the client as a full partner in control of all decisions when providing compassionate and coordinated care based on respect for the client's preferences, values, and needs.

Knowledge: Understand how trauma-informed care is an approach that acknowledges the prevalence of trauma and its effects on an individual's mental, emotional, and physical well-being. It is essential to provide care that is

sensitive to the trauma in order to establish rapport, gain the survivor's trust, and facilitate disclosure of their experiences.

Skill: Provide compassionate, trauma-informed care to victims or suspected victims of trauma while incorporating client values, preferences, and expressed needs in the treatment plan.

Attitude: Respect and encourage individual expression of client values, preferences, and needs in a nonjudgmental manner.

Medication Management, Monitoring, and Education

Medication management, monitoring, and client education are crucial aspects of nursing care for clients with PTSD. In terms of medication management, nurses play a key role in assisting clients in understanding their prescribed medications, including potential side effects, and how to take them correctly and reporting concerns to the health-care provider for prompt adjustments. For many individuals with PTSD, medications may help manage symptoms of depression, anxiety, and intrusive thoughts.

Monitoring is a continuous process in PTSD care, involving regular assessment of the client's response to treatment, changes in symptoms, and any potential side effects of medications. Nurses collaborate with the health-care team to track the client's progress and communicate any necessary adjustments to the treatment plan. Monitoring also extends to assessing the client's safety, particularly with respect to medication changes or when there's a risk of self-harm or worsening symptoms.

Client education is essential for promoting self-management and understanding the condition. Nurses educate clients about the nature of PTSD, coping techniques, and the importance of engaging in psychotherapy or counseling alongside medication for holistic treatment. Client education empowers individuals with PTSD to participate in their recovery and make informed decisions about their care.

Collaborating with the client to set achievable goals related to their mental and emotional well-being is considered **wellness coaching**. Nurses help clients identify strategies for managing their symptoms and improving their overall quality of life. This can include developing healthy routines, encouraging physical activity, and addressing sleep disturbances, all of which play a role in PTSD recovery.

Stress management is essential for clients with PTSD who often experience heightened stress levels and anxiety. Nurses teach stress-reduction techniques, such as mindfulness, deep breathing exercises, and progressive muscle relaxation. These strategies empower clients to cope with stress more effectively and reduce the intensity of PTSD symptoms. Assessing coping mechanisms is vital to understand how clients are managing their condition. The inability to employ personal strategies to manage psychological distress is considered ineffective coping. Some individuals with PTSD may resort to ineffective coping strategies, such as substance misuse or self-harm. Nurses work with clients to identify healthier coping mechanisms, fostering resilience and adaptability.

Client safety is a paramount concern, especially in cases where individuals with PTSD are at risk of self-harm or have a history of suicidal ideation. Nurses conduct ongoing safety assessments, ensuring that clients have access to crisis intervention resources and appropriate support systems.

Therapeutic Relationship/Trauma-Informed Care

Trauma-informed care is an approach to health care that recognizes and responds to the impact of trauma on individuals. Every client receives trauma-informed care regardless of known trauma history (Fleishman et al., 2019). This approach emphasizes creating a safe and supportive environment for those who have experienced trauma by integrating an understanding of the prevalence and effects of trauma into all aspects of care. The key principles of trauma-informed care include promoting safety, trustworthiness, collaboration, choice, and empowerment. It involves recognizing the signs and symptoms of trauma, avoiding retraumatization, and offering support that is sensitive to the unique needs of individuals who have faced traumatic experiences. Trauma-informed care is applied across various settings, including health care, social services, and education, to ensure a compassionate and healing approach that considers the complex effects of trauma on an individual's physical and mental well-being.

27.4 Mental Health in the LGBTQIA+ Community

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define sexual orientation and gender identity
- Identify mental health concerns of persons within LGBTQIA+ communities
- Discuss nurses' role in mental health care of LGBTQIA+ clients

Understanding the intersection of mental health and members of the lesbian, gay, bisexual, Transgender, Queer, Intersex, and questioning LGBTQIA+ community is essential for any health-care professional, particularly in the field of psychiatric-mental health nursing. The LGBTQIA+ community, composed of individuals with diverse sexual orientations, gender identities, and gender expressions, has long experienced unique mental health challenges, often stemming from societal discrimination, stigma, and a lack of acceptance. By recognizing the distinct challenges faced by LGBTQIA+ individuals and offering evidence-based strategies for support, future nurses will be empowered to deliver compassionate, inclusive, and culturally competent care that promotes mental well-being and resilience among LGBTQIA+ individuals.

Sexual Orientation and Gender Identity

Sexual orientation and gender identity are two distinct aspects of a person's being, often related to their understanding of self and their experiences in the world. An individual's emotional, romantic, and sexual attraction to others is their sexual orientation. It encompasses a range of orientations, including **heterosexual** (attracted to the opposite sex or gender), lesbian or gay (attracted to the same sex or gender), and **bisexual/pansexual** (attracted to more than one gender or any gender). People can also identify as **asexual**, which means they experience little to no sexual attraction to any gender. Sexual orientation is innate and not a choice; it is an integral part of a person's identity, independent of their gender identity (Human Rights Campaign, n.d.).

The sex category, typically male or female, that is assigned to an individual at birth based on physical and biological characteristics, such as genitalia and chromosomes is their **assigned sex**. An individual's deeply held sense of their sex, which may or may not align with the sex assigned to them at birth, is their gender identity. Individuals who have a gender identity that matches their assigned sex at birth (e.g., a person assigned female at birth identifies as a woman) are considered cisgender. Individuals who have a gender identity that differs from their assigned sex (e.g., a person assigned male at birth identifies as a woman) are considered Transgender. People who do not exclusively identify as male or female and may have a gender identity that falls outside the traditional binary understanding of gender are considered **nonbinary**, also known as genderqueer, genderfluid, or agender. The umbrella term, **queer**, can encompass various nonheteronormative sexual orientations and gender identities, often used as a self-identifier by individuals who don't fall within traditional categories. Other terms may include **androgyny**, meaning no distinction between male and female, **third gender**, meaning a separate gender apart from male or female, and **two spirit**, meaning incorporating qualities of both binary genders, sometimes used by Indigenous people.

Intersex is a general term used to describe people whose sex traits, reproductive anatomy, hormones, or chromosomes are different from the usual two ways human bodies develop. Some intersex traits are recognized at birth, while others are not recognizable until puberty or later in life. Intersex people and transgender people are not the same (and they are not interchangeable terms); many transgender people have no intersex traits, and many intersex people do not consider themselves transgender. Furthermore, most recent literature refers to the atypical conditions themselves as "differences of sex development," (DSD); nurses may find relevant guidance and evidence with that terminology, even though many intersex people do not use it to refer to themselves and some reject the terminology (Sandberg, 2022; Davis, 2013).

LINK TO LEARNING

There are many lists of recommended terminology, which evolves over time. Review the glossary of terms (https://openstax.org/r/77glossary) from the Human Rights Campaign for some recommendations.

Wellness and aspects of being through the life span are critical considerations in understanding mental health

within the LGBTQIA+ community. LGBTQIA+ individuals often face unique challenges and experiences related to sexual orientation, gender identity, and societal attitudes, which can have a significant impact on their mental well-being.

Coming Out and Identity Formation

Coming out, or the process of disclosing one's LGBTQIA+ identity, can be a pivotal moment in an individual's life. It can lead to feelings of self-acceptance and liberation, but it can also be a source of stress and anxiety, particularly when faced with potential rejection from family and friends. Therefore, support during this period is crucial for positive mental health outcomes.

Adolescence and Young Adulthood

LGBTQIA+ youth are at a higher risk of experiencing bullying, discrimination, and rejection, which can lead to mental health challenges like depression, anxiety, and suicidal thoughts (CDC, 2023b). Providing safe spaces, inclusive sex education, and access to mental health services is essential during this critical developmental stage (CDC, 2023b).

Relationships and Community

As LGBTQIA+ individuals form relationships and seek community, they may face discrimination, exclusion, or a lack of legal recognition, which can impact their mental well-being. Supportive relationships and involvement in LGBTQIA+ organizations or communities can be protective factors for mental health (Ceatha et al., 2021).

Older Adults and Identity

LGBTQIA+ individuals may face unique challenges in older age, including potential social isolation, lack of culturally competent health care, and discrimination in long-term care facilities. Addressing these issues is vital for the mental health of older LGBTQIA+ adults (Masa et al., 2024).

Intersectionality

Many LGBTQIA+ individuals belong to multiple marginalized groups, such as people of color, immigrants, or individuals with disabilities. Intersectionality adds layers of complexity to their experiences because they may face discrimination based on multiple aspects of their identity, which can contribute to mental health disparities (Funer, 2023).

Resilience and Empowerment

Despite the challenges, many LGBTQIA+ individuals demonstrate resilience and empowerment by embracing their identities, advocating for their rights, and seeking support when needed. Building on these strengths is a vital aspect of promoting mental health and well-being.

Culturally Appropriate Care

Mental health professionals and health-care providers must be sensitive to the unique culture and experiences of LGBTQIA+ individuals. This includes understanding the impact of discrimination, addressing concerns related to gender identity or sexual orientation, and offering affirming and inclusive care.

Mental Health Issues and Stigma Against People in LGBTQIA+ Communities

People within the LGBTQIA+ communities frequently grapple with elevated rates of mental health issues, often stemming from the pervasive discrimination, stigma, minority stress, and social rejection they may encounter. LGBTQIA+ individuals are not a homogenous group, and mental health experiences are shaped by intersecting identities, such as race, ethnicity, socioeconomic status, and disability. Intersectional factors can compound the challenges faced by LGBTQIA+ individuals. These stressors and unique obstacles can lead to heightened rates of anxiety, depression, and even suicidality among LGBTQIA+ individuals (Funer, 2023).

Higher Rates of Mental Health Conditions

Research consistently indicates that LGBTQIA+ individuals experience higher rates of mental health conditions compared with the general population (Medina-Martínez et al., 2021). Common mental health issues include depression, anxiety, substance misuse, and suicidal ideation. These disparities are often attributed to the stressors associated with societal discrimination and minority stress.

Some individuals experience gender dysphoria, a psychiatric disorder where the individual feels significant distress or discomfort due to the incongruence between their assigned gender at birth and the gender with which they

identify (Turban, 2022). The distress associated with gender dysphoria can impact various aspects of an individual's life, including emotional well-being, mental health, and social functioning. It's important to note that gender dysphoria is a recognized medical condition, and not every Transgender or gender diverse individual experiences gender dysphoria.

Social Isolation and Internalized Stigma

Some LGBTQIA+ individuals experience social isolation due to a lack of acceptance from their families, communities, or cultures (Firk et al., 2023). This isolation can contribute to feelings of loneliness and depression. Moreover, internalized stigma occurs when LGBTQIA+ individuals internalize negative beliefs and stereotypes about their own sexual orientation or gender identity. This self-stigmatization can lead to feelings of shame, low self-esteem, and poor mental health.

Finding supportive LGBTQIA+ communities and networks can be crucial for combating social isolation and internalized stigma.

Barriers to Accessing Care

Barriers to mental health care can include a lack of culturally competent providers, concerns about stigma and discrimination from health-care professionals, and financial barriers. These obstacles can prevent LGBTQIA+ individuals from seeking and receiving the care they need.

Marginalization and Stereotyping

Marginalization and stereotyping exert a profound impact on the mental health of individuals within LGBTQIA+ communities, erecting significant barriers to accessing mental health care and contributing to mental health disparities. Exclusion, discrimination, and the denial of rights, or marginalization, often leads to feelings of isolation and low self-esteem. It can contribute to mental health issues, such as depression and anxiety (Green et al., 2021). Individuals may refrain from seeking mental health care due to fears of encountering further discrimination from health-care providers. Stereotyping, involving generalized assumptions based on LGBTQIA+ identity, likewise perpetuates stigma and bias, dissuading individuals from seeking mental health support out of concern for judgment or prejudice (Anzani et al., 2024).

Marginalization and stereotyping collectively obstruct access to care, resulting in delayed interventions and exacerbated mental health conditions. Addressing these issues necessitates promoting LGBTQIA+ inclusivity, educating society on acceptance, providing cultural competency training for health-care providers, and creating safe, affirming spaces for mental health care within LGBTQIA+ communities to reduce mental health disparities and ensure equitable access to care.

Minority Stress

The unique stressors and adverse mental health outcomes experienced by individuals in marginalized and stigmatized groups is called **minority stress** (Goldbach, 2021). LGBTQIA+ individuals may face minority stress due to their sexual orientation or gender identity. It encompasses stress-inducing experiences like coming out, experiencing discrimination and microaggressions, and fearing rejection. Minority stress can lead to adverse mental health issues and contribute to disparities in health-care access and outcomes.

LINK TO LEARNING

The Trevor Project (https://openstax.org/r/77TrevorProject) is a nonprofit organization that focuses on crisis and suicide prevention among LGBTQIA+ youth. It provides a crisis hotline number at 866-488-7386 and a text number and chat service for assistance, which are available 24/7, as well as a social networking community.

The Nurse's Role

Client-centered care is of paramount importance for LGBTQIA+ clients in mental health settings because it acknowledges and respects their unique experiences and needs (American Nurses Association [ANA], 2018). Providing care that is client-centered means actively listening to clients, understanding their specific concerns related to sexual orientation and gender identity, and tailoring treatment plans accordingly. It fosters a trusting and affirming therapeutic relationship, which is essential for individuals to feel safe discussing their mental health

challenges, coming out experiences, or questions or concerns about their gender. By prioritizing the client's voice and perspective, health-care providers can offer more effective and compassionate care, ultimately improving mental health outcomes and reducing disparities for LGBTQIA+ individuals (ANA, 2022).

LINK TO LEARNING

The American Nurses Association (ANA, 2022) published a news release (https://openstax.org/r/77genderaffcare) that expresses the ANA's opposition to restrictions on gender-affirming care.

Diverse and Culturally Competent Interventions

Providing inclusive and culturally competent nursing care is imperative when supporting individuals within the LGBTQIA+ community. Nurses play a pivotal role in ensuring that the care they deliver is respectful, affirming, and responsive to the diverse needs of LGBTQIA+ clients. This involves adopting a multifaceted approach that acknowledges the unique experiences and challenges faced by individuals across various gender identities and sexual orientations. From fostering open communication to understanding the nuances of gender-affirming care, the nurse's toolkit encompasses a myriad of specific, diverse, and culturally appropriate interventions. There are many specific, diverse, and culturally competent interventions for the nurse to implement when assisting LGBTQIA+ clients (National LGBT Health Education Center, n.d.), such as:

- Affirming language and pronouns: Use respectful and gender-affirming language. Always ask for and use the client's preferred name and pronouns. This simple gesture helps build trust and respect.
- Cultural sensitivity training: Health-care providers should undergo training on LGBTQIA+ cultural competency to understand the unique challenges, experiences, and health disparities faced by this community. This training should include awareness of intersectionality, or the overlapping identities that affect individuals' experiences.
- Safe and inclusive spaces: Create an environment that is visibly LGBTQIA+-friendly. Display inclusive signage, pamphlets, or materials that signal acceptance and provide privacy for sensitive discussions.
- Inclusive assessment: Ask open-ended questions about the client's experiences, including coming out, family support, and discrimination. Understanding their lived experiences is crucial for tailoring interventions effectively.
- Mental health support groups: Offer LGBTQIA+-specific mental health support groups or therapy options where clients can connect with others who share similar experiences. This can reduce isolation and provide a sense of community.
- Education and resources: Provide educational materials and resources about LGBTQIA+ mental health, including information about coming out, gender dysphoria, and the unique stressors faced by LGBTQIA+ individuals.
- Crisis intervention: Be prepared to provide crisis intervention with sensitivity to LGBTQIA+ issues. LGBTQIA+ individuals may face unique stressors, such as rejection from family or a lack of social support.
- Transgender health care: For Transgender clients, ensure access to gender-affirming care, including hormone therapy and surgical referrals when appropriate. Understand the importance of gender-affirming care in mental health outcomes.
- Family support and education: Offer family therapy or support groups to help families better understand and accept their LGBTQIA+ loved ones. A supportive family can have a significant impact on an individual's mental health.
- Advocacy: Advocate for LGBTQIA+ clients within the health-care system to ensure they receive equitable and respectful care. Address any discriminatory practices or barriers to care.
- Crisis helplines: Provide information about LGBTQIA+ crisis helplines and support services for individuals who may be facing immediate mental health challenges (Bass & Nagy, 2023).

LGBTQIA+ Nurses

LGBTQIA+ nurses may encounter several challenges within the health-care profession. Discrimination and bias, whether from colleagues or clients, can create a hostile work environment. The decision to disclose one's LGBTQIA+ identity at work can be a dilemma, often driven by concerns about potential discrimination or bias. Some health-

care institutions may lack inclusive culture, making it difficult for LGBTQIA+ nurses to feel accepted and respected. Additionally, experiencing discrimination or bias can take a toll on mental health, leading to stress, anxiety, or depression.

To address these challenges, LGBTQIA+ nurses can tap into various resources. Joining LGBTQIA+ support groups, both within and outside the workplace, can provide a safe space for networking, sharing experiences, and seeking guidance. Professional associations like the National LGBTQIA+ Health Education Center (https://openstax.org/r/77LGBTQIAhealth) offer resources and support specifically tailored to LGBTQIA+ health-care professionals, including nurses. Seeking out employers with LGBTQIA+-friendly policies and practices, such as nondiscrimination policies and diversity training, can contribute to a more inclusive work experience. Utilizing mental health services or counseling can help address the emotional toll of discrimination, while continuous education on LGBTQIA+ health issues and cultural competency empowers nurses to advocate for their clients and themselves.

LINK TO LEARNING

GLMA Health Professionals Advancing LGBTQIA Equality (https://openstax.org/r/77LGBTQIAsuport) is the world's oldest and largest association of LGBTQIA+ health professionals. It provides medical professionals, researchers, and advocates with resources, education, and support to address LGBTQIA+ health disparities.

27.5 Mental Health in the Homeless and Displaced Population

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss risks for housing instability and mental health needs of unhoused and displaced persons
- Give examples of barriers to mental health care
- Develop collaborative nursing strategies to promote health

The intersection of mental health and homelessness or displacement has emerged as an important focal point within the realm of psychiatric-mental health nursing. Unhoused and displaced populations face a variety of unique mental health challenges, stemming from a complex web of factors, such as poverty, trauma, and social isolation. For individuals grappling with homelessness or displacement, access to mental health care is often fraught with barriers, ranging from stigmatization to the lack of resources and support networks. In response to these challenges, psychiatric-mental health nurses are often at the forefront of developing innovative strategies aimed at promoting mental well-being and holistic health within these marginalized communities. Nurses explore their distinct mental health needs, the hurdles to care, and the development of nursing strategies designed to bridge the gap, restore dignity, and facilitate recovery within these often-overlooked communities.

Risks for Housing Instability and Accompanying Mental Health Needs

Loss of home or housing stability can result from various risks and causes, often a combination of factors (Table 27.3). Being **homeless** generally means lacking a stable, safe, and adequate place to live, or living without a fixed residence. The term **unsheltered** generally refers to individuals experiencing homelessness who lack any form of shelter, such as those living on the streets, in cars, or in other places not meant for human habitation, without access to conventional housing or shelter facilities. Orenstein (2020) writes that people living in certain situations should be the ones to guide the language used to describe them. For example, some people (and some organizations and advocates) use the term "houseless" or "unhoused" to refer to their specific living situation; a person who lives in a tent may consider themselves "unhoused" but not "homeless," because they do have a home. Nurses should consider the stigma and assumptions that arrive with all terminology.

