PSYCHIATRIC-MENTAL HEALTH NURSING

An Interpersonal Approach

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INSTRUCTOR’S COMPANION

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## CONTENTS

### I. THE PRACTICE OF PSYCHIATRIC-MENTAL HEALTH NURSING

1. Mental Health Trends and the Historical Role of the Psychiatric-Mental Health Nurse 4
2. Interpersonal Relationships: The Cornerstone of Psychiatric Nursing 6
3. Therapeutic Use of Self and Therapeutic Communication: From Self-Discovery to Interpersonal Skill Integration 10
4. Boundary Management 13

### II. HEALTH PROMOTION AND ILLNESS PREVENTION

5. Critical Thinking, Clinical Decision Making, and the Interpersonal Relationship 15
6. Crisis and Crisis Intervention 18
7. Psychiatric Case Management 21
8. Known Risk Factors for Prevalent Mental Illness and Nursing Interventions for Prevention 24
9. Systems Concepts and Working in Groups 27
10. Theories of Mental Health and Illness: Psychodynamic, Social, Cognitive, Behavioral, Humanistic, and Biological Influences 30

### III. ACUTE AND CHRONIC ILLNESS

11. Thought Disorders 33
12. Affective Disorders 38
13. Anxiety Disorders 41
14. Personality Disorders 46
15. Addictive Disorders 51
16. Cognitive Disorders 56
17. Impulse Control Disorders 61
18. Sexual Disorders and Dysfunctions 65
19. Eating Disorders 70
20. Psychological Problems of Physically Ill Persons 73

### IV. GROWTH AND DEVELOPMENT AND MENTAL HEALTH CONCERNS ACROSS THE LIFE SPAN

21. Working With Children 76
22. Mental Health Concerns Regarding Adolescents 79
23. Issues Specific to the Elderly 81
24. Victims and Victimizers 84

### V. MENTAL HEALTH CARE SETTINGS

25. Psychiatric-Mental Health Nursing Across the Continuum of Care 87
26. Vulnerable Populations and the Role of the Forensic Nurse 89

### VI. CULTURAL, ETHICAL, LEGAL, AND PROFESSIONAL ASPECTS OF MENTAL HEALTH CARE

27. Cultural, Ethnic, and Spiritual Concepts 91
28. Ethical and Legal Principles 94
29. Policy, Policy Making, and Politics for Professional Psychiatric Nurses 97
This Instructor’s Companion is designed to assist your instructional efforts in the classroom. Listed are the Key Terms, Expected Learning Outcomes, and Need to Know points from each chapter. The hyperlinks are designed to allow the student to view film(s) that augment the main themes of the chapter. Additional films and/or hyperlinks have been recommended for use by the instructor, and will allow further exposure to the chapter content. Questions and answers from the case studies presented in Chapters 11 to 19 are provided to enhance critical thinking skills for the student, and Answers and Rationales for the NCLEX PREP questions that appear at the ends of each chapter are given.
KEY TERMS

Deinstitutionalization: movement of patients in mental health institutions back into the community
Interpersonal models: models that focus on the interaction of the person with others
Milieu management: the provision and assurance of a therapeutic environment that promotes a healing experience for the patient
Process groups: traditional form of psychotherapy where deep feelings, reactions, and thoughts are explored and processed in a structured way
Psychopharmacology: use of drugs to treat mental illness and its symptoms
Psycho-educational groups: groups designed at imparting specific information about a select topic such as medication
Somatic: referring to the body
Therapeutic communication: patient focused interactive process involving verbal and nonverbal behaviors

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:
1. Identify key events that helped to shape the current view of psychiatric-mental health care.
2. Describe the early role of the psychiatric nurse.
3. Identify the changes in the field of mental health that correlate with the evolution of psychiatric-mental health nursing.
4. Define interpersonal relations as being the foundation for clinical practice.
5. Delineate between the roles and functions of basic and advanced practice in psychiatric-mental health nursing.

NEED TO KNOW

1. Dorothea Dix was instrumental in advocating for the mentally ill. She is credited with the development of state mental hospitals in the United States.
2. In the late 1960s, care of the mentally ill began to shift to community clinics.
3. Psychiatric nursing is practiced at two educational levels: generalist practice (ADN, Diploma, BSN) and advanced practice (MSN, DNP, PhD). Advanced practice nurses are clinical nurse specialists (CNS) and nurse practitioners (NP).