Category	Risks	Description
Economic factors	Financial instability	Job loss, underemployment, low wages, or unexpected expenses can make it difficult for individuals and families to maintain stable housing.
	Rising housing costs	Rapid increases in rent or mortgage payments that outpace income growth can force people out of their homes.
Health-related factors	Medical expenses	High medical bills, especially in the absence of adequate health insurance, can lead to financial distress and housing instability.
	Mental health issues	Mental health challenges can disrupt a person's ability to maintain housing and stability.
	Physical disabilities	Disabilities that limit mobility or the ability to work can impact housing stability.
Family and relationship factors	Domestic violence	Escaping an abusive relationship may require leaving one's home to ensure safety.
	Family disputes	Conflict within families, disagreements over property, or strained relationships can result in loss of housing.
Social factors	Social isolation	Lack of a support network or social connections can contribute to housing instability, as individuals may have no one to turn to in times of crisis.
	Discrimination	Discrimination based on race, ethnicity, gender, or other factors can limit housing opportunities and contribute to housing instability.
Legal factors	Eviction	Legal actions leading to eviction, often due to unpaid rent or lease violations, can result in the loss of housing.
	Foreclosure	Homeowners may lose their homes due to inability to meet mortgage payments, leading to foreclosure.
Natural factors	Natural disasters	Hurricanes, floods, wildfires, or earthquakes can destroy homes and displace individuals and families.
Policy and economic trends	Gentrification	Neighborhood revitalization efforts can lead to increased housing costs, pushing out long-term residents.
	Inadequate affordable housing	Shortages of affordable housing options in some areas can make it challenging for low-income individuals and families to secure stable housing.
Substance use factors	Substance misuse	Substance use and misuse can lead to financial instability and homelessness.
Support services	Limited access	Limited access to social services, mental health treatment, or substance misuse recovery programs can contribute to housing instability for vulnerable populations.

TABLE 27.3 Risks Increasing Likelihood of Housing Instability

Mental Illness

Mental illness is a significant contributing factor to homelessness, and the relationship between mental health and homelessness is complex. According to the National Alliance on Mental Illness (NAMI, 2023), as of 2020, 21.1 percent of the unhoused population in the United States had a **serious mental illness (SMI)**, which means an illness that causes diminished capacity or ability to participate in and function in daily life endeavors. Several key factors illustrate how mental illness can play a role in homelessness and how homelessness can cause or exacerbate mental illness:

- Preexisting mental health conditions: Many individuals experiencing homelessness have preexisting mental health conditions, such as schizophrenia, bipolar disorder, depression, or PTSD. These conditions can make it challenging to maintain stable employment, housing, and social relationships.
- Lack of access to mental health care: Homeless individuals often struggle to access mental health services due to financial constraints, lack of insurance, or limited availability of services. This can result in untreated or undertreated mental illness, exacerbating their challenges.
- Self-medication: Some individuals with mental health issues may turn to self-medication through substance abuse as a way to cope with their symptoms. This can further complicate their ability to secure stable housing and employment.
- Crisis events: Mental health crises, such as severe episodes of psychosis or severe depression, can lead to disruptions in employment and housing. Without adequate support and treatment, these crises can result in homelessness.
- Stigma and discrimination: Stigmatization and discrimination against people with mental health issues can lead to social isolation and exclusion, making it more difficult for them to maintain relationships, find housing, or secure employment.
- Cycling in and out of homelessness: Some individuals with mental illness may experience cycles of homelessness, where they briefly obtain housing but lose it due to difficulties related to their mental health. They encounter **housing instability**, generally a state of uncertainty or vulnerability in one's housing situation, characterized by frequent moves, risk of eviction, difficulty paying rent or mortgage, or a lack of stable, secure housing. It can increase stress, and the cycle can perpetuate homelessness and mental health issues.
- Trauma and PTSD: Homelessness itself can be a traumatic experience, leading to the development or worsening of mental health conditions like PTSD. Trauma from experiences, such as domestic violence, childhood abuse, or military service can also contribute to mental illness and homelessness.

Substance Use Disorder

The relationship between substance use disorder (SUD) and homelessness is also complex, with several key factors highlighting how SUD can contribute to homelessness. For many individuals experiencing homelessness, substances like alcohol or drugs serve as coping mechanisms to manage the immense stress, trauma, and hardships associated with life on the streets. These substances can temporarily numb emotional pain or provide a brief respite from the harsh realities of homelessness. The misuse of substances often leads to addiction and physical dependency. As the addiction progresses, individuals may prioritize obtaining and using drugs or alcohol over maintaining stable housing, employment, or relationships. Maintaining a substance use disorder can be financially draining, as the costs of obtaining drugs or alcohol can deplete financial resources. Consequently, individuals may struggle to afford housing, rent, or utilities, leading to eviction or housing loss.

Additionally, substance use frequently brings legal issues, including arrests for drug-related offenses. Legal problems can result in incarceration, probation, or parole, making it challenging to secure stable housing or employment upon release.

Social isolation is also a consequence of substance use, as it can lead to the isolation of individuals from their support networks and families. This social isolation can result in strained or severed relationships, reducing the likelihood of receiving help from friends or family when faced with housing instability.

Moreover, substance use can exacerbate or co-occur with mental health disorders, further complicating efforts to secure stable housing and employment. These co-occurring disorders often require integrated treatment approaches for effective management.

Further, individuals experiencing homelessness and substance use disorders may encounter barriers to accessing

addiction treatment services. These barriers can include lack of insurance, transportation, or access to detoxification and rehabilitation programs, which hinder their path to recovery and housing stability.

Mental Health Needs of Individuals with SUD Housing Instability

Understanding these complex interconnections between housing and mental illness and housing and substance misuse is crucial for health-care professionals. By comprehending a holistic picture, nurses are able to provide better, comprehensive care and support to individuals facing homelessness and SUD.

Motivational Therapies

Motivational therapies have proven to be effective tools in addressing substance use disorders among homeless individuals. One that is particularly effective is **motivational interviewing (MI)**, a client-centered approach that aims to enhance an individual's intrinsic motivation to change their behavior (Psychology Today, 2022). In the context of homelessness and substance use, MI can be a powerful technique for engaging individuals who may be ambivalent about seeking treatment. By empathetically exploring their concerns and values, MI helps homeless individuals recognize the impact of substance use on their lives, fostering a genuine desire for change. It acknowledges the complex challenges faced by this population and works collaboratively to set achievable goals for recovery. It is a valuable approach to providing tailored support for those struggling with substance use within the homeless community.

Recovery Housing

The concept of **recovery housing**, supportive and structured environments that offer a safe and stable place for individuals in recovery, creates a conducive setting for healing and sobriety. It represents a crucial component in addressing substance use disorder among individuals without housing. Recovery housing typically promotes abstinence, provides access to counseling and support services, and encourages residents to actively engage in their recovery journey. For unhoused individuals grappling with substance use disorders, such housing can be a lifeline, offering not only a physical place to stay but also a community of peers who understand their struggles. It helps break the cycle of homelessness and substance misuse, fostering an environment where individuals can rebuild their lives and work toward sustained recovery.

LINK TO LEARNING

The Substance Abuse and Mental Health Services Administration (SAMHSA) created their Best Practices for Recovery Housing (https://openstax.org/r/77recoveryhousg) in recognition of its crucial role in positive outcomes. It contains evidence-based practice guidelines for creating successful recovery housing.

Barriers to Stability and Results of Instability

Homelessness is compounded by a multitude of barriers for individuals striving to regain housing and financial security. As discussed, living with a mental illness can exacerbate these situations. Barriers include the absence of a credit or rental history, which can deter landlords from renting to those without proven financial reliability. Lack of insurance can hinder access to vital health care, perpetuating health-related issues, while limited transportation options impede access to employment, social services, and medical care. Unemployment remains a central hurdle, as income is crucial for maintaining housing, and the cyclical nature of homelessness often hampers job-seeking efforts. Addressing these multifaceted barriers and fostering stability requires a comprehensive approach, including affordable housing initiatives, employment support, health-care access, and financial literacy programs.

Psychosocial Barriers

Psychosocial barriers play a pivotal role in perpetuating homelessness, encompassing a range of factors that affect an individual's ability to regain stability. Trust issues, often stemming from past traumas or exploitation, can hinder engagement with support services and housing programs. Stigma associated with homelessness can lead to social isolation and keep individuals from seeking assistance, particularly among young and older adults who may face unique challenges due to their age. Limited access to education or lack of skills can constrain employment opportunities, while the cycle of homelessness itself can disrupt education for youth. Overcoming these psychosocial barriers necessitates a holistic approach, including trauma-informed care, anti-stigma campaigns, targeted interventions for vulnerable age groups, and educational support to empower individuals on their journey

toward housing stability (SAMHSA, 2015).

Societal Impact of Instability

The societal impact of barriers to housing stability is far-reaching and multifaceted. Persons living with mental illness and homelessness may be overrepresented among defendants entering the criminal justice system and have higher rates of arrest and victimization (Sipes, 2022). Some life-sustaining activities, such as sleeping, camping, or asking for money in public places can be subject to arrest (National Coalition for the Homeless, 2023). The lack of stable housing can also contribute to increased utilization of emergency medical care; unhoused individuals may rely on emergency rooms for primary health-care needs, straining health-care resources and increasing costs. To mitigate these societal impacts, it is crucial to invest in comprehensive homelessness prevention and support programs that address the root causes of homelessness, ultimately benefiting both individuals and society as a whole.

Special Populations: Veterans, Families, Rural Areas

Homelessness unevenly affects various special populations, each facing unique challenges of which nurses should be aware. Mental health concerns complicate these scenarios. One Veterans Affairs study in 2017 found that out of 300,000 veterans who had been referred for anxiety or PTSD, 5.6 percent experienced homelessness within one year (Tsai et al., 2017). The overall Veteran population shows homelessness of approximately 3.7 percent over a five-year period (U.S. Department of Veterans Affairs, 2021).

Families and children impacted by mental health concerns also constitute a particularly vulnerable group, with homelessness adding to detrimental effects on children's development and well-being. In rural areas, homelessness can be especially hidden and persistent due to a lack of infrastructure and resources, resulting in limited access to shelters and support services. Limited, also, are community mental health centers and resources specifically for the care of a diverse rural population (Morales et al., 2020). Addressing homelessness in these special populations requires tailored interventions, such as veteran-specific housing programs, family-oriented shelters, and outreach efforts in rural communities.

Nursing Collaboration

Collaboration between nursing professionals, other disciplines, and government agencies is essential to improving access to mental health care for unhoused clients (Robert Wood Johnson Foundation, 2021). Nurses often serve as the first point of contact in health-care settings, making them crucial in identifying mental health needs among homeless individuals. To enhance accessibility, nurses can collaborate with social workers, psychologists, and outreach workers to conduct intake assessments in easily accessible locations, such as homeless shelters, drop-in centers, or mobile clinics. This collaborative effort ensures that individuals experiencing homelessness receive timely mental health assessments and referrals to appropriate services. Additionally, partnerships with government agencies at the local, state, and federal levels can help secure funding for mental health programs and increase the availability of resources, including affordable housing and substance misuse treatment, which are vital components of comprehensive care for unhoused individuals with mental health needs. By working together across disciplines and with government support, nurses can help bridge the gap in mental health-care accessibility for unhoused clients and improve their overall well-being.

LINK TO LEARNING

The Robert Wood Johnson Foundation framework (https://openstax.org/r/77robertwoodfnd) can assist nurses who must coordinate with other disciplines and organizations when providing care to clients.

Advocacy for Support

Advocacy for support is a crucial component of psychiatric-mental health nursing. Psychiatric-mental health nurses often witness firsthand the challenges faced by individuals with mental illness who lack stable housing. Communities with supportive housing can not only provide a safe and stable environment, but can also offer essential services like counseling, medication management, and social support that are integral to mental health recovery. Psychiatric-mental health nurses can advocate for increased funding and policy changes to expand supportive programs and services, ensuring that vulnerable populations, such as those experiencing homelessness

or severe mental illness, have access to these vital resources. Individuals living without secure housing also benefit from practical assistance where they are.

LINK TO LEARNING

Nurses can find resources from the American Nurses Association (https://openstax.org/r/77nurseadvocacy) for legislative advocacy.

Homeless Health Nursing/Street Nursing

Homeless health nursing, often referred to as street nursing, is a specialized field that focuses on providing health-care services to individuals experiencing homelessness in nontraditional settings, such as shelters, encampments, or on the streets (Cavazos, 2022). These dedicated nurses play a vital role in addressing the complex health needs of this marginalized population, including mental health and substance use issues, infectious diseases, and chronic illnesses. Street nurses build trusting relationships with their clients, offering not only essential medical care but also support, referrals to social services, and advocacy for improved living conditions. Their work is essential in addressing health disparities and improving the overall well-being of those who are unhoused, often acting as a link between the health-care system and this vulnerable population.

27.6 Objectives for the Future

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss consensus studies for PMH nursing's future
- Identify inclusive strategies for nursing education
- Create a personal future career/service plan

Nurses have a unique opportunity to influence health equity among the clients they support. They can help ensure nursing education uses inclusive strategies for training future nurses, and they can incorporate the components of the consensus studies and create their own service plan to ensure the best possible outcomes for their clients.

Consensus Studies on the Future of Nursing in PMH

The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity (National Academies of Sciences, Engineering, and Medicine, 2021) is a report that outlines a vision for the nursing profession and its role in advancing health equity over the next decade. The report emphasizes the importance of nurses in addressing health disparities and improving health-care access for underserved populations. It calls for nurses to be leaders, advocates, and collaborators in health-care delivery, policy development, and education. Key themes include promoting diversity and inclusion within the nursing workforce, advancing nursing education and practice, and enhancing the role of nurses in health-care leadership. The report underscores the critical role nurses play in achieving health equity and recommends actions to empower and support nurses in this mission.

The American Academy of Nursing (AAN) is dedicated to promoting organizational excellence, nursing leadership, and evidence-based policy. To enhance nurse well-being, in 2023 the organization released *American Academy of Nursing Consensus Recommendations to Advance System Level Change for Nurse Well-being.* This paper recommends actions by key organizations to drive systemic changes in workplace safety, increase professional mobility, and advocate for policies that improve access to health-care resources. These recommendations stem from the expertise of AAN's Expert Panels on Building Health Care System Excellence, Psychiatric Mental Health and Substance Use, and Global Health. Achieving transformative improvements in health-care work environments and advancing nurse well-being and equity will require innovative policy changes and collaborative efforts involving associations, organizations, nonprofits, the public, and the media within government and health-care sectors.

Determinants of Mental Health

The determinants of mental health are integral to the objectives for the future of mental health nursing. For instance, mental health nurses could actively engage in addressing the social determinant of access to stable housing. In practical terms, this might involve collaborating with community organizations to provide housing support and advocating for affordable housing initiatives to reduce homelessness, a factor closely linked to mental

health challenges. Furthermore, mental health nurses can work toward improving educational opportunities, recognizing that a lack of education can be a barrier to both employment and mental health. They may collaborate with schools and provide support to at-risk youth to ensure access to education and enhance resilience against mental health issues.

Another key focus of mental health nursing objectives is the integration of care across the biological, psychological, and social determinants of mental health (Naegle et al., 2023; National Academies of Sciences, Engineering, and Medicine, 2021). For instance, nurses may take a holistic approach in the care of individuals with a family history of mental illness (biological determinant) by providing education on coping strategies and resilience-building techniques (psychological determinant) and connecting them with community resources that offer social support. This personalized care approach aligns with the future objectives, aiming to provide tailored interventions that consider an individual's unique circumstances, ultimately improving mental health outcomes. By addressing specific determinants with targeted actions and interventions, mental health nurses contribute to a more equitable and comprehensive mental health-care system.

Care Coordination/Changing Populations

Care coordination in nursing is evolving in response to changing populations and health-care landscapes. Salmond and Echevarria (2017) identified a newly expanding role for the registered nurse as coordinator of care. Specific areas of health care to address include improved client satisfaction, improved population health, and reduced health-care costs (Salmond & Echevarria, 2017). Several key trends and developments reflect this evolution:

- Focus on population health: Nursing care coordination shifted from primarily addressing individual client needs to incorporating a population health approach. Nurses now work to manage the health of entire populations, identifying common health issues and implementing strategies for prevention and early intervention. This approach helps health-care systems manage chronic conditions, reduce hospital readmissions, and promote overall community well-being.
- Technological advancements: Health-care technology, including electronic health records (EHRs) and telehealth platforms, has transformed care coordination. Nurses use digital tools to access client information, communicate with health-care teams, and remotely monitor clients. Telehealth, in particular, has become a vital tool for reaching underserved populations and providing ongoing care management.
- Interprofessional collaboration: Care coordination has become increasingly interprofessional, involving collaboration among nurses, physicians, pharmacists, social workers, and other health-care professionals. This team-based approach ensures that clients receive comprehensive care that addresses their physical, mental, and social needs.
- Community-based care: With the recognition that many health-care needs extend beyond the hospital, nursing care coordination will expand into the community. Nurses work in various settings, including home health care, schools, and outpatient clinics, to provide preventive care and support clients in managing chronic conditions.
- Cultural competency: As populations become more diverse, cultural competency gains greater importance in care coordination. Nurses are called to understand and respect the cultural beliefs and values of their clients, ensuring that care plans are culturally sensitive and appropriate.
- Aging population: With the aging of the population, care coordination must adapt to address the unique needs of older adults, including complex medical conditions, polypharmacy, and geriatric syndromes. This involves a focus on holistic, person-centered care.
- Health-care policy changes: Health-care policy reforms have emphasized care coordination as a means to improve quality, reduce costs, and enhance client outcomes (Salmond & Echevarria, 2017). These policies have encouraged health-care organizations to implement care coordination models and programs.
- Client engagement: There is a growing emphasis on client engagement and shared decision-making in care coordination. Nurses work to empower clients to actively participate in their care planning, making informed decisions about their health.

Care Delivery Models/Treatment Settings

The evolving landscape of nursing care encompasses both changes in care delivery models and shifts in treatment settings to adapt to current health-care trends. Care delivery models are increasingly emphasizing a client-centered and holistic approach. Nurses are playing pivotal roles in interprofessional teams that collaborate to provide

comprehensive care, acknowledging that clients often have multifaceted health-care needs. These care models are being applied across various treatment settings, from hospitals to community clinics, ensuring that clients receive well-rounded care that addresses their physical, mental, and social health.

In tandem with these care models, treatment settings are undergoing transformation to better align with contemporary health-care demands. A notable trend is the growing emphasis on community-based care settings. Health-care services are extending beyond traditional hospital confines, with the goal of enhancing accessibility and client-centeredness. This encompasses a diverse range of treatment settings, including home health care, outpatient clinics, and telehealth services. Home health care, for example, allows clients to receive care in the familiar surroundings of their homes, benefiting those with chronic conditions or mobility limitations.

Emerging Technologies

Telehealth services, accelerated by the COVID-19 pandemic, provide a means for remote consultations, monitoring, and education, effectively breaking down geographical barriers and expanding access to care. Automated medical equipment for both clients and nurses include wearable and portable devices. Electronic centralized command centers broaden safe, efficient practice. Clients can monitor and report their own health status and access self-care support through apps for mental health and other medical concerns. By embracing technology, innovative care delivery models, and a variety of treatment settings, nursing is poised to offer more accessible, holistic, and effective health-care services in response to the evolving needs of diverse client populations.