**HYPERLINKS**

*Restoration of Sanity*, a 1957 Russian film depicting then “state of the art” treatment of mental illness. The role of the nurse is profiled as that of custodial care taker.
1. [http://www.youtube.com/watch?v=BZ1Ll--yQl4](http://www.youtube.com/watch?v=BZ1Ll--yQl4)
2. [http://www.youtube.com/watch?v=BWEUDLKqudM](http://www.youtube.com/watch?v=BWEUDLKqudM)

**Films to Augment Chapter Material**

*Bedlam*. (1946). Classic film that illustrates historical/political treatment of the mentally ill

*One Flew Over the Cuckoo’s Nest*. (1975). Film that sparked changes in the mental health system due to its portrayal of treatment of the mentally ill

**ANSWERS TO NCLEX PREP QUESTIONS**

1. c. In the late eighteenth century, medicine began to view psychiatry as a separate branch and mental illness was being treated with medical interventions such as bloodletting, immobilization, and specialized devices. These practices were stopped during the early nineteenth century with Dr. Benjamin Rush advocating the use of supportive, sympathetic care in an environment that was quite, clean, and pleasant. Psychoanalytic theory developed in the early twentieth century. The National Institute of Mental Health was established in 1949.

2. d. Hildegard Peplau emphasized the use of the interpersonal process and interpersonal relations. Florence Nightingale was the first person to identify the need to view a patient holistically. Linda Richards is credited as being the first American psychiatric nurse. Dorothea Dix advocated for the needs of the mentally ill through the establishment of state hospitals throughout the United States.

3. b. Advanced practice psychiatric-mental health nurses (PMHNs), through their expanded education and preparation at the graduate level can perform psychotherapy. PMHNs practice at the basic or advanced level. The advanced level requires a master’s degree or doctorate for practice. PMHNs, whether practicing at the basic or advanced level, practice in a wide range of settings and focus on 13 specific areas or phenomena of concern. A patient’s ability to function is just one of these areas.

4. c. Integration of interpersonal models in psychiatric-mental health nursing led to use of therapeutic communication, milieu management, and nurses working in groups, including psycho-educational and process groups. Psychopharmacology revolutionized the treatment of mental illness. However, it is not a result of the use of interpersonal models.

5. a. The Mental Retardation Facilities and Community Mental Health Centers Act was part of President John F. Kennedy’s New Frontier program and led to the deinstitutionalization of many who had been in state-run and other mental health facilities providing long term mental health care and treatment. The National Mental Health Act provided governmental funding for programs related to research, mental health professional training, and expansion of facilities including state mental health facilities, clinics and treatment centers. The Omnibus Budget Reconciliation Act provided a set amount of funding for each state, with the state deciding how to use the funds. The Surgeon General’s Report on Mental Health, the first national report focused on mental health identified the need to improve the quality of mental health in the nation.
KEY TERMS

**Emerging identities:** phase of Travelbee’s model characterized by the nurse and the ill person perceiving each other as unique individuals. The bond of a relationship is beginning to form.

**Empathy:** phase of Travelbee’s model characterized by the ability to share in the other person’s experience; putting yourself in the other person’s shoes, or seeing the world through the other person’s eyes.

**Empathetic linkages:** the ability to feel in oneself the emotions experienced by another person in the same situation.

**Exploitation phase:** phase of Peplau’s nurse-patient relationship where the bulk of the work is accomplished with the patient taking full advantage of the nursing services offered. This phase encompasses all of the therapeutic activities that are initiated to reach the identified goal.

**Hope:** a mental state characterized by the desire to gain an end or accomplish a goal combined with some degree of expectation that what is desired or sought is attainable.

**Human being:** unique irreplaceable individual, a one-time being in this world, like yet unlike any person who has ever lived or ever will live.

**Identification phase:** second phase of Peplau’s nurse-patient relationship in which the patient recognizes his or her needs for healthcare for which the nurse can provide assistance.

**Interpersonal relationship:** the connection that exists between two or more individuals with observation, assessment, communication, and evaluation skills serving as the foundation.

**Orientation phase:** first phase of Peplau’s nurse-patient relationship that includes the initial contact the nurse has with the patient.