Inclusive Strategies for Nursing Education

One of the most pressing issues in education, including psychiatric-mental health nursing education, is the ongoing faculty shortage. According to Kaas (2019), the American Association of Colleges of Nursing (AACN) states that there is a continuing shortage of qualified faculty for undergraduate, graduate, and postgraduate students. This shortage continues to worsen as current faculty members retire and others are kept away by higher-paying positions.

Another one of the most important issues in current educational trends is **diversity, equity, and inclusion (DEI)** (Jolley & Peck, 2022), which represents the commitment to recognizing and embracing differences, ensuring fairness, and fostering a sense of belonging for all individuals in order to create a more equitable and enriched nursing profession and health-care system. This can enhance nursing education by exposing students to various perspectives and experiences, enabling nurses to provide holistic and client-centered care that respects and meets the unique needs of diverse populations. Additionally, by fostering DEI in nursing education, programs can attract students from underrepresented backgrounds and create a more diverse nursing workforce. This diversity helps improve access to care, client satisfaction, and client outcomes, as individuals tend to feel more comfortable and understood when cared for by health-care professionals who share their cultural or linguistic background.

Another important purpose of emphasizing DEI is to address health disparities caused by social determinants of health (see Holistic Health and Interventions) and systemic inequalities and biases (Bradford et al., 2022). Underrepresented populations, such as Black and Hispanic people, are especially at risk for experiencing greater obstacles to health (Ndugga & Artiga, 2023). Nursing education can equip students with the knowledge and skills to identify and challenge these disparities.

Digital Platforms/Simulation

Digital platforms and simulation techniques, such as the use of artificial intelligence (AI), are increasingly central to current and future trends in psychiatric-mental health education. These technologies offer immersive and interactive learning experiences for students, enabling them to practice clinical skills, decision-making, and communication in a safe and controlled environment. Simulation scenarios can replicate complex mental health situations, allowing students to develop critical thinking skills and gain exposure to a wide range of client presentations. Moreover, digital platforms provide access to a wealth of educational resources, including online lectures, interactive case studies, and virtual client assessments, which complement traditional classroom teaching.

Clinical Specialization/Preceptorships

Clinical specialization and preceptorships play pivotal roles in both current and future psychiatric-mental health education trends. These experiences offer students the opportunity to delve deeply into specific areas of psychiatric nursing, such as child and adolescent mental health or substance use disorders. By working closely with

experienced preceptors in real clinical settings, students gain invaluable hands-on experience, enhance their clinical skills, and develop a deeper understanding of client populations and treatment modalities. These specialized clinical experiences provide the practical knowledge and expertise necessary for delivering high-quality, client-centered care in a rapidly evolving field.

Creating a Personal Future Career/Service Plan

Nashwan (2023) advocates for nurses to create a personal future career or service plan as a professional in the field. Such a plan involves setting clear goals, such as further education or specialization, and defining the populations or mental health issues they are passionate about serving. It also entails identifying opportunities for professional development and staying current with evolving best practices and research. A service plan can include a commitment to promoting mental health awareness, reducing stigma, and advocating for equitable access to mental health care. By outlining their aspirations and strategies for growth, psychiatric-mental health nurses can ensure meaningful and purpose-driven careers dedicated to improving the mental well-being of individuals and communities.

Professional/Educational Development

Nurses are encouraged to assume a deliberate focus on professional and educational development. In this process, nurses take proactive steps to enhance their skills, knowledge, and expertise to advance in their careers and contribute effectively to health care. This development may encompass pursuing advanced certifications, such as registered nurse board certification, or specialized training to gain specialized expertise in areas, such as psychiatric-mental health nursing. Additionally, nurses can engage in continuous learning through workshops, seminars, and conferences to stay updated on the latest research and best practices in the field. They may also seek mentorship or preceptorship opportunities to learn from experienced professionals. This dedication to professional and educational growth not only helps nurses provide better care but also positions them for leadership roles and opportunities to influence the future of psychiatric-mental health nursing through research, policy advocacy, and innovation.

Advocacy/Networking

Advocacy and networking are important aspects of creating a personal career or service plan in nursing. Advocacy entails actively speaking out for the needs of clients, the nursing profession, and health care in general, spanning individual client advocacy to influencing health-care policies. Nurses can develop advocacy skills to become effective change agents, improving client outcomes and shaping the future of health care. Concurrently, networking involves building relationships within the nursing profession and the broader health-care community. It opens doors to opportunities like mentorship, research collaboration, and access to resources. Nurses can expand their networks through conferences, professional organizations, online forums, and community involvement, providing valuable insights and collaborative prospects that advance their careers and amplify their impact in health care.

Well-Being: Self and Others

In the formulation of a personal future career or service plan in nursing, it is crucial to emphasize the well-being of both oneself and others. This holistic approach encompasses various facets. First and foremost, nurses must prioritize self-care to maintain their physical and mental health. This involves setting boundaries, practicing stress-reduction techniques, and seeking support when necessary to prevent burnout, ensuring they can consistently provide high-quality care to their clients. Central to this plan is a steadfast commitment to the well-being of clients, entailing a dedication to continually improving the quality of care delivered, staying updated on evidence-based practices, and advocating for client rights and safety. Moreover, fostering a supportive network among colleagues is pivotal, as nurses can collaborate, share experiences, and offer emotional support to create a positive work environment. Beyond clinical settings, nurses can extend their impact by promoting community health through education, outreach, and advocacy for health-care policy changes, particularly in underserved populations. In essence, a well-rounded personal career or service plan in nursing recognizes the interconnectedness of self-care, client well-being, and community impact, ensuring that nurses are equipped to provide exceptional care while contributing positively to health care at large.

Summary

27.1 Effects of the COVID-19 Pandemic

The COVID-19 pandemic has had a profound and lasting effect on mental health and care delivery. Many people reported increased anxiety and depression during the pandemic, but had problems accessing services due to lockdowns and other issues causing problems with access to care. Nurses became crucial in assisting clients with accessing care by providing education and services to connect them with providers, including therapists, nurse practitioners, and physicians. Much of mental health care shifted to the virtual environment, and nurses helped connect clients to virtual care. Nurses also found themselves facing their own mental health issues exacerbated by the pandemic and client care. These stressors require nurses to pay special attention to their own mental health, emphasizing self-care and fighting the results of burnout and compassion fatigue.

27.2 Human and Sex Trafficking

Human trafficking is the illegal trade of vulnerable people, typically for forced labor or commercial sexual exploitation, using coercion, fraud, or force. It includes child soldiering, debt bondage, labor trafficking, and sex trafficking. There are numerous resources for prevention and awareness, both government and nonprofit, of which nurses should be aware. Nurses have a responsibility to adequately assess clients and be aware of potential signs of human trafficking, and to report suspected cases of human trafficking to the appropriate authorities.

27.3 PTSD and Veteran Trauma

Post-traumatic stress disorder is a mental health condition that can develop after a person experiences or witnesses a traumatic event. These events can include combat exposure, natural disasters, accidents, physical or sexual assault, and other life-threatening incidents. PTSD can be helped by a combination of psychotherapy, medication, and complementary therapies. When working with clients with PTSD, nurses must gather a thorough history, including a history of symptoms, provide education on therapies, evaluate for treatment responses, and tailor the treatment plan accordingly. Interventions include education, wellness coaching, stress management, and monitoring client safety. Trauma-informed care is especially important to the therapeutic relationship between the nurse and the client with PTSD. It creates a relationship of trust with an emphasis on safety, collaboration, choice, empowerment, and avoiding revictimization.

27.4 Mental Health in the LGBTQIA+ Community

Sexual orientation refers to an individual's emotional, romantic, and sexual attraction to others. Gender identity refers to an individual's deeply held sense of their gender, which may or may not align with the sex assigned to them at birth. Mental health concerns within LGBTQIA+ communities often include higher rates of depression, anxiety, and suicidal ideation due to the discrimination, stigma, and minority stress they may experience. Additionally, issues related to coming out, family acceptance, and societal pressures can contribute to these mental health disparities. Nurses play a crucial role in the mental health care of LGBTQIA+ clients by providing culturally competent, nonjudgmental, and inclusive support, addressing the unique mental health challenges they may face due to discrimination or identity-related stressors, and connecting them with appropriate resources and therapy that affirms their gender identity and sexual orientation.

27.5 Mental Health in the Homeless and Displaced Population

Unhoused and displaced persons often experience a range of complex mental health needs, including depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders, stemming from the trauma of homelessness, social isolation, and exposure to violence or harsh living conditions. Addressing these mental health needs is essential for facilitating their stability, reintegration into society, and access to long-term housing solutions. Nurses can provide invaluable assistance to unhoused clients with mental health issues by offering compassionate care, mental health assessments, and connecting them to appropriate resources, including shelters, mental health services, and substance misuse treatment. Advocating for supportive housing initiatives and engaging in street nursing programs allows nurses to reach vulnerable populations directly.

27.6 Objectives for the Future

Objectives for the future of the nursing profession can be defined by nurses themselves. There are two major report/

studies that have been issued to address the future of the nursing profession: *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* from the National Academy of Medicine (2021) and the *American Academy of Nursing Consensus Recommendations to advance system level change for nurse well-being* (2023).

The first emphasizes the importance of nurses in addressing health disparities and improving health-care access for underserved populations. The second recommends actions by key organizations to drive systemic changes in workplace safety, increase professional mobility, and advocate for policies that improve access to health-care resources. Inclusive strategies for nursing education involve creating culturally sensitive curricula and fostering diversity, equity, and inclusion. Creating a personal future career or service plan as a psychiatric-mental health nurse is essential for any professional in the field. Such a plan involves setting clear goals, such as further education or specialization, and defining the populations or mental health issues they are passionate about serving.

Key Terms

androgyny no distinction between male and female
asexual people who experience little to no sexual attraction to any gender
assigned sex category, typically male or female, that is assigned to an individual at birth based on physical and biological characteristics, such as genitalia and chromosomes
bisexual/pansexual attracted to more than one gender or any gender
diversity, equity, and inclusion (DEI) commitment to recognizing and embracing differences, ensuring fairness, and fostering a sense of belonging for all individuals in order to create a more equitable and enriched nursing profession and health-care system
exploitation different ways in which traffickers financially benefit from their victims' labor or sexual services
flattening the curve public health strategy aimed at slowing the spread of a contagious disease, like COVID-19, to ensure that the health-care system can manage the capacity
force physical or psychological violence used to control victims, including threats, abuse, or confinement
gender identity individual's deeply held sense of their gender, which may or may not align with the sex assigned to them at birth
heterosexual attracted to the opposite sex or gender
homeless lacking a stable, safe, and adequate place to live
housing instability state of uncertainty or vulnerability in one's housing situation, characterized by frequent moves, risk of eviction, difficulty paying rent or mortgage, or a lack of stable, secure housing
human trafficking illegal trade of people, typically for forced labor or commercial sexual exploitation, using coercion, fraud, or force
marginalization exclusion, discrimination, and denial of rights
minority stress unique stressors and adverse mental health outcomes experienced by individuals in marginalized and stigmatized groups
motivational interviewing (MI) client-centered approach that aims to enhance an individual's intrinsic motivation to change their behavior
nonbinary people, also known as genderqueer, genderfluid, or agender, who do not exclusively identify as male or female and may have a gender identity that falls outside the traditional binary understanding of gender
queer term that can encompass various nonheteronormative sexual orientations and gender identities
recovery housing supportive and substance-free living environment that offers individuals recovering from substance use disorders a structured and safe living space
secondary trauma where health-care providers experience symptoms similar to those of trauma survivors, including intrusive thoughts, nightmares, and hypervigilance
serious mental illness (SMI) mental, behavioral, or emotional disorders that significantly impair an individual's ability to carry out major life activities and engage in social, occupational, or educational roles
third gender separate gender apart from male or female
Transgender individuals who have a gender identity that differs from their assigned sex
two spirit incorporating qualities of both binary genders, sometimes used by Indigenous people
unsheltered individuals experiencing homelessness who lack any form of shelter, such as living on the streets, in cars, or in other places not meant for human habitation
vicarious trauma emotional toll that exposure to the trauma of others can have on health-care providers
vulnerability ability to be harmed or influenced

wellness coaching collaborating with the client to set achievable goals related to their mental and emotional well-being

Assessments

Review Questions

1. What is the psychological phenomenon characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment related to one's work?
    a. Burnout
    b. Compassion fatigue
    c. Depression
    d. Trauma

2. How has the COVID-19 pandemic influenced psychiatric nursing and mental health care?
    a. increased demand for psychiatric nursing services and reduced stress among psychiatric nurses
    b. decreased access to mental health care while elevating the importance of self-care for psychiatric nurses
    c. improved mental health-care outcomes in psychiatric nursing and reduced nursing burnout rates
    d. no impact on either psychiatric nursing or mental health-care practices

3. What is a possible indicator of human trafficking?
    a. high levels of education and employment stability
    b. migrant workers with legal work visas
    c. individuals unable to leave their workplace or living situation
    d. active involvement in community organizations and social groups

4. What should a nurse do when faced with a suspected case of human trafficking?
    a. discreetly ignore the situation to avoid complications
    b. notify local law enforcement immediately
    c. question the suspected victim aggressively to gather more information
    d. offer the victim a job referral to improve their situation

5. What is a common symptom of post-traumatic stress disorder?
    a. increased ability to relax and sleep soundly
    b. persistent avoidance of reminders of the traumatic event
    c. enhanced sense of safety and reduced vigilance
    d. improved social interactions and relationships

6. What term refers to the inability to employ personal strategies to manage psychological distress?
    a. burnout
    b. compassion fatigue
    c. ineffective coping
    d. exhaustion

7. What term can encompass various nonheteronormative sexual orientations and gender identities?
    a. bisexual
    b. heterosexual
    c. cisgender
    d. queer

8. What is a crucial aspect of nursing care for LGBTQIA+ mental health clients to promote a supportive and inclusive environment?
    a. Avoid discussing the client's gender identity or sexual orientation to prevent discomfort.

b. Use heteronormative language and assumptions to ensure a sense of familiarity.
c. Provide a safe space for open and nonjudgmental communication about gender identity and sexual orientation.
d. Avoid addressing mental health concerns related to gender identity or sexual orientation.

9. What is a common mental health need among unhoused and displaced persons?
a. low rates of mental health issues due to the resilience they develop
b. frequent access to mental health care and support services
c. elevated rates of depression, anxiety, and trauma-related disorders
d. exclusively physical health concerns without psychological factors

10. What is a significant barrier to mental health care for unhoused individuals with mental health issues?
a. instability or lack of consistent shelter
b. strong social support networks and access to community resources
c. easy access to specialized mental health services and medications
d. minimal impact of homelessness on their mental health

11. What is one of the primary reasons contributing to the ongoing shortage of nursing faculty in academia?
a. decreased interest among nurses in pursuing teaching careers
b. sufficient funding and resources for nursing education programs
c. limited demand for nursing education due to declining student enrollment
d. the retirement of experienced nursing faculty without an adequate number of replacements

12. What is a crucial step in creating a personal future career/service plan for nursing students and/or nurses?
a. setting short-term goals without considering long-term aspirations
b. neglecting self-assessment and reflection on personal values and interests
c. omitting the consideration of opportunities for ongoing professional development
d. identifying clear career objectives aligned with personal values and long-term goals

Check Your Understanding Questions

1. How have psychiatric-mental health nurses promoted self-help and community services?

2. Describe some challenges and emotional reactions faced by nurses who work with human trafficking victims.

3. Describe the different types of psychotherapy shown to be helpful for clients with a diagnosis of PTSD.

4. What is the difference between assigned sex and gender identity?

5. What are some barriers to stability for unhoused clients with a mental health diagnosis?

6. In what ways is care coordination in nursing evolving in response to changing populations and health-care landscapes?

Reflection Questions

1. Describe what physical characteristics you should consider when assessing a client for signs of human trafficking.

2. Why are group therapy and peer support especially helpful for veterans with a diagnosis of PTSD?

3. Describe minority stress and how it contributes to mental health issues within the LGBTQIA+ community.

4. Why is a collaborative effort between nursing and other professions particularly beneficial for clients who are unhoused and who have a mental health diagnosis?

What Should the Nurse Do?

Estelle, a seventy-year-old female, presents at the community health clinic reporting symptoms of increased anxiety and persistent sadness. Her medical history includes a diagnosis of generalized anxiety disorder managed with

outpatient therapy. Estelle describes heightened anxiety related to the uncertainties and challenges brought on by the COVID-19 pandemic. She reports difficulty sleeping, changes in appetite, and feelings of isolation due to social distancing measures. Estelle acknowledges the impact of the pandemic on her mental health and expresses concern about the future. Vital signs are a blood pressure of 140/85 mmHg, a heart rate of 110 bpm, a respiratory rate of 16 breaths per minute, and a temperature of 98.7°F (37°C).

1. As a nursing student, how would you analyze the potential interplay between Estelle's preexisting generalized anxiety disorder and the additional stressors introduced by the pandemic?
2. How would you generate solutions to address both the immediate concerns related to pandemic-related stress and the ongoing management of Estelle's generalized anxiety disorder?

Irina, a twenty-five-year-old female, presents at the emergency department with signs of physical trauma, malnutrition, and anxiety. Her medical history is unknown, and vital signs are a blood pressure of 150/85 mmHg, heart rate of 115 bpm, respiratory rate of 16 breaths per minute, and temperature of 99°F (37.2°C). Irina is accompanied by a male companion who is overly controlling, and she avoids eye contact during the assessment. Irina exhibits signs of physical abuse, such as bruising and lacerations. She appears fearful and hesitant to speak independently. The companion provides limited information about her condition, attributing the injuries to accidental falls. Irina avoids disclosing personal information and appears emotionally distressed.

3. What specific cues in Irina's presentation might indicate the possibility of human trafficking, and how do her physical injuries and behavior contribute to this suspicion?
4. What specific actions would you take to connect Irina with resources for victims of human trafficking, and how would you navigate the presence of her companion during this process?

JJ is thirty-two years old and presents at the local urgent care clinic reporting symptoms of severe anxiety, recurring nightmares, and hypervigilance. JJ's medical history indicates a traumatic experience during military service. Vital signs are within normal range, but JJ appears tense, avoids discussing details of the trauma, and demonstrates signs of emotional distress. JJ describes experiencing flashbacks and intrusive thoughts related to a combat-related incident during deployment. JJ also struggles with disrupted sleep patterns, social withdrawal, and challenges in maintaining relationships.

5. As a nursing student, how would you analyze JJ's avoidance of discussing details of the trauma and the impact of symptoms on daily functioning and relationships?
6. How would you generate solutions to address JJ's symptoms, considering therapeutic interventions, psychoeducation, and connection with appropriate resources?

Jordan, a twenty-two-year-old nonbinary individual, arrives at their primary care physician's office reporting symptoms of persistent sadness, anxiety, and social withdrawal. Jordan has a medical history of previous depressive episodes and is currently not on any psychiatric medications. During the assessment, Jordan expresses concerns related to difficulties in disclosing their sexual orientation and gender identity to family and friends. Jordan describes feelings of isolation and discrimination related to their LGBTQIA+ identity, contributing to a sense of loneliness and heightened anxiety. Their vital signs are a blood pressure of 110/70 mmHg, heart rate of 115 bpm, respiratory rate of 16 breaths per minute, and temperature of 98.8°F (37°C).

7. As a nurse, what hypotheses would you prioritize in understanding the interplay between societal attitudes, Jordan's LGBTQIA+ identity, and their current mental health symptoms?
8. How would you generate solutions to address Jordan's mental health concerns, considering the importance of providing a safe and affirming environment and connecting them with LGBTQIA+ community resources?