**Original encounter:** first phase of Travelbee’s model characterized by first impressions by the nurse of the ill person and by the ill person of the nurse. Both the nurse and the ill person perceive each other in stereotypical or traditional roles.

**Rapport:** nursing actions that alleviate an ill person’s distress; a concern for others and an active interest in them, a belief in the worth, dignity, uniqueness, and irreplaceability of each individual human being, and an accepting, nonjudgmental approach.
Resolution phase: last phase of Peplau's nurse-patient relationship occurring when the patient's needs have been met through the collaborative work of nurse and patient.

Suffering: feeling of displeasure which ranges from simple transitory mental, physical, or spiritual discomfort to extreme anguish, and to those phases beyond anguish, namely, the malignant phase of despairful not caring, and the terminal phase of apathetic indifference.

Sympathy: phase of Travelbee's model occurring when the nurse desires to alleviate the cause of the patient's illness or suffering.

**EXPECTED LEARNING OUTCOMES**

After completing this chapter, the student will be able to:

1. Define interpersonal relationships.
2. Identify the two predominant interpersonal models in psychiatric nursing.
3. Discuss the stages of the interpersonal process as described by Hildegard Peplau.
4. Explain the six roles that nurses may assume during Peplau's interpersonal process.
5. Correlate Peplau's stages of the interpersonal process with the steps of the nursing process.
6. Identify the three key concepts associated with Joyce Travelbee's Human to Human Relationship theory.
7. Discuss the five phases of Travelbee's model.
8. Describe the importance of these theories in the professional practice of psychiatric mental health nursing.
9. Apply Peplau's and Travelbee's theories to patient care delivery in the clinical setting.
10. Incorporate the models of interpersonal relationships in professional psychiatric nursing practice.

**NEED TO KNOW**

1. Interpersonal relationships are the connections between two or more people. Skillful management of interpersonal relationships is essential to psychiatric-mental health nursing.
2. Peplau is considered the founder of psychiatric-mental health nursing.
3. According to Peplau, nurses integrate an understanding of their own behaviors and self-awareness to assist patients in identifying problems and in working toward achieving health and well-being.
4. The four phases of the interpersonal process as identified by Peplau are the orientation phase, identification phase, exploitation phase, and resolution phase. Later, she condensed these phases into three phases: orientation phase, working phase, and termination phase.
5. Nurses may find themselves in any or all of six roles (stranger, resource person, teacher, leader, surrogate, or counselor) when working with patients.
6. Human being, suffering, and hope are the three main concepts of Travelbee's Human to Human Relationship Theory.
7. The five phases of the Travelbee's nurse-patient relationship are original encounter, emerging identities, empathy, sympathy, and rapport.
HYPERLINKS

Peplau, various clips of interviews with Dr. Peplau as well as highlights of her theory and student re-enactment of her model in action.

1. http://www.youtube.com/watch?v=3ZvwNVVWyZ4
2. http://www.youtube.com/watch?v=Nmq6CxF9paA
4. http://www.youtube.com/watch?v=ydSHzzhjOc&playnext=1&list=PL427F7EC89D65EE7D
5. http://www.youtube.com/watch?v=_72omxkmgCI

Films to Augment Chapter Material

Note: Recorded October 30, 1992, St. Louis, MO.
Dr. Peplau discusses her theory

Synopsis: The therapeutic interpersonal process between patient and nurse; nursing as an educative instrument, a maturing force, that aims to promote creative, constructive, productive, personal, and community living for the patient.

Synopsis: Hildegard Peplau explains and demonstrates her timeless theory of the Nurse-Patient Relationship which has served as a major foundation of psychiatric nursing theory.

ANSWERS TO NCLEX PREP QUESTIONS

1. c. During the orientation phase, the nurse would most likely assume the role of a stranger because this is the initial contact that the nurse has with the patient. It is at this time that the nurse interacts with the patient in a nonjudgmental manner and creates a climate of courtesy and acceptance. The counselor, teacher and surrogate roles would most likely be assumed in the later phases of the relationship.

2. c. Peplau's exploitation phase correlates with the implementation step of the nursing process. It is during this phase that the majority of the work is done and therapeutic activities are initiated to help the patient attain his or her goals. Assessment correlates with the orientation phase; planning correlates with the identification phase; and evaluation correlates with the resolution phase.