Tanya, a forty-five-year-old female, is brought to the community health clinic by outreach workers. She is unhoused and has been living on the streets for several months. Tanya reports symptoms of severe anxiety, insomnia, and auditory hallucinations. Her medical history is unknown, and her vital signs are a blood pressure of 140/90 mmHg, heart rate of 115 bpm, respiratory rate of 16 breaths per minute, and temperature of 99°F (37.2°C). Tanya appears disheveled and is hesitant to share information about her mental health. Tanya describes constant fear, difficulty sleeping due to the noises of the street, and hearing voices that seem to exacerbate her anxiety. She has faced challenges accessing consistent shelter and food.

9. What specific cues in Tanya's presentation indicate the potential impact of homelessness on her mental well-being, and how do her reported symptoms align with common mental health challenges observed in unhoused individuals?

10. How would a nurse generate immediate solutions to address Tanya's basic needs, considering collaborative strategies with outreach workers and connecting her with mental health services?

Competency-Based Assessments

1. Create a poster with information for nurses on self-care strategies. Make your poster visually engaging and make sure to include tips that will help with mind, body, and spirit. Address the holistic needs of the nurse.
2. Describe an approach you would take to provide culturally competent and affirming care to an LGBTQIA+ client with a mental health diagnosis, including specific strategies you would employ to ensure that their unique needs are met and they feel safe and respected throughout the care process.
3. You are asked to educate a group of health-care professionals about culturally sensitive and inclusive care for unhoused clients with mental health diagnoses. Develop a brief presentation highlighting key considerations, communication strategies, and resources that promote culturally competent care for this population.

References

AcademyHealth. (n.d.). *Interdisciplinary research group on nursing issues*. https://academyhealth.org/professional-resources/interest-groups/interdisciplinary-research-group-nursing-issues/page/interdisciplinary-research-group-nursing-issues

Aloweni, F., Ayre, T. C., Teo, I., Tan, H. K., & Lim, S. H. (2022). A year after Covid-19: Its impact on nurses' psychological well-being. *Journal of Nursing Management*, *30*(7), 2585–2596. https://doi.org/10.1111/jonm.13814

American Nurses Association. (2018). *Position statement: Nursing advocacy for LGBTQIA+ populations*. https://www.nursingworld.org/~49866e/globalassets/practiceandpolicy/ethics/nursing-advocacy-for-lgbtq-populations.pdf

American Nurses Association. (2022). *2022 News Releases. American Nurses Association opposes restrictions on Transgender healthcare and criminalizing gender-affirming care*. https://www.nursingworld.org/news/news-releases/2022-news-releases/american-nurses-association-opposes-restrictions-on-transgender-healthcare-and-criminalizing-gender-affirming-care/

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association. (2017, July 31). *Medications*. https://www.apa.org/ptsd-guideline/treatments/medications

American Psychological Association. (2020, June). *Treatments for PTSD*. https://www.apa.org/ptsd-guideline/treatments

Anzani, A., Siboni, L., Lindley, L., Galupo, M. P., & Prunas, A. (2024). From abstinence to deviance: Sexual stereotypes associated with Transgender and nonbinary individuals. *Sex Res Soc Policy, 21*, 27–43. https://doi.org/10.1007/s13178-023-00842-y

Bass, B., & Nagy, H. (2023, November 13). Cultural competence in the care of LGBTQ patients. In: StatPearls [Internet]. StatPearls Publishing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK563176/

Bradford, H. M., Grady, K., Kennedy, M. B., & Johnson, R. L. (2022). Advancing faculty diversity in nursing education: Strategies for success. *Journal of Professional Nursing*, *42*, 239–249. https://doi.org/10.1016/j.profnurs.2022.07.006

Byrne, M., Parsh, S., & Parsh, B. (2019). Human trafficking. *Nursing Management*, *50*(8), 18–24. https://doi.org/10.1097/01.numa.0000575304.15432.07

Cavazos, D. M. (2022). Street nursing: Teaching and improving community health. *Hispanic Health Care International*, *21*(2), 55–59. https://doi.org/10.1177/15404153221098958

Ceatha, N., Koay, A. C. C., Buggy, C., James, O., Tully, L., Bustillo, M., & Crowley, D. (2021, November 7). Protective

factors for LGBTI+ youth wellbeing: A scoping review underpinned by recognition theory. *Int J Environ Res Public Health, 18*(21),11682. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8583439/

Centers for Disease Control and Prevention. (2023a, September 23). *CDC covid data tracker*. https://covid.cdc.gov/covid-data-tracker/#datatracker-home

Centers for Disease Control and Prevention. (2023b). *LGBTQ+ youth: Addressing health disparities with a school-based approach*. https://www.cdc.gov/lgbthealth/youth.htm

Chan, G., Bitton, J., Allgeyer, R., Elliott, D., Hudson, L., & Moulton Burwell, P. (2021). The impact of covid-19 on the nursing workforce: A national overview. *OJIN: The Online Journal of Issues in Nursing, 26*(2). https://doi.org/10.3912/ojin.vol26no02man02

Cleveland Clinic. (2022, March 29). *EMDR therapy: What it is, procedure & effectiveness*. https://my.clevelandclinic.org/health/treatments/22641-emdr-therapy

Davis, Georgiann. The Power in a Name: Diagnostic Terminology and Diverse Experiences. Psychology & Sexuality 5, no. 1 (2014): 15–27. doi:10.1080/19419899.2013.831212.

Firk, C., Großheinrich, N., Scherbaum, N., & Deimel, D. (2023). The impact of social connectedness on mental health in LGBTQ + identifying individuals during the COVID-19 pandemic in Germany. *BMC Psychol, 11*, 252. https://doi.org/10.1186/s40359-023-01265-5

Fleishman, J., Kamsky, H., & Sundborg, S. (2019). Trauma-informed nursing practice. *OJIN: The Online Journal of Issues in Nursing*, *24*(2). https://doi.org/10.3912/ojin.vol24no02man03

Funer, F. (2023, November 24). Admitting the heterogeneity of social inequalities: Intersectionality as a (self-)critical framework and tool within mental health care. *Philos Ethics Humanit Med*, *18*(1), 21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10668443/

Goldbach, J. T., Rhoades, H., Mamey, M. R., Senese, J., Karys, P., & Marsiglia, F. F. (2021). Reducing behavioral health symptoms by addressing minority stressors in LGBTQ adolescents: A randomized controlled trial of Proud & Empowered. *BMC Public Health, 21*, 2315. https://doi.org/10.1186/s12889-021-12357-5

Gould, M. S., & Lake, A. M. (2021, September). *Suicide prevention and 988: Before, during and after COVID-19 - NASMHPD*. nasmhpd.org. https://nasmhpd.org/sites/default/files/3_SuicidePrevention-988_FinalRevised_UPDATED%209.21.21.pdf

Green, A. E., Price, M. N., & Dorison, S. H. (2021). Cumulative minority stress and suicide risk among LGBTQ youth. *American Journal of Community Psychology*, *69*(1–2), 157–168. https://doi.org/10.1002/ajcp.12553

Health Care Toolbox. (n.d.). *What is culturally-sensitive trauma-informed care?* https://www.healthcaretoolbox.org/culturally-sensitive-trauma-informed-care

Hoeft, T. J., Stephens, K. A., Vannoy, S. D., Unützer, J., & Kaysen, D. (2019). Interventions to treat posttraumatic stress disorder in partnership with primary care: A review of feasibility and large randomized controlled studies. *General Hospital Psychiatry*, *60*, 65–75. https://doi.org/10.1016/j.genhosppsych.2019.05.008 https://www.healthcaretoolbox.org/culturally-sensitive-trauma-informed-care#

Human Rights Campaign. (n.d.). Sexual orientation and gender identity definitions. https://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions

James, K. M., Silk, J. S., Scott, L. N., Hutchinson, E. A., Wang, S. Sequeira, S. L., Lu, C., Oppenheimer, C., & Ladouceur, C. D. (2023, July). Peer connectedness and social technology use during COVID-19 lockdown. *Research on Child and Adolescent Psychopathology, 51*(7), 937–948. https://doi.org/10.1007/s10802-023-01040-5

Jolley, C. E., & Peck, J. L. (2022, May 31). *Diversity, equity, & inclusion policies of national nursing organizations*. The Online Journal of Issues in Nursing. https://ojin.nursingworld.org/table-of-contents/volume-27-2022/number-2-may-2022/diversity-equity--inclusion-policies-of-national-nursing-organizations/

Kaas, M. J. (2019). Will we be ready? Preparing psychiatric-mental health nurses for future practice. *Journal of the*

American Psychiatric Nurses Association, *26*(1), 112–119. https://doi.org/10.1177/1078390319878767

Kameg, B. N., Fradkin, D., Lee, H., & Mitchell, A. (2021). Mental wellness among psychiatric-mental health nurses during the COVID-19 pandemic. *Archives of Psychiatric Nursing*, *35*(4), 401–406. https://doi.org/10.1016/j.apnu.2021.05.003

Masa, R., Inoue, M., Prieto, L., Baruah, D., Nosrat, S., Mehak, S., & Operario, D. (2024). Mental health of older adults by sexual minority status: Evidence from the 2021 National Health Interview Survey. *Journal of Applied Gerontology, 43*(3), 276–286. https://doi.org/10.1177/07334648231203838

Medina-Martínez, J., Saus-Ortega, C., Sánchez-Lorente, M. M., Sosa-Palanca, E. M., García-Martínez, P., & Mármol-López, M. I. (2021). Health inequities in LGBT people and nursing interventions to reduce them: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(22), 11801. https://doi.org/10.3390/ijerph182211801

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020, May 4). A call to action to address rural mental health disparities. *J Clin Translon Sci*, *4*(5), 463–467. https://doi.org/10.1017/cts.2020.42.

Mortazavi, S. S., Assari, S., Alimohomadi, A., Rafiee, M., & Shati, M. (2020). Fear, loss, social isolation, and incomplete grief due to COVID-19: A recipe for a psychiatric pandemic. *Basic and Clinical Neuroscience, 11*(2), 225–232. https://doi.org/10.32598%2Fbcn.11.covid19.2549.1

Naegle, M. A., Kelly, L. A., Embree, J. L., Valentine, N., Sharp, D., Grinspun, D., Hines-Martin, V. P., Crawford, C. L., & Rosa, W. E. (2023, February 1). *American Academy of Nursing consensus recommendations to advance system level change for nurse well-being*. Nursing Outlook. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9889942/

Nashwan, A. J. (2023, May 10). The vital role of career pathways in nursing: A key to growth and retention. *Cureus, 15*(5), e38834. https://doi.org/10.7759/cureus.38834.

National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on the Future of Nursing 2020–2030; Flaubert JL, Le Menestrel S, Williams DR, et al., editors. (2021, May 11). *The future of nursing 2020–2030: Charting a path to achieve health equity*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK573919/

National Alliance on Mental Illness. (2023, April). *Mental health by the numbers*. https://nami.org/mhstats

National Association of State Mental Health Program Directors. (2021, September). Suicide prevention and 988: Before, during and after COVID-19. https://www.nasmhpd.org/sites/default/files/3_SuicidePrevention-988_FinalRevised_UPDATED%209.21.21.pdf

National Coalition for the Homeless. (2023). *Civil rights and homelessness.* https://nationalhomeless.org/civil-rights-criminalization-of-homelessness/

National Human Trafficking Hotline. (2023). *Home*. https://humantraffickinghotline.org/en

National LGBT Health Education Center. (n.d.). *Providing inclusive services and care for LGBT people*. https://www.lgbtqiahealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf

Ndugga, N., & Artiga, S. (2023). Disparities in health and health care: 5 key questions and answers. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

Orenstein, N. (2020). *Homeless? Unhoused? Unsheltered? Word choice matters when reporting on Oaklanders who don't have permanent housing*. https://oaklandside.org/2020/11/10/homeless-unhoused-unsheltered-word-choice-matters-when-reporting-on-oaklanders-who-dont-have-permanent-housing/

Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023, April 25). *The implications of COVID-19 for mental health and substance use*. KFF. https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Peterson, C. J., Lee, B., & Nugent, K. (2022, June 15). COVID-19 vaccination hesitancy among healthcare

workers—A review. *Vaccines (Basel), 10*(6), 948. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9227837/

Psychology Today. (2022). *Motivational interviewing*. https://www.psychologytoday.com/us/therapy-types/motivational-interviewing

Robert Wood Johnson Foundation. (2021, May 4). *RWJF's approach*. https://www.alignforhealth.org/framework/

Salmond, S. W., & Echevarria, M. (2017, January/February). Healthcare transformation and changing roles for nursing. *Orthop Nurs, 36*(1), 12–25. https://doi.org/10.1097/NOR.0000000000000308.

Sandberg DE, Gardner M. Differences/Disorders of Sex Development: Medical Conditions at the Intersection of Sex and Gender. Annu Rev Clin Psychol. 2022 May 9;18:201-231. doi: 10.1146/annurev-clinpsy-081219-101412.

Sipes, L. A., Jr. (2022, March 30). *The homeless are far more likely to commit crimes and to be victims*. https://www.crimeinamerica.net/the-homeless-are-far-more-likely-to-commit-crimes-and-to-be-victims

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral health services for people who are homeless*. Tip 55. https://store.samhsa.gov/sites/default/files/sma13-4734_literature.pdf

Substance Abuse and Mental Health Services Administration. (2020). *Intimate partner violence and child abuse considerations during COVID-19*. https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf

Tsai, J., Hoff, R. A., Harpaz-Rotem, I. One-year incidence and predictors of homelessness among 300,000 U.S. Veterans seen in specialty mental health care. *Psychological Services, 14*(2), 203–207. https://doi.org/10.1037/ser0000083

Turban, J. (2022, August). *What is gender dysphoria?*. Psychiatry.org. https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

U.S. Department of State. (2021, January 10). *Identify and assist a trafficking victim - United States Department of State*. https://www.state.gov/identify-and-assist-a-trafficking-victim/

U.S. Department of Veterans Affairs. (2021). *Homelessness*. https://www.research.va.gov/topics/homelessness.cfm

U.S. Department of Veterans Affairs. (2023a). *Medications for PTSD*. https://www.ptsd.va.gov/understand_tx/meds_for_ptsd.asp

U.S. Department of Veterans Affairs. (2023b). *Spotlight on improving healthcare for veterans with PTSD*. https://www.hsrd.research.va.gov/news/feature/ptsd2023.cfm

World Health Organization. (2024). *Covid-19 cases | WHO COVID-19 Dashboard*. https://data.who.int/dashboards/covid19/cases?n=c

CHAPTER 28

Critical Thinking in Psychiatric-Mental Health Nursing

FIGURE 28.1 Community-based programs approach mental health treatment from a cooperative perspective. (credit: "Compassion" by Sonya Revell/flickr, Public Domain)

CHAPTER OUTLINE

INTRODUCTION When nurses analyze research evidence for client care, it entails critical thinking. Critical thinking is problem-solving using the nurse's reasoning ability. In the context of the client's identified needs, the nurse selects the most appropriate information from analysis of the evidence. The nurse's application of the selected information to client care is clinical judgment. Clinical judgment directs the nurse's decisions for client care and nursing practice. Because clients have individual needs, and nursing care evolves over time with the client, critical thinking and clinical judgment are ongoing in nursing practice.

To illustrate, the psychiatric-mental health (PMH) nurse is working with a young adult client who experiences anxiety. The client is struggling to manage this condition. The nurse researches anxiety-reduction strategies (critical thinking), selects mindfulness to teach the client as a self-care technique (clinical judgment), provides the client education, and evaluates the outcome (nursing practice).

Nursing interventions are unique to the client's situation and are based on analysis of cues recognized in nursing assessment. Some concepts are universal in the treatment setting, such as safety and collaboration, though interventions are developed specific to the client's expressed and identified needs guided by standards of care.

Nursing judgments avoid labeling and seek to plan actions that will promote mental health.

Nurses may use various models for clinical judgment to provide a structure to their reasoning in practice. Some available models include the Clinical Judgment Measurement Model (National Council of State Boards of Nursing [NCSBN], 2019a), Tanner's Model (Tanner, 2006), and Lasater's Clinical Judgment Rubric (Lasater, 2011). Terminology may differ in these models while the concepts remain the same:

- data collection by nursing assessment
- data analysis for meaning and interpretation specific to the client
- care planning involving the client
- nursing action (nursing interventions)
- effect of nursing action determined through evaluation, leading to revision of the plan or addressing additional problems

Sample care plans are provided in this chapter to assist in application of clinical judgment based on these concepts.

28.1 Nursing Process

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define the nursing process in psychiatric-mental health care
- Use the nursing process to plan nursing care for a client with a mental health problem

Psychiatric-mental health nurse theorist and educator Ida Jean Orlando is credited with development of the **nursing process** in 1958 (Toney-Butler & Thayer, 2023); the nursing process is a decision-making method based in science and, just as importantly, in the art of psychiatric-mental health nursing. Specific to mental health care, nurses bring factual data and research evidence to clinical reasoning developed within the therapeutic relationship with recipients of nursing care.

The nursing process incorporates deliberate measures and actions to resolve health-care problems identified in partnership with the client. The client's need for support determines the level of nursing involvement. The nursing process is dynamic, continues through all of the phases of the therapeutic relationship, and strives for client stability, remission, recovery, and self-care.

The Nursing Process in Psychiatric-Mental Health Care

The nursing process is a decision-making model for client care in every setting. Nurses make assessments: recognizing and prioritizing cues from the client interview and examination and from the client's medical record, and utilizing **critical thinking**, a cognitive process that is learned academically and experientially on the continuum of nursing practice. Nurses then formulate hypotheses about the causes of the client's health problem/need with proposed solutions in order of priority. Nurses then take action to resolve the identified problems and evaluate these actions for effectiveness. Actions partially effective or not effective require revision.

The therapeutic relationship, also known as nurse-client relationship, helping relationship, or therapeutic alliance, establishes nursing practice within the **therapeutic environment**. The therapeutic environment comprises the safe physical location, such as a hospital, clinic, or home, and the supportive conditions within that location. Within the therapeutic environment, practitioners define mental health problems and begin the process toward resolution. The therapeutic relationship is structured by the nurse to benefit the client and is time-limited, meaning that the nurse owes a duty to the client during the time they are working together. This duty comprises the promotion of health and safety.

The relationship is not a social one; it is conducted within professional guidelines and is continually evaluated by the nurse through reflection upon their practice (Figure 28.2). Reflection utilizes feedback from peers and mentors, and includes personal examination of one's own actions and experience. Level of client participation in the relationship varies with the client's health state.

FIGURE 28.2 At the same time a nurse is asking the client a question, they should ask themselves some reflection questions throughout the nursing process when collecting, analyzing, implementing, and evaluating. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

The science in the process includes analysis of data collected by assessment and observation, which means leading the nurse to hypothesize causes, priorities, and solutions. Considering risks and benefits of available resources, the client's ability to participate, and the nurse's own skill and experience, the team formulates a plan of care. Decision-making from use of critical thinking in the nursing process is described as **clinical judgment** (Hughes, 2008). Clinical judgment utilizes five repeating components of the nursing process:

- assessment, recognizing cues
- analysis, interpreting cues, setting client-specific priorities
- planning, generating solutions/goals with client's input
- implementation, taking action, nursing interventions
- evaluation, determining outcomes as effective or revising the plan

The process is ongoing and flexible throughout the therapeutic relationship, adapting to client needs and focused on outcomes of care. It is important to recognize risks early in the process and to evaluate plans of care continually for effectiveness. The plan of care is shared with other professionals who collaborate in the interdisciplinary team care planning process, which is a meeting of the client and those involved in the client's care, and may include the family members.