3. a. According to Travelbee, one of the most powerful interventions that a nurse can provide to a patient is the instillation of hope. Relief of suffering is a main function of nursing but it is not the most powerful intervention. Human being refers to an individual, be it the patient or nurse, both of whom are involved in the interpersonal relationship. Empathy is a phase of Travelbee's nurse-patient relationship, not one of her major concepts.

4. d. Rapport is characterized by nursing actions that alleviate an ill person's distress. Emerging identities is characterized by the nurse and ill person perceiving each other as unique individuals. Empathy is characterized by the ability to share in the other person's experience. Sympathy occurs when the nurse desires to alleviate the patient's illness or suffering.
5. b. During the orientation phase, the focus of communication is on the patient. The patient conveys his or her needs, asks questions and shares information. The reason for seeking help is just one aspect of the communication. The nurse provides information about the expected routines and time frames but this is not the primary focus of the communication.

6. a. Peplau was influenced by Harry Sullivan and his beliefs about needs and anxiety. Frankl and Orlando influenced Travelbee. Neither theorist was influenced by Freud.
KEY TERMS

Active listening: concentrated effort on the part of the nurse to pay close attention to what the patient is saying, both verbally and nonverbally

Attitudes: general feelings or that which provides a frame of reference for an individual.

Beliefs: ideas that an individual holds to be true

Communication: the transmission of information or a message from a sender to a receiver.

Empathy: phase of Travelbee’s model characterized by the ability to share in the other person’s experience; putting yourself in the other person’s shoes, or seeing the world through the other person’s eyes.

Process recording: the written report of an interaction. The interaction between the patient and nurse is recorded verbatim to the extent possible and includes both verbal and nonverbal communication of both parties. The content of the interaction is analyzed for meaning and pattern of interaction.

Self: the entire person of an individual; an individual's typical character and an individual's temporary behavior; and as the union of elements (as body, emotions, thoughts, and sensations) that constitute the individuality and identity of a person

Self-awareness: the process of developing an understanding of one's own values, beliefs, thoughts, feelings, reactions, motivations, biases, strengths and limitations and recognizing their effect on others.

Self-disclosure: the nurse revealing genuine feelings or personal information about him- or herself.

Therapeutic: of or relating to the treatment of disease or disorders by remedial agents or methods

Therapeutic communication: patient focused interactive process involving verbal and nonverbal behaviors

Therapeutic use of self: complex process that involves a process of self-awareness through one’s own growth and development as well as one’s interactions with others.

Values: Abstract positive and negative concepts that represent ideal conduct and goals

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Describe the term self.
2. Define therapeutic use of self.
3. Identify key concepts associated with the therapeutic use of self.
4. Describe ways to develop greater self-awareness.
5. Define therapeutic communication.
6. Discuss the key concepts of therapeutic communication.
7. Explain the significance of therapeutic communication to establish and maintain therapeutic nurse-patient relationships.
8. Identify techniques of therapeutic communication.
9. Describe barriers to effective therapeutic communication.

**NEED TO KNOW**

1. The concept of self refers to a person's entirety that develops throughout the lifespan as an individual experiences similarities and differences with others and gains insight into his or her identity.
2. Carl Rogers, the founder of person-centered counseling, identified three core conditions needed to support development of the other person: congruence, empathy, and unconditional positive regard.
3. Therapeutic use of self is a key element of the therapeutic nurse-patient relationship. The psychiatric-mental health nurse develops it through self-awareness and self-reflection.
4. Self-awareness develops by examining one's values, attitudes, and beliefs. Self-reflection focuses on examining whose needs are being met.
5. Different skills need to be applied by the psychiatric-mental health nurse as he or she accompanies the patient through the therapeutic journey across the four stages of Peplau's interpersonal therapeutic relationship.
6. For a therapeutic relationship, the psychiatric-mental health nurse must develop empathy, the ability to put him- or herself in the patient's shoes or see the world through the patient's eyes.
7. Communication involves a sender, message, receiver, and feedback. With therapeutic communication, the patient is the focus of the interaction.
8. Active listening is an important therapeutic communication technique that requires the nurse to focus closely on the patient's message and evaluate the congruency between the verbal and nonverbal messages.
9. Self-disclosure can be an effective therapeutic communication technique if it is used to benefit the patient.
10. Physical surroundings such as noise or furniture, as well as communication techniques such as giving advice, using clichés/stereotypical or judgmental comments, or providing false reassurance can act as barriers to effective therapeutic communication.

**HYPERLINKS**

*Therapeutic Communication, Effective Communication Practices for Healthcare Professionals* highlights a basic review of how we develop communication skills and how to best apply them effectively and therapeutically in the health care setting.

1. http://www.youtube.com/watch?v=09kPWcCA3dw&feature=related
Films to Augment Chapter Material

My Dinner with Andre. (1981). Film illustrates the power of effective conversation

ANSWERS TO NCLEX PREP QUESTIONS

1. a. Self is described as the lifelong journey of discovery of one's personal identity. It involves an awareness of the physical, psychological, social and cultural similarities and differences that emerge as individuals begin to understand the unique, interactive, and shared experiences of him- or herself and others. This discovery is not limited to an interaction between two or more persons. Self develops from early childhood experiences and continues as the person transitions from family, school, social, and work life towards old age.

2. c. Carl Rogers, the founder of person-centered counseling, identified three core conditions of the therapeutic relationship. Peplau developed the interpersonal theory and the nurse-patient relationship. Phil Barker developed the Tidal Model, the first recovery mental health recovery model. Joyce Travelbee described the therapeutic use of self as the ability of nurses to be self aware and consciously use themselves to establish a sense of relatedness with patients and structure therapeutic nursing interventions.

3. b. A low tone of voice would most likely be congruent with the patient's statement of being “so down lately.” A wide facial grin would be more suggestive of. Figiditing would suggest possible anxiety or agitation. A slumped, rather than an erect, posture would be congruent with the patient's statement of feeling “so down.”

4. b. The nurse would initiate the communication by using a broad opening statement to demonstrate to the patient that he or she is ready to listen to what the patient is experiencing. Such a statement emphasizes the patient's needs and his importance to the relationship. Using silence might be appropriate later on to allow the patient time to think through his thoughts and respond. Asking the patient if he is having problems with anxiety requires a yes or no answer and does not address the patient's needs. Additionally, asking the patient why he came here is intimidating because the patient may not know or understand what the problem is.

5. d. The nurse is giving the patient advice, telling the patient what he should do when he feels anxious. This would be inappropriate because it imposes the nurse's view on the patient and implies that the nurse is better than the patient. Rather the nurse should focus on asking the patient what he thinks would work. Clarifying, a therapeutic technique would be reflected by the nurse asking, “when you say you get anxious, what does that mean?” False reassurance, a nontherapeutic technique, would be reflected by a statement such as “everybody gets anxious, so I wouldn't worry about it.” Validating, a therapeutic technique would be reflected by a statement such as, “Do I understand you correctly? You feel overwhelmed with your anxiety?”
KEY TERMS

**Boundaries:** the professional spaces between the nurse's power and the patient's vulnerability

**Boundary crossing:** a transient, brief excursion across a professional boundary. The action may be inadvertent, unconscious, or even purposeful (if done to meet a specific therapeutic need)

**Boundary violation:** situation resulting when there is confusion between the needs of the nurse and those of the patient; allows nurse to meet his or her own needs rather than the patient's needs.

**Countertransference:** occurrence when the healthcare professional develops a positive or negative emotional response to the patient's transference.

**Transference:** a psychodynamic term used to describe the patient's emotional response to the health care provider

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define boundaries.
2. Identify tangible boundaries that can be established in an interpersonal relationship.
3. Explain the intangible boundaries important in interpersonal relationships.
4. Differentiate between a boundary crossing and a boundary violation.
5. Identify risk factors for establishing unhealthy boundaries.
6. Apply the concepts of boundary management when engaging in an interpersonal relationship.