LINK TO LEARNING

Access "Clinical reasoning: What do nurses, physicians, and students reason about?" (https://openstax.org/r/77nursereasong) to read insights into interprofessional collaboration in practice through interviews with nurses and nursing students, physicians, and medical students.

Assessment in Mental Health Nursing

The first step, **assessment**, is the collection of available data to inform care planning. Assessment in nursing is important to identify problems and develop a plan of care. Nursing Assessment and Clinical Tools addresses physical assessment for the PMH client, and Nursing Assessment and Care Plans covers use of the mental status exam.

Psychiatric-mental health nurses specifically assess clients by observing behaviors, interviewing and interacting with the client, and reviewing the health record. This process of gathering data is important in determining what the priority problems are and being able to move to the next step in the nursing process. The nurse might observe the client pacing in the hallway and ask about anxiety. They might ask about thoughts of self-harm and also look for any physical injuries. The data they collect during the assessment drives their analyses and implementation of their plans. Basic observation means taking notice of information or events, reporting them, and synthesizing the information to identify priority problems. The professional nurse recognizes cues found in observation to determine actual and potential problems. The nurse analyzes these cues to actively formulate the nursing plan of care.

Data and cues collected during assessment fall into different categories: objective, subjective, primary, and secondary. Objective data is what the nurse obtains through their abilities and senses. Nurses may see the client's attire, listen to the client's lung sounds, or detect a client's hand tremor by touch during physical assessment. Sources of objective data include use of screening tools or checklists, visual observation and monitoring, or measuring vital signs. Statistical reports, such as laboratory and diagnostic testing results, constitute objective data.

Subjective data is what the client shows or says. Subjective data is obtained from the client's expressions, whether verbal or nonverbal. Nurses may listen to client comments or notice that the client has been crying. When eliciting subjective information, the nurse must be culturally sensitive (see Cultural Considerations). Expressions, body language, and emotions should not be interpreted through a lens of the nurse's own experience or beliefs. In order to interpret subjective data, the nurse should ask open-ended questions that do not lead the client, such as, "How can we best help you while you are here?" or "Are there customs you would like to keep or members of your family you would like involved in your care?" Sources of subjective data include use of appropriate questionnaires, interviews, or screening tools; therapeutic groups; clients' written expressions, compositions, or artwork; and the interaction between nurse and client during one-on-one time.

Primary data is collected directly from the client by the nurse. Any information shared with, or witnessed by, the nurse from the client is primary data, so this information may be objective or subjective in nature. When clients answer the nurse's questions or are withdrawn from interaction, these are both sources of primary data. During transfer of care, the offgoing nurse provides primary data.

Secondary data is collected or expressed by another and reviewed by the nurse. Information about the client is secondary data, such as family reports, medical records, and clinical documentation by other professionals. Secondary data may be objective or subjective in nature, for example, a discharge summary from another facility or a family member's opinion. During transfer of care, the oncoming nurse receives secondary data and will go on to collect their own primary data.

All data collection in nursing assessment is to be done without bias and this may be a learned skill for some nurses. Without personal reflection, the nurse may draw automatic conclusions from client data that may be inaccurate. Some client behaviors, perspectives, or histories may provoke emotional responses in the nurse, which can influence the therapeutic relationship. Collaboration with colleagues of diverse backgrounds may be helpful, as may the guidance of a mentor. Every nurse should continually work to increase their self-awareness in client care.

Analysis in Mental Health Nursing

After completing the assessment and data collection, the nurse analyzes the information to partner with the client to make a determination of what the client's problem or level of risk may be. Together, they identify the client's strengths, such as motivation, physical health, or family support. As mentioned, the nurse approaches all client interaction and assessment with cultural sensitivity.

This type of **analysis** entails critically examining the meaning of identified cues that inform the nurse on necessary levels of support for the client. For example, if the nurse assesses the client's mood as sad and observes they are tearful and the client verbalizes suicidal thoughts, the nurse would analyze this information to determine the client is at risk for suicide. This problem, or risk, will then focus the care planning and interventions. Analysis also requires prioritizing client problems and needs and creating nursing hypotheses. Partnership with the client is essential to the process because this **therapeutic alliance** enhances outcomes for the client.

The nurse prioritizes the urgency of identified problems and needs. For example, a client with suicidal ideation who has lost their employment has a safety need at a higher level than the social/economic need to be reemployed (though this need is to be acknowledged). To prioritize client needs, the nurse utilizes clinical judgment. This requires the nurse to construct clinical questions and create answers by analyzing assessment data. Again, partnership with the client is part of this process, which means that the nurse establishes trust with the client (and family, as indicated) and invites their participation in prioritizing the challenges presented. The nurse shares information that is relevant to the client's care or status, and the nurse acknowledges the client as the expert on self.

Nurses may use established models to prioritize care, such as Maslow's Hierarchy of Needs, wherein a client with panic due to an asthma attack would need respiratory support first. This is an example of prioritizing physiological needs over safety needs, though the client's feeling of anxiety would be addressed immediately upon physical stabilization. Another consideration in prioritization is the concept of life-saving, health-saving, and health-promoting, which would prioritize interventions for blood loss, for instance, over intent for self-injury, over long-term recovery. Nurses must nevertheless remain aware of the importance to the client of all problems and needs.

Nurses should also remain self-aware for potentially inappropriate focus on tasks to complete quickly and successfully, at the expense of missing the need for more complex interventions. For example, the nurse may be more likely to first obtain and document vital signs because these tasks are easy to complete. If the client has stated a clear intent for self-harm, however, exploring the existence of a self-harm plan would take priority over obtaining the vital signs. Ultimate outcomes of care must address all aspects of clients' well-being.

Identifying client strengths helps to build a relationship where the nurse shares the power with the client. Identification of client strengths, abilities, and available resources also extends the helping relationship toward the client's independence. Further, this action informs nursing interventions, for example, providing printed material for clients at their reading literacy level and in their primary language, encouraging connection with community supports, or verbalizing positive feedback for a client's efforts.

Planning in Mental Health Nursing

The next step, **planning**, is the cognitive process of generating solutions to identified problems, setting goals of treatment, and developing nursing interventions to accomplish these objectives. Health-care knowledge and research changes and evolves rapidly.

One part of planning is developing a nursing diagnosis. The North American Nursing Diagnosis Association developed a classification system for nursing diagnosis terminology. The organization still exists as NANDA International (NANDA-I). Rodríguez-Suárez et al. (2023) acknowledge some uncertainty of the effectiveness of this taxonomy, asserting that further research is indicated to determine current relevance to population health and health promotion.

LINK TO LEARNING

See this sample NANDA-I Diagnoses (https://openstax.org/r/77NANDADxTable) table on the National Library of

Medicine website.

Another part of planning is remaining up to date on current best evidence for client care and using that evidence to inform interventions. The American Nurses Association (ANA) (2023) emphasizes nurses' use of current scientific knowledge over tradition or nurses' preference for client care. This approach permits the inclusion of evolving health-care knowledge (ANA, 2023). The term **evidence-based practice (EBP)** refers to the intersection of formal research findings, nursing competency, and the preferences of the client and family (Figure 28.3). These factors are all considered when planning client care.

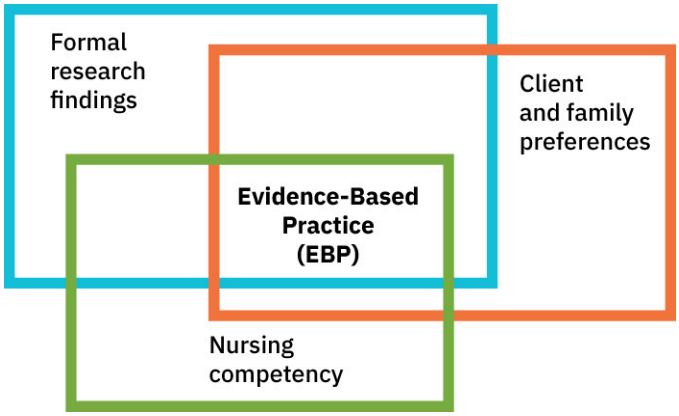


FIGURE 28.3 Formal research findings, nursing competency, and the preferences of the client and family intersect to form evidence-based practice. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

In addition to evidence-based practice, health-care organizations have policies to guide procedures. These policies may be based on scientific information from pharmaceutical companies and medical research, legal aspects of data management, government safety regulations, and the organization's mission and code of ethics. When nurses plan client care, such policies can be a source of information. Kelly et al. (2021) found little evidence to support nurses' routine use of organizational policies, despite the policies' proposed intent of safe practice. Over 200 direct care nurses were surveyed as to their use of policies for clinical guidance in the study. The time away from client care to review policies was cited as one reason nurses did not consult policies more frequently. The authors recommend organizational efforts to streamline and update policies to address these barriers (Kelly et al., 2021).

Nursing competency refers to the skill level of the nurse and to the skill level of any others to whom the nurse may delegate. Competency also includes consulting available mentors, preceptors, and other professionals. This consideration will enable the nurse to plan care that is safe and effective and utilize appropriate resources, such as making referrals or requesting assistance with procedures or decision-making.

Respect for client preferences is key and includes cultural considerations. The client's engagement in treatment enhances success of the plan of care. The nurse encourages the client to express their values and beliefs and participate in goal-setting throughout the care planning process. The nurse can pose relevant queries such as, "How can we assist you from a spiritual or cultural perspective?" or "How do you see your family's involvement in your care?"

LINK TO LEARNING

The Agency for Healthcare Research and Quality provides a Health Literacy Universal Precautions (https://openstax.org/r/77cultureguides) Toolkit. Guidance for considering culture, customs, and beliefs in health care is their tool #10.

Goal-Setting and Implementation in Mental Health Nursing

Goal-setting is a collaborative process with the client that entails formulating interventions customized to accomplish specific goals of treatment, or to avoid risks (NCSBN, 2019a). The step of **implementation** is the nursing action of putting the items from the plan of care into effect. Implementation may be through delegation, as

appropriate, and may involve other members of the client's treatment team. The nurse takes therapeutic action to implement solutions addressing the highest priority needs/problems first. These actions are interventions based on nursing knowledge, with goals planned to promote, maintain, or restore a client's health. All aspects of the implementation phase involve team collaboration and nursing documentation.

A client may be working with the nurse on stress management, for example. In partnership with the client, the nurse develops stress-reduction strategies that include prescribed short-term use of anxiolytic medication, mindfulness exercises, and dietary modifications. The nurse must establish rationales for the interventions to provide a scientific basis and support the plan. During implementation, the nurse conducts health teaching and monitoring, and the client reports their experiences. For example, the nurse sets goals for care as: the client will teach back information about prescribed medication by (date); client will practice mindfulness exercises daily by (date); and client will verbalize a diet plan by (date). The client approves the plan, or suggests changes, and the nurse and client work together to accomplish the goals within the time frame.

REAL RN STORIES

Nurse: Maria P, RN ADN
Years in Practice: One
Clinical Setting: Mental health unit of a general hospital
Facility Location: Virginia

In my first year of RN practice, I was twenty-six years old and I worked on the mental health unit of a general hospital in Virginia. During a busy shift, I allowed a young adult assigned to me to go out into the unit courtyard, unescorted, "to work off some energy" by playing basketball. The client eloped over the courtyard wall.

The unit manager and the unit educator spent time with me to notify the doctor, fill out the incident report, and process the event. I was tearful as they talked to me and I felt like resigning from my job. Though the client was safely returned by the family later that day, I was so embarrassed and extremely disappointed in myself.

The manager and educator helped me to explore my accountability and my decision-making throughout the situation. With their support, I reviewed my actions and realized that I had missed earlier signs that day of impulsivity in the client's behavior (grabbing food from another's tray at breakfast, and refusing a PRN medication offered by the med nurse). I had skipped a significant portion of clinical reasoning by taking an action without thorough assessment.

Evaluation in Mental Health Nursing

Measurable responses to interventions utilized during the implementation phase of nursing care planning are called **outcomes of care**. The next step in the nursing process, **evaluation**, is the process of reviewing these outcomes of care for effectiveness, as defined by the nurse and the client together. Goals may be described as met, partially met, or unmet.

Met goals result in the client's stability, improved functional capacity, safety and recovery, and client satisfaction with the outcome. Evaluations where goals are met include, for example, intended effects of medication, management of medication side effects, or client's report of reduced anxiety.

Partially met goals may include client sleeps four hours each night with goal of six hours or client is able to speak with family member on the telephone with goal of client and family member face-to-face therapy session. If goals are partially met, the nurse and client should review the plan to determine if interventions need to be altered.

Unmet goals may include client being uncomfortable due to side effects of newly prescribed medication or client reporting inability to sleep. Unmet goals call for modification or revision of the plan. Goals may be considered partially met or unmet if not reached within the established time frame.

Use of the Nursing Process throughout the Therapeutic Relationship

The process of nursing care may occur over acute or extended-time situations, but no matter the situation, the nurse must continually apply clinical judgment. The therapeutic relationship has no mandated time frame. It covers

the time nurses and clients work together, whether over moments or months. To review the phases of the therapeutic relationship, in the preorientation phase, the nurse learns about the client and prepares for the interaction. During orientation, the nurse establishes rapport with the client and sets the expected time frame ("During your stay here," or "As long as you are seen in this clinic") so the client knows what to expect. Working is the active phase where the nurse and client implement the plan of care. Termination brings the relationship to an end; the nurse and client mutually review their work together.

As nurses develop expertise and are exposed to more client care situations, they refine the cognitive components of care planning, enabling them to adapt the plans to client needs and available resources. Planning should always be individualized, include all steps of the process, and not become mechanical or habitual. This is the meaning of **person-centered care**, when the client is the focused recipient of nursing care.

Expert nurses who manage client care situations are not resorting to default actions. They are using clinical judgment that incorporates learned pattern recognition, rapid response abilities, and wisdom. Consider these two examples. In a crisis with a client experiencing psychosis, the nurse manages the situation within an hour. By contrast, a nurse and client working together in a community setting may review the client's employment prospects and discuss strategies for success over scheduled weekly interactions. The similarity in these two scenarios is that the nurse uses clinical judgment to plan problem-based care. The difference is that this planning can occur in moments or over time.

CLINICAL JUDGMENT MEASUREMENT MODEL

Sample Care Plans: Acute Time Frame and Extended Time Frame

Sample Care Plan—Acute Time Frame	Clinical Judgment for Nursing Plan of Care (Involve client/family throughout the process.)	Sample Care Plan—Extended Time Frame
Objective Data: attempting to push through window, striking with fists Subjective Data: shouting, responding to internal stimuli Primary Data: not responding to verbal redirection Secondary Data: nurse reported earlier refusal of medication	Recognizing Cues—from all assessment data: objective, subjective, primary, and secondary data	Objective Data: presents to clinic appointment with several job applications, mild anxiety Subjective Data: "I'm not sure which one I'd be good at," client states their medication causes drowsiness Primary Data: answers nurse's questions about personal goals for employment Secondary Data: nurse reviews copy of client's most recent job performance review, which cites client attendance as concern; client has history of alcohol use disorder
Danger to self, panic, disconnected from reality Schizophrenia diagnosis with paranoia, young adult, history of adverse childhood events	Analyzing Cues—possible meaning of signs and symptoms, significance of medical and psychosocial history, age, culture, risk factors	Possible continued alcohol use, decreased self-esteem, possible medication side effects, unemployed adult

Concept reference: Timken, 2023.

Sample Care Plan—Acute Time Frame	Clinical Judgment for Nursing Plan of Care (Involve client/family throughout the process.)	Sample Care Plan—Extended Time Frame
Safety is priority, reduction of stimuli, internal and external, reduction of anxiety; manage environment; manage client recovery from acute episode; reintroduce into community	Prioritizing Problems/ Needs—name problems in priority order (use a prioritization model)	Substance use may be priority, promote self-esteem; investigate medication effects; refer for social services
Emergency medication administration Remove from community Manage environment Establish trust Avoid additional stressors	Generating Solutions/ Goal Setting—develop specific strategies to improve client's condition, or reduce risk	Arrange referrals as indicated Use therapeutic relationship to increase self-esteem Collaborate with prescriber
Administer injection per order now, assist to quiet room on 1:1 observation by camera and staff now × 1 hour, assure as to safety throughout process, explain procedures in brief and repeat as needed	Taking Actions—outline independent, dependent, delegated, or collaborative interventions to resolve identified problems; set a measure and a time frame	Conduct screening assessment for alcohol use this visit, refer as indicated; provide feedback, offer support, provide medication teaching this visit, schedule appointment with prescriber; connect with employment assistance
Goals partially met, client resting in quiet room on 1:1 observation, anxiety moderate, remains preoccupied with internal stimuli, continue with oral medication per schedule and anxiety reduction measures as needed, ongoing nursing assessment	Evaluating Outcomes—determine if goals are met, partially met, or unmet; if met, move to next priority plan; if partially met, review plan for change; if unmet, revise plan	Goals partially met, client takes responsibility for alcohol use though expresses reluctance to return to counselor, agrees medication dose could be taken in the evening, accepts appointment with prescriber, schedules next clinic appointment for ongoing care
Working phase Termination phase at transfer of care	Connection to Therapeutic Relationship	Working phase Termination phase at discharge from clinic

Concept reference: Timken, 2023.

Referring to the two care plan scenarios just described, the nurse-client relationship may terminate when the nurse's assignment ends or when the client is discharged from care. The nursing process is ongoing through the point at which other professionals assume care or the client is no longer utilizing the service.

Continuous monitoring is a concept in nursing care in general, such as vital signs or physical assessments every four hours or hourly rounding. This is because clients' conditions can change and then the nurse's plan of care will change. This real-life complexity is now portrayed in questions on the next generation style testing on the National Council Licensure Examination (NCLEX), which began in 2023. These questions offer scenarios and unfolding case studies to better replicate actual nursing practice.

28.2 Measurement of Clinical Judgment

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Define how the National Council of State Boards of Nursing (NCSBN) utilizes the Clinical Judgment Measurement Model (CJMM)
- Discuss assessment of nursing knowledge by the NCLEX
- Apply clinical judgment to client care

Nursing judgment is a learned skill. The ability to think critically develops more fully over time in nursing practice. Basic understanding of the process is evaluated pre-licensure during the nurse's academic preparation and on the licensure examination for nursing graduates.

Every two years, the National Council of State Boards of Nursing (NCSBN) investigates nursing education and aspects of the nursing workforce via survey in the United States. These surveys provide information on the type of practice required and the availability of working nurses. This information is utilized for curriculum development in schools of nursing and workforce planning in health-care settings as well as in the development of questions for NCLEX. This section addresses the measurement of nursing judgment, specifically on the licensure examination, and in nursing practice.

National Council of State Boards of Nursing (NCSBN) and the Clinical Judgment Measurement Model

American states and territories establish what constitutes legal nursing practice through their own Nurse Practice Acts to safeguard recipients of nursing care and to protect nurses within the profession. These acts specify requirements of nursing education programs, requirements to be licensed as a nurse, scopes of practice at the levels of professional, practical, assistant, and advanced nursing, and disciplinary action for violations in practice. These are regulatory functions of state boards of nursing. The **National Council of State Boards of Nursing (NCSBN)** is the agency that coordinates these regulatory functions in the United States.

Boards of nursing also have research functions, as described in the preceding paragraph regarding surveys. Evidence-based research informs regulatory criteria and contributes to the overall nursing and health-care database. In 2023, this research action resulted in changes to the **National Council Licensure Examination for Registered Nurses (NCLEX-RN)**.

LINK TO LEARNING

This brief video introduces the National Council of State Boards of Nursing (https://openstax.org/r/77NCSBNHistory) to provide information about the work and scope of NCSBN, the history of the organization, its work, and its role in protecting the public.

Presentation of the Clinical Judgment Measurement Model (CJMM)

Utilizing research data, the NCSBN identified a need to measure nursing judgment and knowledge of clinical skills more realistically. Because the NCLEX-RN measures graduate nurses' understanding of safe practice at the entry level, this was a critical public health and professional competency initiative. The Clinical Judgment Measurement Model (CJMM) was developed for this purpose. It is a decision-making model for answering questions on the NCLEX-RN, though it is valuable in nursing practice as well.

LINK TO LEARNING

The NCSBN created the Clinical Judgment Measurement Model (CJMM) (https://openstax.org/r/77CJMM2) based on the organization's research regarding nurses' real-life use of clinical judgment. The CJMM was developed to enable testing of nurses' clinical learning by the licensure examination.

Nurses may be familiar with other decision-making models. One is a simple visual flowchart or algorithm called a decision tree, which graphs predictions or consequences of actions (Figure 28.4).

FIGURE 28.4 A decision tree is one type of decision-making model that can be used by nurses in practice. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Another model is the scientific PICOT format that nurses may have used in academic research courses. A clinical inquiry is proposed by the researcher and formatted to streamline a literature search process. Figure 28.5 shows an example.

PICOT **MODEL OF CLINICAL INQUIRY**	
	Example of Clinical Inquiry: Among adolescent clients in a diabetes management clinic would teaching with mobile applications for diet guidelines compared to brochures result in lower A1c over one year?
POPULATION **P**	Adolescent clients in a diabetes management clinic
INTERVENTION **I**	Teaching with mobile applications for diet guidelines
COMPARISON **C**	Brochures
OUTCOME **O**	Lower A1c
TIMEFRAME **T**	One year

FIGURE 28.5 This format is a model of inquiry. P=Population or Problem being studied, I=Intervention/nursing action, C=Comparison to other or existing or no action, O=expected Outcome, and T=Time frame to conduct the study. (modification of work from *Fundamentals of Nursing*. attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

Decision-making models serve as frameworks for analysis of possible solutions to identified problems. Decision-making models assist with clarifying collected data toward a conclusion for best action. The CJMM presents a decision-making process specifically designed for nursing practice.

Levels of Clinical Decision-Making/Reasoning

The CJMM has layers, which represent levels of decision-making. The nurse applies critical-thinking skills to discern what clients need at any given time.

Layers 0 and 1 represent a continual loop between client needs, application of nursing judgment to clinical

decisions, and back to more assessment of client needs. Expert nursing practice was defined by Benner's classic work (1982) as the length of practice at five years or more wherein the client's needs are identified and addressed by clinical decisions using clinical judgment. Notice the word *satisfied* is shown at Level 1, meaning goals of treatment were met. The expert nurse goes on to the next client need from here, or supports the client's recovery, repeating Layers 0 and 1 through termination of the therapeutic relationship. The process is grasped intuitively by the nurse at this level of practice and nursing interventions are efficiently focused (Ozdemir, 2019).

Layers 2, 3, and 4 depict the actions nurses can take, and the concepts to consider, if the client's needs are *not satisfied* (meaning goals are unmet or partially met). These words are shown in the middle of the graphic at Level 2, showing that evaluation leads back to more review of the data. Layers 2, 3, and 4 are guidelines that can result in outcomes of care, which will again be evaluated for effectiveness. The entire process is learned over time as nurses increase in practice proficiency.

Layer 4 includes the environment, which is everything surrounding the nurse-client relationship that will influence outcomes. The term *individual* refers to nurses themselves and to nurses' abilities (Table 28.1). All of these considerations factor in to determine if the client's need can be met in this environment by this individual. Keep in mind that the CJMM was developed to evaluate cognitive skill of the test-taker. Therefore, on Layer 4 under Individual Factor Examples, "Candidate Characteristics" refers to the nursing graduate taking the NCLEX-RN. In licensed practice, this would be "Nurse Characteristics."

Type of Factor	Factor	Examples
Environmental (everything surrounding the client)	Environment	Everything surrounding the nurse-client interaction: physical setting/location, like temperature of the space, privacy, presence of others, lighting, noise, odors; emotional atmosphere, like accepting, supportive, nurturing versus judgmental, hostile, frightening
	Client observation	Assessment data, expressed symptoms
	Resources	Equipment, supplies, levels, and numbers of staff and support services
	Medical records	Electronic access, history, recent events
	Consequences and risks	Potential for violence, danger, infection, adverse reactions, medical errors, falls, potential outcomes
	Time pressure	Rapid developments, workload, schedules
	Task complexity	Components of care, steps in a procedure or process, knowledge/assistance required
	Cultural considerations	Age, belief systems, traditions, client's social structure
Individual (the nurse)	Knowledge	What is understood about the client's situation
	Skills	Technical and cognitive proficiency as result of teaching and training
	Specialty	Clinical certification, practice in defined nursing fields

TABLE 28.1 Layer 4 of the CJMM

Type of Factor	Factor	Examples
	Candidate (nurse) characteristics	Patience, flexibility, motivation, confidence versus anxiety, rigidity, reluctance, self-doubt
	Prior experience	Applicable to current demands
	Level of experience	Entry-level, competent, expert

TABLE 28.1 Layer 4 of the CJMM

Assessment of Nursing Knowledge by the NCLEX-RN

As stated, the NCLEX-RN changed in 2023 due to research evidence of the need for nursing graduates to show increased understanding of safe practice at the entry level. Focus and format of the questions on the licensure examination changed to meet this goal. Time frame for completion of the NCLEX-RN examination is five hours after the candidate opens the test on the computer. The examination presents the test-taker with items (questions) that pose problem-solving scenarios, in short form as specific questions, or in longer form as client need categories. Candidates can expect items to address categories as depicted in Figure 28.6.

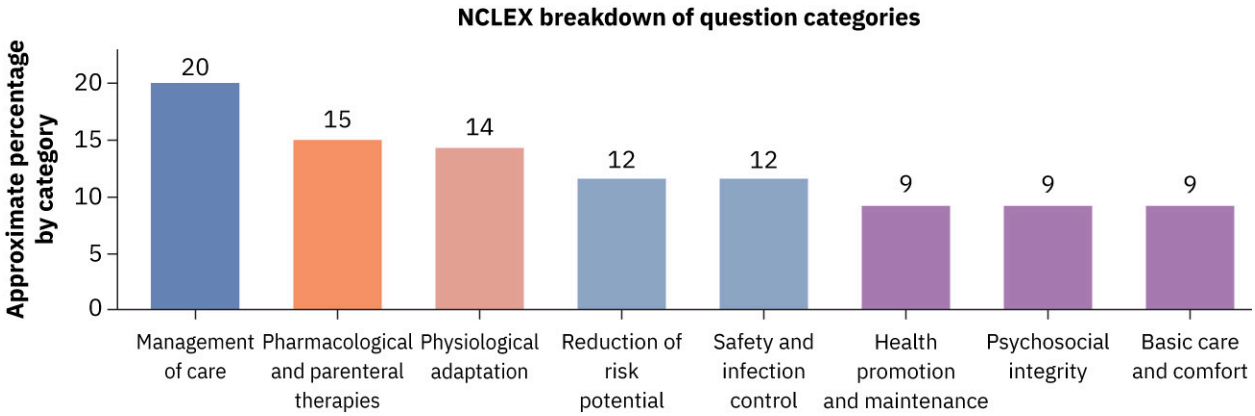


FIGURE 28.6 This graph shows the approximate breakdown in categories of questions on the NCLEX, but distributions may vary slightly based on individual examinations. (attribution: Copyright Rice University, OpenStax, under CC BY 4.0 license)

To guide the candidate's study, meaning of the categories depicted left-to-right on the graph are as follows:

- Management of care means the nurse observes scope of practice guidelines, incorporates all available supports, delegates and directs others, and conserves resources.
- Pharmacological and parenteral therapies mean the nurse safely administers or supervises safe administration of prescribed medications, fluids, and blood products by all routes and teaches and monitors indication, intended effect, side effects, and adverse reactions.
- Physiologic adaptation means the nurse manages and promotes clients' adjustment to emergency, corrective or supportive care, interventions, and treatments.
- Reduction of risk potential means the nurse monitors for complications of clients' diagnoses and educates and intervenes to mitigate potential harms and adverse outcomes to care and treatment.
- Safety and infection control means the nurse recognizes and mitigates harm and risks, observes practice standards, monitors client acuity, and educates others.
- Health promotion and maintenance means the nurse brings preventative care and wellness care at all stages of human development, detects potential problems, and conducts health screening.
- Psychosocial integrity means the nurse promotes clients' adaptation and stress management, teaches others, integrates nursing interventions, advocates for emotional, social, and spiritual wellness, and delivers

psychiatric nursing care in therapeutic settings.
- Basic care and comfort mean the nurse provides and directs physical care for basic needs, such as nutrition, hydration, comfort, elimination, activity, and rest.

The essence of nursing practice is the identification of client needs, which are then addressed through the nursing process. By successful completion of the NCLEX-RN, nursing graduates show their competence at the entry level of practice. Nursing graduates must think about how all these categories apply in psychiatric-mental health (PMH) nursing.

Computerized Interactive Questions

The NCLEX-RN items measure clinical judgment by case study and stand-alone questions. Case studies present multiple questions about a realistic nursing care scenario. Stand-alone items ask for application of the six elements in Layer 3 of the CJMM, which are steps of the nursing process, and, as discussed, depict the actions the nurse can take. Answers may be entered by "click to specify" or "click to highlight" chosen responses. Test item formats include bow-tie, drag and drop, drop-down, extended multiple response, and matrix. Visualizing questions on a split screen is another new feature of the exam.

- Bow tie: Move provided answers to provided categories.
- Drag and drop: Move provided answers to the correct target.
- Drop down: Select an option from text, chart, or table.
- Extended multiple response: Select all applicable responses; partial credit is awarded for items with more than one key.
- Matrix: Select from a table of options in columns or rows.

Presented in the next section will be examples of these question types used in an evolving case study.

Available Resources

Knowledge base and examination preparation together are essential for NCLEX success.

Schools of nursing provide preparation for the NCLEX throughout the nursing program, many utilizing a software package. Near graduation, programs offer more specific preparation in the forms of exit exams, capstone projects, clinical preceptorship/field placements, or wrap-up components of the school's software product. In addition, final semester students frequently present a project that is designed to bring together multiple concepts of nursing practice.

There are numerous NCLEX preparation offerings. Nursing graduates may personally decide how to customize the process. What is important to the test-taker? Graduates should consider their own learning style. Printed materials, online formats, mobile applications, videos on demand, practice questions, recorded mini-lectures, question libraries, and real-time study groups, coaches, and tutors are all available.

Graduates may want to consider whether the study resource contains access to customized study help and access to user reviews. Cost is another factor, whether purchase or subscription. The testing programs selected by the graduate's school of nursing can serve as a guide for NCLEX prep or prompt investigation into what other schools use. Important to consider is practice with simulated adaptive NCLEX-style test items. The graduate's selection of preparation packages should include those that provide a focus on Next Gen type questions.

LINK TO LEARNING

The NCLEX Frequently Asked Questions page (https://openstax.org/r/77NCLEXquestpge) provides a lot of useful information for nursing graduates preparing to take the exam.

Application of Clinical Judgment to Client Care

Nursing graduates can think of the NCLEX-RN as a safety test. The test evaluates candidates' ability to decide how to proceed in client care situations, not memorization of answers to standard questions. Expect scenarios posing complex decisions that require cultural competence and use of available resources. NCLEX-RN seeks to present situations that occur in real health-care settings. There is an increased focus on client acuity and nursing

management of change in condition. The goal is improvement in care that avoids medical errors by emphasizing clinical judgment.

Specific to PMH nursing, the licensure exam will address nursing process in care of clients experiencing disorders covered in this textbook, recognition of signs and symptoms, risk factors, aspects of recovery, legal and ethical concerns, and nurses' self-care. Psychopharmacology, therapies, theories, client behaviors, and clients' experience will also be topics for test items.

Collaboration for Client Care Approaches

As presented in this chapter, evidence-based practice is a combination of science, nursing expertise, and client preferences. Quality and Safety Education for Nurses (QSEN) concepts call for multiple health-care professionals to practice in partnership with the client and family. Interprofessional collaboration is endorsed by multiple professional organizations (University of North Carolina, n.d.). NCLEX-RN test items will present problem-solving scenarios to evaluate skills in these domains.

LINK TO LEARNING

Researchers from Ohio State University have effectively summarized the QSEN Competencies for Graduate Nurses (https://openstax.org/r/77QSENgradnurse) in their article on quality processes.

Table 28.2 provides examples of nursing actions to meet the QSEN Competencies as related to PMH nursing.

QSEN Competency:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:
Person-Centered Care	Form a therapeutic alliance with the client. Obtain and interpret assessment data (recognize cues) through therapeutic communication.	Utilize active listening with a family member reluctant to have a loved one hospitalized.	Document the client's expression of anxiety.	Determine client's preference prior to a procedure.	Role model for others' consideration for client's values and beliefs.
Teamwork and Collaboration	Participate as client advocate during interdisciplinary team meetings.	Share decision-making with peers and colleagues who are participating in the client's care.	Consult with, or offer referral to, other professionals when clients express or demonstrate select needs, i.e., spiritual support.	Inform clients that their personal information is kept confidential.	Inform clients that their information is shared with the care team only, especially when safety is a concern.

TABLE 28.2 QSEN Competencies for PMH Nursing (Dolansky & Moore, 2013; QSEN Institute, n.d.)

QSEN Competency:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:	PMH Nurses can:
Evidence-Based Practice	Refer to organizational policy and procedure to understand rationale for care.	Seek membership in councils or research groups in the workplace.	Keep informed of current pharmacological data.	Distinguish opinion from research evidence.	Keep informed of current practice, especially regarding most restrictive interventions, i.e., seclusion and restraint.
Quality Improvement (QI)	Use available data to monitor outcomes of care.	Ensure that care is safe and effective.	Use QI processes within the organization to plan practice change.	Identify unit-based opportunities to improve safety.	Role model advocacy for the client's experience.
Safety	Reduce risk through effective nursing care and delegation.	Observe established practice guidelines.	Teach clients strategies for personal safety.	Monitor client situations for increased risk, i.e., rising anxiety or increased social withdrawal.	Keep a safe environment.
Information	Use informatics and technology to inform clinical decision-making.	Protect the client's confidentiality.	Share client information with appropriate team members when safety is a concern.	Use stored data for analysis of client care.	Teach and assist utilization of telehealth as indicated.

TABLE 28.2 QSEN Competencies for PMH Nursing (Dolansky & Moore, 2013; QSEN Institute, n.d.)

Developing Clinical Judgment

According to the American Association of Colleges of Nursing (AACN):

> As one of the key attributes of professional nursing, clinical judgment refers to the process by which nurses make decisions based on nursing knowledge (evidence, theories, ways/patterns of knowing), other disciplinary knowledge, critical thinking, and clinical reasoning (n.d., para 1).

Clinical judgment, involving critical thinking and clinical reasoning as applied to nursing care scenarios, is an essential skill for the nurse to provide quality care. Clinical judgment develops over time in clinical practice through exposure to various client care situations with application of these thought processes to nursing practice.

Prior to licensure, schools reinforce learning of clinical judgment using the Clinical Judgment Measurement Model. NCLEX test items are intended to reflect the atmosphere of the clinical setting where actions, including errors, have consequences. Safety and effectiveness of all nursing care depends upon accurate application of the nursing process.

Nurses can develop clinical judgment through both independent and collaborative actions, such as:

- Ask coworkers for tips and suggestions; observe and assist others.
- Receive feedback professionally and request review of work.

- Review the medical record and learn to make connections to care, for example, medications to lab values, vital signs, or client experience.
- Become familiar with screening tools and assessment resource material.
- Ask questions about the rationale for procedures.
- Review unit-based data for fall rates, infections, or readmissions.
- Read research abstracts, follow up on those of interest.

Collaborative action:

- Engage with clients, families, and other professionals in care planning.
- Seek supportive relationships with educators and mentors in the workplace.
- Discuss research evidence with other nurses.
- Participate in unit-based or facility-wide activities for education, community involvement, or employee morale.
- Accompany clients off-unit to imaging or diagnostic procedures, to support the client and interact with other professionals in those departments.
- As appropriate, be present when consultants, therapists, and medical providers interact with clients to support the client and learn how services interface.
- Request a "shadow shift," especially in areas connected to your unit, for example, emergency department and medical-surgical floor, intensive care unit and step-down unit.

28.3 Applying Clinical Judgment to Client Care through Unfolding Case Study Dissection

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Interpret information given in NCLEX question types that promotes critical thinking and the use of clinical judgment in PMH nursing
- Examine an unfolding case study in mental health as an exemplar of the type of NCLEX questions

A nursing skill for success on NCLEX, and in practice, is the ability to divide a clinical picture into its elements. This skill is useful in all areas of nursing practice and enables nurses to understand the complexities of client care. This understanding not only leads to planning of person-centered nursing care, it also enhances nurses' personal satisfaction in their work.

Interpret Information Given in NCLEX Question Types

This section offers guidelines to interpret information presented in NCLEX question types. Nurses use critical thinking to interpret data, which leads them to apply clinical judgment. NCLEX question formats seek to measure knowledge necessary for safe practice at the entry level of nursing. The exam offers partial credit for select questions.

Drag and Drop

These question types pertain to a client care scenario. Answers are chosen by identifying the steps in a procedure or components of a process, such as prioritizing the client's room placement or staff assignment or filling in blanks in a description. Taking the licensure exam, the computer screen shows information on the right and left sides. Answers are moved to appropriate spaces by dragging or by highlighting and clicking arrow keys. All options may or may not be used.

Multiple Choice/Multiple Response

Multiple choice questions have traditionally required application of knowledge and analysis of data, demonstrated by selecting one correct answer for one question. Multiple choice test questions still make up most of NCLEX items, providing statements that are answered from a list of options.

NCLEX-RN seeks to present higher-order multiple choice questions. This means answers come not from the candidate's memory but from learning and problem-solving ability. Test-takers are asked to interpret data and apply clinical reasoning to address client situations. Questions may have more than one answer.

Highlight—Text or Table

This question type requires highlighting or removing highlighting by use of the computer mouse or keyboard. A case study provides client care information wherein the candidate highlights the cues prompting a nurse to plan interventions (take action). Questions of this type call for clinical decision-making and may have as many as ten possible answers. Partial credit is given for these questions.

Bow Tie/Trend

The bow tie question is identified by the visual design it forms on the computer screen. A client care situation is presented with data and the test-taker is to discern whether it requires or does not require nursing intervention. The scenario may offer cues to a potential complication of the client's condition if interventions are not taken.

On the computer screen, tabs are located at the top of an image containing client information, for example, vital signs, nurses' notes, or other data from the medical record. These test items are created to test all aspects of the CJMM: recognizing and analyzing cues, formulating and prioritizing hypotheses, generating possible solutions, taking actions, and evaluating outcomes of care as effective or not effective.

A trend test item prompts the nurse to forecast future client needs over time. Trend questions may utilize computer screen images similar to the bow tie to test candidates' ability to predict and prepare for what may be needed next.