NEED TO KNOW

1. Boundaries may be physical or psychological, and can be classified as rigid, flexible, or enmeshed.
2. Boundaries are initially established during the orientation or original encounter phase.
3. Managing transference and counter-transference are essential to boundary management.
4. The nurse dresses appropriately, addresses patients by their proper names, and uses self-disclosure appropriately to maintain intangible boundaries.
5. Patients commonly test boundaries by attempting to change a therapeutic relationship into a social one.
6. Boundary crossings between nurses and patients can be reversible and in some instances therapeutic.
7. Boundary violations are never helpful and can lead to harm for the patient and possible criminal charges for the nurse. Detachment from a patient to the point of neglect is also a boundary violation.
8. Warning signs of boundary problems include:
   • Not monitoring transference and counter-transference
   • Over/inappropriate use of self-disclosure
   • Feeling as though the relationship with a patient is “special”
   • Getting personal needs met (e.g., admiration, physical compliments) through a relationship with patients
   • Becoming distant and secretive from peers

**HYPERLINKS**

*Boundaries in Nursing Practice, Ethical Issues In Nursing—Commitment: Patients, Professionalism, and Boundaries*; highlights some core concepts regarding boundaries in the nurse-patient relationship.

1. http://www.youtube.com/watch?v=XtuanLybaZ

**Films to Augment Chapter Material**

*Nurse Jackie. (Season Premier 2009)*. Episode illustrates poor boundaries in the nurse-patient relationship and in nursing practice in general.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. c. Physical boundaries include privacy, touching, physical proximity, and sexual behavior. Feelings, choices, and spirituality are examples of psychological boundaries.

2. b. The patient is exhibiting transference. Transference occurs when a patient responds emotionally to the nurse because the patient thinks or feels that the nurse reminds him of that significant person. Boundary testing occurs when the patient attempts to violate the established boundary, such as by trying to initiate a social relationship or trying to gain personal information about the nurse. Boundary crossing occurs when the nurse briefly crosses the established boundary inadvertently, unconsciously, or purposefully. Counter-transference occurs when the nurse responds to the patient’s transference.

3. a. When establishing boundaries, giving the patient information about the nurse’s personal life would be inappropriate. Self-disclosure should be used only when its purpose is to model, educate, foster a therapeutic alliance, or validate a patient’s reality. Explaining the reason for the nurse being there, describing what the nurse can offer the patient, and discussing the time, place, and frequency of the meetings would be appropriate actions to establish boundaries during the orientation phase.

4. d. Boundary crossings are transient, brief excursions across a professional boundary and may be used to meet a specific therapeutic need. They can be therapeutic in some instances and can result in a return to established boundaries. However, if boundary crossings occur with increased frequency or severity, the boundary crossing can progress to a boundary violation. Boundaries are necessary regardless of the situation because there is an imbalance of power in the nurse-patient relationship.

5. b. The patient is attempting to initiate a social relationship with the nurse and is testing the boundaries. The nurse needs to address this immediately and refocus the patient on the need to maintain a professional therapeutic relationship. Telling the patient that it would be fun is inappropriate because the underlying message suggests that a social relationship would be okay. The “Don’t be silly” statement is demeaning to the patient. The statement about keeping the meeting secret indicates a boundary violation.
KEY TERMS

Critical thinking: refers to a purposeful method of reasoning that is systematic, reflective, rational, and outcome-oriented.

Critical thinking indicators™ (CTIS) behaviors that demonstrate the knowledge, characteristics, and skills needed to promote critical thinking for clinical decision making.

Dispositions: the way a person approaches life and living

Nursing Process: systematic method of problem solving that provides the nurse with a logical, organized framework from which to deliver nursing care.

Psychoeducational intervention: interventions that include a significant educational component

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify the basic concepts involved in critical thinking.
2. Correlate critical thinking with clinical decision making.
3. Describe the framework for critical thinking.
4. Describe how the nursing process is related to critical thinking and clinical decision making.
5. Correlate the stages of the nursing process with Peplau’s phases of the interpersonal relationship.

NEED TO KNOW

1. Critical thinking is a purposeful method of reasoning that is systematic, reflective, rational, organized, and outcome-oriented. Effort, practice, and experience are necessary to develop critical thinking.

2. The four domains of critical thinking are: elements of thought, abilities, affective dimensions, and intellectual standards. Critical thinking involves the use of cognitive skills and working through dispositions or the way a person approaches life and living.
3. The psychiatric-mental health nurse uses critical thinking skills to find the answer to the question about what to do or say to meet the patient's needs.

4. Both the nursing process and the interpersonal relationship reflect a problem-solving approach to providing care. Psychiatric-mental health nurses integrate the nursing process and interpersonal relationship for sound clinical decision making in psychiatric-mental health nursing.