Examining a Case Study with NCLEX Style Questions

In order to make clinical judgments and decisions, nurses are called to reflect on what is known (from formal education or from life experience) and apply this to clinical scenarios. Nurses can practice these skills using case studies. An **unfolding case study** is an example of a client care scenario where the situation changes. This seeks to replicate a real-life situation and to call upon decision-making skills of the nurse to respond as client needs present or change.

Generating an action based on gathered cues is likely a cognitive process nurses have previously utilized. Other types of decision-making nurses use include predetermining success or selecting different actions based on changes in the situation. In the case study presented here, the nurse, Jan, prepares for the therapeutic relationship with the client, Dylan, in the emergency department.

Unfolding Case Study: Therapeutic Relationship

Dylan, a young adult, is referred to the emergency department from an appointment at the local mental health clinic for elevated vital signs and change in condition. Dylan was transported by a family member who remains in the waiting room.

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Preorientation Phase	Nurse determines recipients of care: Dylan, a young adult; family member who remains in the waiting room	During the preorientation phase of the therapeutic relationship, the nurse will: A. set goals with the client B. administer medication C. document care provided D. consider who are the recipients of care The correct answer is D.

Before meeting with Dylan, the nurse, Jan, reviews accompanying information, which reveals the following:

Referred for BP 160/102. No significant medical history, no known allergies. Prescribed Risperidone orally 4 mg daily (which was taken today) and lorazepam orally as needed for anxiety 0.5 mg twice daily (not taken × 48 hours).

Diagnosed with schizophrenia four years ago, used several antipsychotics over this time but experienced side effects, now has good control of symptoms; recently unemployed and now socially withdrawn; has complied with

clinic appointments and medication adherence. No substance misuse history or currently. Lives alone, eats poorly, fears taking the bus to the grocery store.

Jan recognizes cues from the history.

Stage of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Preorientation Phase	Nurse prepares self, collects secondary data: Clinically significant: BP, prescribed medications and dosages and last dose; diagnosis history and experience with psychotropic medications; change in social history	The nurse collects secondary data during medical record review consisting of: A. client's present cooperation B. current vital signs C. client's interaction with the nurse now D. client's prior diagnosis Correct answer is D.

Upon interview, Dylan does not return Jan's greeting, avoids eye contact, answers questions slowly, and appears to struggle with concentration.

Jan explains care and says, "I'll be working with you while you're here in the emergency department. How can we help you today? I understand you came from your clinic appointment."

Dylan states, "They sent me here because of my blood pressure," and correctly identifies the environment as the "hospital ER." His clothing is soaked with perspiration. Dylan flexes fingers, shakes hands, swallows repeatedly, and states, "My neck feels tight."

Vital signs: oral temp 38°C, pulse 116 irregular, respirations 28 irregular, BP 156/104, repeat BP 148/96.

At this stage, Jan recognizes cues, analyzes cues (identifies problems), and prioritizes (identifies the priority problem).

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Orientation Phase	Explains care (sets termination phase, i.e., "I'll be working with you while you're here in the emergency department"), collects primary data	An important aspect of the orientation phase is: A. goal-setting B. referring to radiology reports C. setting termination of the relationship D. that most interventions occur Correct answer is C.
	• Client responses: oriented to reality, social aspects blunted; diaphoresis, muscle rigidity, elevated BP 156/104, moderate anxiety • Priority: potentially life-threatening medication reaction, symptom cluster for neuroleptic malignant syndrome	Rank these assessment items in priority order: A. blunted affect B. BP 176/90 C. muscle rigidity D. moderate anxiety The correct order is B, C, D, A.

Jan offers basic hygiene and dry clothes to Dylan who begins to cry and states, "My back hurts now, what is wrong with me?" Jan helps Dylan to reposition, then retakes the vital signs: oral temperature 40°C, pulse 120 irregular, respirations 24 irregular, BP 126/76.

At this stage, Jan generates solutions (What can be done? What goals can be set?) and takes action (What nursing interventions are indicated? What medical orders can be anticipated?).

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Working Phase	Comfort measures, build trust, assure as to safety, monitor condition	During the working phase, the client's condition begins to change as evidenced by: A. sudden complaints of pain B. ongoing conversation C. asking questions D. thanking the nurse Correct answer is A.
	Psychosocial stability and advanced medical care are goals Manage moderate anxiety, offer relaxation technique, coordinate care	A medical order that can be anticipated is: A. discharge to home versus rehab B. transfer to higher level of care C. specific medications D. relaxation techniques Correct answer is B.

Collaborating prescriber orders IV fluids, ECG, CXR, lab work, UA with C&S. Dylan is cooperative with phlebotomy and other procedures, then becomes increasingly confused, unable to provide urine specimen, stating, "Where am

I? I can't really stay here, can I? How can I get out of here?"

At this stage, Jan generates solutions (How can the nurse use the therapeutic relationship? What is the goal?).

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Working Phase	Anxiety is severe	The nurse recognizes deterioration in client's condition with: A. low anxiety B. regular respirations C. sudden confusion D. asking for water Correct answer is C.
	Manage severe anxiety, repeat directions, reality orientation, assure as to safety	The nurse decides to utilize the therapeutic relationship to manage rising anxiety by: A. informing client of the rules B. assuring as to safety C. providing reading material D. giving privacy Correct answer is B.

Laboratory results returned with the following:

- Abnormalities of hyponatremia (Normal range: 136–145 meq/L)
- Creatine kinase (CK) elevation (Normal range: 30–170 units/L)
- ECG shows supraventricular tachycardia (Normal range: heart rate 50–100; QRS interval 0.08–0.10 seconds)
- WBC WNL (Normal range: 4000–10,000/μL)
- CXR normal (Normal result: clear lungs, no abnormalities noted)

At this stage, Jan takes action: What nursing interventions are indicated?

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Working phase	Lab work and CXR may rule out infection as cause of fever, blood pressure labile, elevated CK indicates muscle damage, fever is priority Prepare for transfer, participate in family and client teaching	Select the laboratory value indicative of worsening physical condition: A. elevated CK B. Hbg 14.0 g/dl C. temperature of 37°C D. skin cool and dry Correct answer is A.

Prescriber calls for admission to ICU for cooling blanket, cardiac monitoring, and supportive care.

Prescriber and nurse collaborate in discussion with client and family regarding necessity for higher level of care for treatment of possible severe medication adverse reaction.

Dylan verbalizes understanding and Jan tells Dylan, "I'll go upstairs with you," and Dylan answers, "Thank you, nurse—thank you for helping me."

At this stage, Jan evaluates outcomes: Are the nursing interventions effective for the goal? How is Dylan's medical condition changing? How is Dylan's psychosocial condition changing? What is the next nursing action?

Stages of the Therapeutic Relationship	Sample Nursing Actions	NCLEX Style Questions
Working/ Termination Phase	Medical condition worsening; psychosocial condition improving-anxiety reduced due to nursing interventions Nursing action: Transfer of care-accompany client to ICU, give bedside handoff report to receiving nurse	Select the behaviors indicative of improving psychosocial condition: A. client refuses to answer questions B. client demands to leave C. obvious muscle tension D. client thanks the nurse Correct answer is D.

Assessment and Analysis

In this scenario, assessment information consists of secondary data in the form of a printed report from the community clinic. During this preorientation phase, Jan recognizes the following cues from this data:

> Clinically significant: BP, prescribed medications and dosages and last dose; diagnosis history and experience with psychotropic medications; change in social history

Jan analyzes this information and continues to the orientation phase of the therapeutic relationship. Jan collects primary assessment data by interacting with Dylan, observing Dylan's behavior, and taking the vital signs. Jan analyzes the combined data as:

> Client responses: oriented to reality, social aspects blunted; diaphoresis, muscle rigidity, fever, elevated vital signs, moderate anxiety

> Priority: potential life-threatening medication reaction, symptom cluster for neuroleptic malignant syndrome

Planning and Implementation

During analysis, Jan forms hypotheses about what could be causing the presenting problems. Jan determines problems of fever, elevated vital signs, and moderate anxiety may be due to medication reaction. Jan identifies the priority problem and begins to plan additional care and collaboration by generating solutions, considering: What can be done? Jan sets goals of treatment and reassures the client.

> Comfort measures, build trust, assure as to safety, monitor condition

> Psychosocial stability and advanced medical care are goals

Jan implements the plan, moving into the working phase of the therapeutic relationship.

Jan is working within a shortened time frame due to the severity of the client's condition, which has the potential to worsen. Regarding delegation, though a licensed practical nurse or nursing assistant could provide some of the basic care, Jan will not delegate any tasks. Dylan's condition is unstable and requires continual assessment by the professional nurse. Jan factors all this data into the decision-making. Jan takes action to implement the plan, considering: What nursing interventions are indicated? What medical orders can be anticipated?

> Manage moderate anxiety, offer relaxation technique, coordinate care

Evaluation (and Revision/Continuation of Care)

As Jan is coordinating care with the prescriber, Dylan's psychosocial status changes. Dylan becomes unable to cooperate with the ordered laboratory specimen collection due to confusion and anxiety escalating from moderate to severe. Jan evaluates the goal of psychosocial stability as unmet. Jan recognizes these cues of a change in condition, which necessitate a change in nursing approach.

Jan revises the plan of care and implements these nursing interventions. They are effective for psychosocial stability, though medical condition is worsening.

Manage severe anxiety, repeat directions, reality orientation, assure as to safety

Diagnostic test results come back, and the prescriber arranges a transfer to a higher level of care for intensive treatment.

Medical condition worsening; psychosocial condition improving—anxiety reduced due to nursing interventions

Nursing action: Transfer of care—accompany client to ICU, give bedside handoff report to receiving nurse

Dylan is now receptive to interaction with Jan and the prescriber, as they explain the transfer procedure and rationale. Dylan's family member is brought into the conversation. This is the termination phase of the therapeutic relationship, and nursing care has been effective for goals of psychosocial stability and advanced medical care.

REAL RN STORIES

Nurse: Donna K, RN-BC, MSN
Years in Practice: Twelve
Clinical Setting: State hospital
Geographic Location: Florida

Something happened when I worked at the state hospital in Florida that made person-centered care very real to me. Walter was a fifty-six-year-old who had history of conflict with law enforcement in the local community and, consequently, was repeatedly admitted to the state hospital. Walter had shown a pattern of stabilizing during hospital stays, then stopping medication soon after discharge, inevitably becoming paranoid and aggressive and often being arrested. Social services had investigated issues of finances, transportation, and access, and had been unable to identify a specific factor to explain Walter's nonadherence to prescribed medication. Some people believe that clients in state hospitals stay there for life, but we discharged many back to their communities.

Walter's discharge day came due. During discharge teaching, I gave honest praise for Walter's progress during the stay and mentioned that with medication and follow-up visits, there was every reason for continued success. Walter looked at me very seriously and said, "Nurse, I can't take that medicine once I get home." I almost said, "Why not?" out of surprise, but I managed to answer therapeutically and say, "Tell me about that." Walter looked away from me and said, "It messes with my nature." I have never thought of myself as naïve, but I did not know what Walter was talking about. We sat in silence for a moment, and I said, "Help me understand that." Walter went on to describe what I then understood as sexual function side effects. I telephoned the prescriber who joined us for a teaching session and then worked with Walter to formulate a medication management plan. Walter was discharged as planned, and I never saw him again, though I will always remember what I learned from our relationship.

Summary

28.1 Nursing Process

This section addresses the nursing process in PMH nursing and the critical thinking involved. Nursing judgment is applied throughout the nurse-client relationship. The nurse engages in personal reflection as the plan of care unfolds. The nurse utilizes data collection from available sources, and interprets the data for its meaning in client care. The nurse and client collaborate to set goals and formulate a plan. Nurses provide competent practice that is evidence-based. The plan of care is adapted to stated outcomes of care and client needs. The nurse's clinical judgment guides the process through all phases of the therapeutic relationship.

28.2 Measurement of Clinical Judgment

This section addressed measuring nursing judgment, specifically on the licensure examination, and in nursing practice. Critical thinking and clinical judgment develop in nursing practice over time and through models like the CJMM. Schools of nursing evaluate these skills for successful completion of academic courses. The NCLEX evaluates these skills prior to licensure as a professional nurse. Nurses must act efficiently and safely, while identifying and seeking to meet client care goals.

28.3 Applying Clinical Judgment to Client Care through Unfolding Case Study Dissection

This section has presented concepts for critical thinking in clinical decision-making in PMH nursing. Recognizing that client care is complex, NCLEX presents test items to evaluate nurses' ability to manage these variations. Clinical judgment skills continue in licensed practice. Successfully stabilizing a client's anxiety, pain, or fear will enhance outcomes of care. In addition, nurses are likely to feel personally rewarded in their careers.

Key Terms

analysis critical examination of the meaning of identified cues
assessment collection of available data to inform care planning
clinical judgment decision-making from use of critical thinking in the nursing process
critical thinking metacognitive process that is learned academically and experientially on the continuum of nursing education and practice
evaluation process of reviewing outcomes for effectiveness, as determined by the nurse and the client
evidence-based practice (EBP) interventions formed by a combination of formal research findings, nursing competency, and the preferences of the client and family
implementation nursing action of intervening according to the plan
National Council Licensure Examination for Registered Nurses (NCLEX-RN) exam that measures graduate nurses' understanding of safe practice at the entry level
National Council of State Boards of Nursing (NCSBN) agency that coordinates the regulatory functions of individual state boards of nursing in the United States
nursing process decision-making method in nursing practice
outcomes of care measurable responses to interventions; results of goal-setting
person-centered care client is the focused recipient of nursing care
planning cognitive process of generating solutions to identified problems, setting goals of treatment, and developing nursing interventions to accomplish these objectives
therapeutic alliance partnership with the client
therapeutic environment safe physical location, such as a hospital, clinic, or home, and the supportive conditions within that location
unfolding case study example of a client care scenario where the situation changes, seeking to replicate a real-life situation and to call upon decision-making skills of the nurse to respond as client needs present or change

Assessments

Review Questions

1. Before providing the client with brochures on available community resources, the nurse identifies the client's personal strengths in which stage of the nursing process?

a. assessment
b. analysis
c. planning
d. implementation

2. The nurse receives transfer of care report and recognizes the highest priority client need when learning what detail about the client?
a. The client was silent during some of the admission interviews.
b. There is medical history of preeclampsia with a pregnancy last year.
c. The client's family brought in some magazines and left them at the desk.
d. The client states the partner will "be sorry" for their breakup.

3. Riley refuses to attend therapeutic groups while in the hospital. The nurse listens to Riley's comments and plans to speak to the interdisciplinary team counselor about Riley's concerns. What does this situation represent, relative to the nurse–client interaction?
a. This is an example of the client's inappropriate behavior.
b. This is an example of secondary, objective data collection.
c. This is an example of professional sharing in care planning.
d. This is an example of evaluation in the nursing process.

4. What are the three components of evidence-based practice?
a. research/client preference/nurse competency
b. nurse experience/collaboration/teamwork
c. research/client safety/client preference
d. nurse experience/client teaching/delegation

5. When the nurse has developed a therapeutic relationship with the client, what is a true statement about nursing care?
a. The nurse remains friends with the client after discharge from care.
b. The nurse considers the client a partner in care planning.
c. The nurse adheres to the plan of care without change.
d. The nurse avoids a directive approach at all times.

6. Each American state and territory establishes legal nursing practice through what?
a. research function
b. Nurse Practice Act
c. evidence-based practice guidelines
d. building of a nursing database

7. What was the Clinical Judgment Measurement Model (CJMM) developed to be?
a. a model to measure expert nursing knowledge
b. a model to define scope of nursing practice
c. a model to regulate nursing education
d. a model to measure nursing judgment and knowledge of clinical skills

8. What environmental factor must the nurse must consider in decision-making if the client is due for a diagnostic test and the transport team is waiting?
a. medical records
b. resources
c. task complexity
d. time pressure

9. How does the nurse interpret assessment data in planning client care?

a. generating solutions
b. analyzing cues
c. taking action
d. evaluating outcomes

10. An adult client has described a personal loss. Before touching the client to offer comfort, what should the nurse consider?
a. the client's recent vital signs
b. the client's cultural background
c. if the doctor should be notified
d. if the client has been sad recently

11. The nurse manager conducts a hand hygiene surveillance project on the mental health unit. This activity demonstrates nursing competency in which two QSEN categories?
a. safety and quality improvement
b. teamwork and informatics
c. safety and informatics
d. evidence-based practice and person-centered care

12. How will the nurse evaluate if trust has been established with the client?
a. The client states, "I wish my mom was here."
b. The client states, "You don't even know me."
c. The client states, "I'll tell you about my sister."
d. The client states, "I looked up that doctor online."

13. What is a true statement about the nursing process?
a. Cues are analyzed during assessment.
b. Hypotheses are formed with evaluation.
c. Nurses use only secondary data.
d. Unmet goals are discontinued.

14. What is the value of nurses' critical thinking?
a. standardization of all nursing care
b. elimination of future client needs
c. memorization of nursing care plans
d. interpretation of client care data

15. What is a true statement about NCLEX drag-and-drop test items?
a. They cannot use every answer option.
b. They cannot test prioritization.
c. They show split computer screen.
d. They make up 50 percent of test items.

Check Your Understanding Questions

1. During the admission process, vital signs, lab work, the intake interview, demographic data screens, and signature forms need to be completed. The client is tremulous, crying, and rocking in their seat with fists clenched. State what action to take first and explain why.

2. You delegate hygiene and nutrition care to a practical nurse who is newly employed. The client has stabilized recently after showing some resistance to care. Identify how this delegation might go.

Reflection Questions

1. How would you apply clinical judgment to a hospital client's reluctance to engage in therapy and refusal of

medication?

2. To demonstrate the QSEN competency of informatics, describe how you can use the medical record to create a fall prevention plan for a client.
3. The offgoing RN tells you in report that client, Jorrie, has "settled down" after the nurse provided the unit rules guidebook about telephone hours. Do you believe this nursing action was effective? What would you do differently?

What Should the Nurse Do?

1. Kim is the RN working with an eighty-year-old male, Asim, recently widowed and admitted from the primary care office after family members took him there out of concern for his mental state. Asim has been reclusive, refusing medication, and is not eating. Kim reviews the medical record and learns that Asim is Muslim with stated religious preference for the Islamic faith. Kim wants to use evidence-based decision making to formulate a plan of care. Combining the three components of EBP, what information should Kim access to plan care for Asim?
2. An adolescent client has been admitted for self-harm behaviors. The client has been diagnosed with type 1 diabetes and has been refusing insulin, dietary modifications, and medical care. As you approach this client, and plan person-centered care, what psychosocial nursing knowledge can guide your interaction?
3. An older adult client complains of vague pain symptoms without specific signs. Diagnostic imaging has been negative. There is no history of injuries. For person-centered care, you consider there may be cultural aspects and you plan to open a therapeutic conversation with the client. How might you approach this topic?

Competency-Based Assessments

1. Compose a plan of care for an adult client who showed a change in condition resulting in revision of the plan of care.
2. Compose an end-of-shift/transfer of care report describing rationale for a revised care plan.
3. Survey your classmates asking what method or strategy they would use to prioritize a client's needs as a guide to care planning. Summarize the results and present your findings to the class through face-to-face discussion or posting on your learning management system.
4. Read this research article about inpatient nurses (https://openstax.org/r/77inpatintnurse) in mental health facilities. In a group discussion or short essay, summarize one of the three themes found in this analysis and offer one strategy to address the concept.
5. What are the cues in this client's presentation? Discuss in small groups face-to-face and compare with the class. Or, if online, post to the discussion thread on your learning management system and respond to two other posts.

(credit: "Depression-2912424 1280" by "whoismargot"/Wikimedia Commons, Public Domain)

6. You are charge RN on the Mental Health Unit with one LPN and two mental health techs. Dietary staff is at the unit door with the meal cart. This is the unit dayroom as you come on shift:

    - Dell and Ivory are playing cards and arguing over who is winning.
    - Alex is sleeping on the floor.
    - Shawn is standing by the window, twisting a piece of newspaper.
    - McKenna is curled up in a corner chair with hands over head.
    - Gusta and Mari are dancing and singing to music from the overhead television.
    - Dana is pacing with fists clenched and head down.
    - Cameron is tapping on the nurses' station window.
    - Latrell is leaning against the unit exit door.
    - Pat rushes up to you as you walk in, laughing, and asking, "So when are you busting me out of here?"
    - Jaylen is sitting at a table reading the client admission packet.

    Discuss in face-to-face small groups in the classroom and compare answers or post on your discussion thread on your learning management system and respond to at least two other posts.

    a. Which client do you approach first? State rationale.
    b. What assignment do you delegate? State rationale.

References

American Association of Colleges of Nursing. (n.d.). *Clinical judgement*. https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/clinical-judgement

American Nurses Association. (2023). *What is evidence-based practice in nursing?* https://www.nursingworld.org/content-hub/resources/workplace/evidence-based-practice-in-nursing/

ATI Nursing Education. (2020). *ATI guide for clinical judgment*. https://www.atitesting.com/docs/default-source/default-document-library/ati-clinical-judgment-guide.pdf

Ball, W. S. (2023). *NCLEX-NGN and the six clinical judgment skills*. https://nurse.plus/become-a-nurse/nclex-ngn-six-clinical-judgment-skills/

Benner, P. (1982). From novice to expert. *The American Journal of Nursing, 82*(3), 402–407. http://www.jstor.org/stable/3462928.

Dickison, P. (2021). *Next Generation NCLEX update*. https://www.ncsbn.org/public-files/presentations/2021_MYM_pdickison_NGN.pdf

Dolansky, M. A., & Moore, S. M. (2013, September 30). Quality and Safety Education for Nurses (QSEN): The Key is systems thinking. *OJIN: The Online Journal of Issues in Nursing, 18*(3), Manuscript 1. https://doi.org/10.3912/OJIN.Vol18No03Man01

ExamSoft. (2023). *6 new question types you will find on the Next Gen NCLEX® exam*. https://examsoft.com/resources/6-new-question-types-nclex/

Hughes, R. G. (2008). *Patient safety and quality: An evidence-based handbook for nurses*. Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK2643/

Jones, C. T., Jester, P. M., & Casey, B. D. (2012). Quality processes at the research site: Setting the standard for education, safety and success. *The Monitor, 26*, 47–53 https://www.researchgate.net/publication/235687760_Quality_processes_at_the_research_site_setting_the_standard_for_education_safety_and_success

Kelly, U., Edwards, G., & Shapiro, S. (2021). Nursing policies and protocols: Do nurses really use them? *Journal of Nursing Care Quality, 36*(3), 217–222. https://www.nursingcenter.com/cearticle?an=00001786-202107000-00004&Journal_ID=54010&Issue_ID=5924896

Lasater, K. (2011). Clinical judgment: The last frontier for evaluation. *Nurse Education in Practice, 11*(2), 86–92. https://doi.org/10.1016/j.nepr.2010.11.013

National Council of State Boards of Nursing. (2019a). The Clinical Judgment Measurement Model. *Next Generation NCLEX News*. https://www.ncsbn.org/public-files/NGN_Winter19.pdf

National Council of State Boards of Nursing. (2019b). Clinical Judgment Measurement Model and action model. *Next Generation NCLEX News*. https://www.ncsbn.org/public-files/NGN_Spring19_ENG_29Aug2019.pdf

National Council of State Boards of Nursing. (2021a). The 2020 National Nursing Workforce Survey. *Journal of Nursing Regulation, 12*(Supplement), S4–S6. https://www.ncsbn.org/public-files/2020_NNW_Executive_Summary.pdf

National Council of State Boards of Nursing. (2021b). Next Generation NCLEX: Stand-alone items. *Next Generation NCLEX News*. https://www.ncsbn.org/public-files/NGN_Spring21_Eng.pdf

National Council of State Boards of Nursing. (2023). *Next Generation NCLEX-RN® test plan*. https://www.ncsbn.org/public-files/2023_RN_Test%20Plan_English_FINAL.pdf

National Council of State Boards of Nursing. (2024a). *Clinical Judgment Measurement Model A framework to measure clinical judgment & decision making*. https://www.nclex.com/clinical-judgment-measurement-model.page

National Council of State Boards of Nursing. (2024b). *Frequently asked questions: Get answers to common NCLEX questions*. https://www.nclex.com/faqs.page.

Ozdemir, N. H. (2019). The development of nurses' individualized care perceptions and practices: Benner's novice to expert model perspective. *International Journal of Caring Sciences, 12*(2), 1279–1285. https://internationaljournalofcaringsciences.org/docs/81_ozdemir_special_12_2.pdf

QSEN Institute. (n.d.). *QSEN competencies*. https://qsen.org/competencies/pre-licensure-ksas/

Rodríguez-Suárez, C. A., González-de la Torre, H., Hernández-De Luis, M. N., Fernández-Gutiérrez, D. Á., Martínez-Alberto, C. E., & Brito-Brito, P. R. (2023). Effectiveness of a standardized nursing process using NANDA International, nursing interventions classification and nursing outcome classification terminologies: A systematic review. *Healthcare (Basel), 11*(17), 2449–2468. https://doi.org/10.3390/healthcare11172449

Shirey, M. R., Bonamer, J., Clarke, S., Hass, S., Ivory, C., Kitto, S., Price, D., Weiss, M., Yakusheva, O., Chappell, K., & Johantgen, M. (Ed). (2021). Multi-site research playbook: A practical guide to support multi-site research studies for greater impact. American Nurses Credentialing Center's Research Council. American Nurses Credentialing Center. https://4850206.fs1.hubspotusercontent-na1.net/hubfs/4850206/ANCC%20Multi-Site%20Research%20Playbook/ANCC%20Research%20Council%20Multi-Site%20Research%20Playbook.pdf

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of*

Nursing Education, 45(6), 204–11. https://doi.org/10.3928/01484834-20060601-04 .

Timken, M. (2023). *Problem-based care planning and concept mapping instrument based on the Clinical Judgment Measurement Model*. https://evolve.elsevier.com/education/wp-content/uploads/sites/2/2023/04/21-NHPep-0437_Whitepaper_ProbBasedCarePlan_Final.pdf

Toney-Butler, T. J., & Thayer, J. M. (2023, April 10). Nursing process. In *StatPearls [Internet]*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK499937/

University of North Carolina. (n.d.) *Interprofessional education (IPE): Organizations and reports*. https://guides.lib.unc.edu/interprofessional/organizations

APPENDIX A

Brief Psychiatric Rating Scale

The Brief Psychiatric Rating Scale (BPRS) is an assessment tool to be administered by a mental health professional who has been trained in its application. It is used in clinical treatment and in research. The scale ranks symptoms such as depression, anxiety, or psychosis on a scale of 1, if symptoms are not present, to 7, if symptoms are severe. The BPRS can be useful to determine baseline symptoms or treatment effect. There are different formats of the instrument; some with ranking by numbers and some with terms, such as mild, moderate, and severe. Items on the scale indicate interview as the assessment technique, though some are answered through rater observation. Family report may also provide assessment data.

NAME: _____ DATE: _____

PATIENT ID#: _____ MD: _____

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. SOMATIC CONCERN Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.	SCORE ☐	**10. HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness."*)	SCORE ☐
2. ANXIETY Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.	SCORE ☐	**11. SUSPICIOUSNESS** Brief (*delusional or otherwise*) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.	SCORE ☐
3. EMOTIONAL Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.	SCORE ☐	**12. HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.	SCORE ☐
4. CONCEPTUAL DISORGANIZATION Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.	SCORE ☐	**13. MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.	SCORE ☐
5. GUILT FEELINGS Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.	SCORE ☐	**14. UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.	SCORE ☐
6. TENSION Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.	SCORE ☐	**15. UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.	SCORE ☐
7. MANNERISMS AND POSTURING Unusual and unnatural motor benavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.	SCORE ☐	**16. BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement.	SCORE ☐
8. GRANDIOSITY Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.	SCORE ☐	**17. EXCITEMENT** Heightened emotional tone, agitation, increased reactivity.	SCORE ☐
9. DEPRESSIVE MOOD Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.	SCORE ☐	**18. DISORIENTATION** Confusion or lack of proper association for person, place or time.	SCORE ☐

FIGURE A1 The Brief Psychiatric Rating Scale was first published in 1962 and revised in 1965. (credit: "Brief Psychiatric Rating Scale" by Overall and Gorham, Public Domain)

APPENDIX B

Abnormal Involuntary Movement Scale

The Abnormal Involuntary Movement Scale (AIMS) is an assessment tool used to document presence of tardive dyskinesia (TD), as well as to follow progression or remission of TD over time (Figure B1). TD can develop within three months of initial treatment with psychotropic medication; the AIMS is usually administered two to three times per year. There are different formats of the instrument (including fillable online), some with ranking by numbers and some with terms, such as mild, moderate, or severe. The scale is generally 12 questions with rating 0 (none) to 4 (severe). The items may be addressed by interview or observation. The client is observed standing, walking, and sitting. The presence of dentures is noted. The client is asked to extend the arms, move the legs and feet, open the mouth, and move the tongue while the examiner observes for abnormal movements, contractions, and grimaces. Lower scores in fewer categories are interpreted as requiring close monitoring, while higher scores in more categories indicate presence of TD. There are FDA-approved drugs to help stop the progression of TD.

Abnormal Involuntary Movement Scale (AIMS)

NAME:_____ DATE:_____

Prescribing Practitioner:_____

CODE 0 = None 1 = Minimal, may be extreme normal 2 = Mild 3 = Moderate 4 = Severe

	MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.	RATER Date	RATER Date	RATER Date	RATER Date
Facial and Oral Movements	**1. Muscles of Facial Expression** e.g., movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and Perioral Area e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw e.g., biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Extremity Movements	**5. Upper (arms, wrists, hands, fingers)** Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Trunk Movements	**7. Neck, shoulders, hips** e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Global Judgments	**8. Severity of abnormal movements overall**	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements				
	Rate only patient's report				
	No awareness 0	0	0	0	0
	Aware, no distress 1	1	1	1	1
	Aware, mild distress 2	2	2	2	2
	Aware, moderate distress 3	3	3	3	3
	Aware, severe distress 4	4	4	4	4
Dental Status	**11. Current problems with teeth and/or dentures?**	No Yes	No Yes	No Yes	No Yes
	12. Are dentures usually worn?	No Yes	No Yes	No Yes	No Yes
	13. Edentia?	No Yes	No Yes	No Yes	No Yes
	14. Do movements disappear in sleep?	No Yes	No Yes	No Yes	No Yes

FIGURE B1 The Abnormal Involuntary Movement Scale was first created in 1976 for assessing tardive dyskinesia. (credit: "Abnormal Involuntary Movement Scale" by National Institute of Mental Health, Public Domain)

ANSWER KEY

Chapter 15

Unfolding Case Study

1. a, b, d, f, h
Rationale: The client has cues that could indicate electrolyte imbalance, head trauma, substance use or mental health disorder, such as confusion, delirium, pacing and muttering, agitation, and suspicion. Also, the client has exhibited a change in personality and is exhibiting abnormal behavior with reported audio hallucinations. The client's blood pressure and heart rate, while still within normal limits, are considered high for this client given the circumstances.
The client is oriented to time, place, and person, which is a normal finding. Likewise, respirations, temperature, and oxygen are all within normal limits.

2.

Cue	Electrolyte Imbalance	Head Trauma	Mental Illness
Confusion	X	X	X
Agitation	X	X	X
Hallucinations			X
Altered personality		X	X
Suspicion			X
Altered vitals	X	X	X

Rationale: Electrolyte imbalance manifests with confusion, agitation, and altered vital signs.
Head trauma manifests with confusion, agitation, altered personality, and altered vital signs.
Mental illness manifests with confusion, agitation, hallucinations of some form, altered personality, and suspicion.

3. d
Rationale: Safety is always a key priority in caring for clients who are disturbed, particularly ensuring the safety of others, including family, visitors, other clients, and staff.

4.

Actions	Recommended	Not Recommended	Irrelevant
Administer haloperidol		X	
Urodynamic study (UDS)	X		
Close observation	X		
Administer insulin			X
Bandage head of client			X

Let the mother sit with client		X	
Comprehensive metabolic panel (CMP)	X		

Rationale: The diagnosis has not been confirmed yet; therefore, haloperidol would not be administered. Urodynamic study (UDS) would be conducted to help ascertain a diagnosis. Following release from restraints, the client would be under close observation to prevent further outbursts of aggression. There is no need to administer insulin or bandage the head of the client. It would not be recommended to allow the mother to sit with the client as this might trigger the client to be aggressive again. A comprehensive metabolic panel (CMP) would be conducted to help ascertain a diagnosis.

5. The nurse knows that the client will be prescribed risperidone (Risperdal) that may result in side effects such as blurred vision, constipation, and dry mouth. The client will be evaluated for improvement in his condition as evidenced by the client engaging in therapeutic modalities and complying with his medication.
Rationale: Given his symptoms and behavior, the client will be prescribed an antipsychotic medication such as risperidone (Risperdal), which may have side effects such as blurred vision, constipation, and dry mouth. The client will demonstrate improvement in their condition when they engage in therapeutic modalities and comply with medication.

6.

Behavior	Effective	Ineffective	Irrelevant
Takes his medications	X		
Watches television			X
Complains that people are following him		X	
Is isolated and talking to himself		X	
Talks in group therapy sessions	X		
Talks to his mother on the telephone	X		
Can talk about what might trigger a psychotic episode	X		

Chapter 16

Unfolding Case Study

1. Recently widowed; reports a decreased and depressed mood for the past month, with low energy and periods of feeling; appetite is diminished; weight loss; low appetite; has not been participating in any of the activities; has lost enjoyment and pleasure; has suicidal thoughts; family history of depression and anxiety; brother had been diagnosed with bipolar II disorder; mother and father appeared to have had depression; sister has had two suicide attempts; feels lonely and isolated; has been unable to go to services; anxious, passive suicidal ideation, blunted affect, depressed mood; blood pressure: 145/92.
Rationale: The client has cues that could indicate depression and also has passive suicidal ideation. He is recently widowed, isolated, and lonely. The things that used to bring him purpose are not in his daily life (church, work). His blood pressure is high, which could indicate anxiety, pain, or hypertension. The client is oriented to person, place, time, and situation, which is a normal finding. Likewise, respirations, temperature, and oxygen are all within normal limits.

2.

Cue	Contributes	Does Not Contribute	Irrelevant
Oxygenation level			✓
Chronic health conditions	✓		
Family history of depression	✓		
Orientation to person, place, and time		✓	
Use of alcohol		✓	
Isolation	✓		
Audio visual-hallucinations		✓	

Rationale: The chronic health conditions, a family history of depression, and the isolation he is experiencing in the living facility have all contributed to his depression. He is orientated; therefore, this has not contributed to his depression and he does not drink or report any hallucinations so these are not contributing to his depression as they could for other clients. His oxygenation level is normal and not a relevant factor.

3.

Cue	Depression	Anxiety	Insomnia
Anxiety	✓	✓	✓
Poor sleep	✓	✓	✓
Low appetite	✓	✓	
Low mood	✓		✓
Suicidal ideation	✓	✓	✓
Withdrawn	✓		

Rationale: Depression presents with low mood, sadness, low energy, anhedonia, and can include anxiety and insomnia.
Anxiety manifests with anxiety, insomnia, and can be a warning sign for suicide.
Insomnia can manifest with anxiety, depression, and can be a warning sign for suicide.

4. a
Rationale: Safety of the client is always the first priority in planning nursing care.

5. a, b, d, f, g, i
Rationale: The client is in danger and needs to be placed under observation to ensure his safety (a). The nurse should communicate with him therapeutically (b), give him emotional support (f), and validate his experiences and feelings (g). To encourage his recovery, he should be encouraged to come out of his room (d) and participate in activities that he enjoys (i). He avoids social interaction where he lives, so it would be inappropriate for someone from the assisted living community to visit (c) and his medications would not be withheld (e). His intake needs to be monitored and encouraged so he would not be eating his meals in private in his room (h).

6.

	Expected Outcome	Unexpected Outcome
Joins in activities in the assisted living community	✓	
Does not wish to meet with his son		✓
Takes his medication	✓	
Wants to keep living	✓	
Loses weight		✓
Eats meals in private		✓

Rationale: Following his stay in the unit, the client should no longer have suicidal ideation, should take his medication as prescribed, and join in the activities expected of him when he returns to the assisted living community. Having recovered from his depressed state, he should no longer be wishing to isolate himself in his room and continue losing weight; also his desire to socialize with others, such as his son, should improve.

Chapter 19

Unfolding Case Study

1. Irritability and anxiety, mild tremors, and headache; last drink was the previous evening at 1900; anxiety 10/10; visibly fidgeting; consumes at least one bottle to a bottle and a half of wine every night; taking her prescribed benzodiazepine and alprazolam throughout the day rather than just before bedtime; unable to participate in family activities; symptoms of insomnia, anxiety; BP, 145/92 mmHg; heart rate, 109 bpm; pain, 3/10
   Rationale: The client has cues that could indicate alcohol and possibly, benzodiazepine, withdrawal, anxiety, irritability, tremors, and headache. Also, the client has exhibited a change in functioning and ability to participate in daily life. The client's blood pressure and heart rate are considered high and are indicative of a possible withdrawal.
   The client is oriented to person, place, time, and situation, which is a normal finding. Likewise, respirations, temperature, and oxygen are all within normal limits.
2. The nurse will initiate the CIWA scale and medicate the client according to the observations and the client's answers to this clinical scale. The client's vitals will be closely monitored throughout the shift to decrease the chance that her BP becomes seriously high, increasing her risk for withdrawal seizures. The plan of care will include making sure that medication is available in the evening to decrease the client's anxiety and help her sleep.
3. Delirium tremens; 2. Increased BP and HR
   Rationale: The client exhibits signs of anxiety and is at highest risk for withdrawal and DTs.
   Altered physiological signs (vital signs, sweating, tremors) and affect and increased anxiety are signs that are currently being exhibited so this is the risk.
4. 1. Administer lorazepam per CIWA protocol; 2. Monitor for seizures and loss of consciousness.
   Rationale: Lorazepam is indicated to help with withdrawal symptoms and prevent seizures in ETOH withdrawal.
   ETOH withdrawal can cause seizures and DTs, which can lead to loss of consciousness.
5. Nursing action includes comfort measures, hydration, and continued monitoring.
   Rationale: The client reports feeling less anxious and is now lying on her bed ready to take a nap. Her BP and pain score are decreased. Nurse has administered lorazepam per CIWA protocol.
6. Client's BP, pain score, and anxiety are decreased.
   1. Continue to follow the CIWA protocol and repeat based on the scores received.
   2. Encourage the client to drink plenty of water.

3. Monitor for seizures and loss of consciousness.
Rationale: Close monitoring is imperative when a person is withdrawing from ETOH. Medicate as indicated by the CIWA protocol. Encouraging the client to drink water helps the medications to work better and cleanse the alcohol from her system. ETOH withdrawal can cause seizures and DTs, which can lead to loss of consciousness.

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