5. During the planning and implementation stages of the nursing process and the exploitation phase of the interpersonal relationship, the nurse works with the patient and uses critical thinking skills to determine the most plausible strategies, analyze these strategies, and ultimately arrive at the best courses of action for the patient.

6. Psychoeducation is an excellent intervention that can consist of verbal one-on-one interaction, printed handouts, or other audio-visual materials.

7. Interventions need to be appropriately timed and paced to be successful.

**HYPERLINKS**

*Steps in Critical Thinking.* Two brief films outlining what critical thinking is and a simple 5 step process to practice critical thinking skills.

1. [http://www.youtube.com/watch?v=ZQwe4Mwi1po](http://www.youtube.com/watch?v=ZQwe4Mwi1po)
2. [http://www.youtube.com/watch?v=bUVEvi8SqQM](http://www.youtube.com/watch?v=bUVEvi8SqQM)

**Films to Augment Chapter Material**

*Here Be Dragons: An Introduction to Critical Thinking.* Here Be Dragons is a free 40 minute video introduction to critical thinking. It is suitable for general audiences and is licensed for free distribution and public display. Most people fully accept paranormal and pseudoscientific claims without critique as they are promoted by the mass media. Here Be Dragons offers a toolbox for recognizing and understanding the dangers of pseudoscience, and appreciation for the reality-based benefits offered by real science. Can be downloaded and shown in class from [http://herebedragonsmovie.com/](http://herebedragonsmovie.com/)

**ANSWERS TO NCLEX PREP QUESTIONS**

1. b. Creativity is considered a disposition for critical thinking; it is also a critical thinking indicator as identified by Alfaro-LeFavre. Cognitive skills include interpretation, analysis, evaluation, inference, explanation, and self-regulation.

2. d. The nurse is using inference which involves drawing a reasonable conclusion after considering relevant information and proposing alternatives. Evaluation involves assessing the credibility of the information and determining if it is logical and significant. Explanation involves presenting the information in a coherent, logical, and rational manner. Interpretation involves understanding the meaning or significance of the information with the ability to categorize, decode and clarify its significance and meaning.

3. a. The resolution phase of the interpersonal relationship correlates to the evaluation stage of the nursing process. Assessment correlates with the orientation and identification phases. Planning and implementation correlate with the exploitation phase.
4. c. The most important aspect of critical thinking, clinical decision making, the therapeutic relationship and the nursing process is the patient’s needs. Identification of the patient’s needs is the central focus. Although psychiatric-mental health nurses need to be self-aware to avoid impacting the interpersonal relationship, the patient's needs are the priority. Outcome achievement is also important but it is directly related to what the patient's needs are. Critical thinking, clinical decision making, the therapeutic relationship and nursing process occur in all care settings.

5. b. The first step in critical thinking is to identify the problem, that is, determining the problem or issue at hand. Then the nurse would examine or question what factors or circumstances may be contributing to surrounding this problem. Next, the nurse would identify plausible options, arrive at the best course of action, listing the reasons for that action. Finally, the nurse would re-examine the issue and ask what might have been missed.
KEY TERMS

Crisis: a time-limited event, usually lasting no more than 4 to 6 weeks, that results from extended periods of stress unrelieved by adaptive coping mechanisms

Crisis intervention: a time limited professional strategy designed to address an immediate problem, resolve acute feelings of distress or panic, and restore independent problem-solving skills

Debriefing: method used following a crisis incident to allow staff to verbalize their feelings and thoughts about the event.

Maturational crisis: crisis that occurs during an individual’s normal growth and development, at any point of change.

Situational crisis: crisis that stems from an unanticipated life event that threatens one’s sense of self or security.

Social crisis: also called an adventitious crisis; crisis that results from an unexpected and unusual social or environmental catastrophe that can either be a natural or man-made disaster.

Stress: an increase in an individual’s level of arousal created by a stimulus.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Discuss how the body responds to stress.
2. Define crisis.
3. Identify the characteristics of crisis.
4. Explain the factors that impact an individual’s response to stress and development of crisis.
5. Differentiate between the types and magnitudes of crisis.
7. Trace the historical and current role of the psychiatric-mental health nurse in crisis intervention and stress management.
8. Apply the nursing process for crisis intervention to develop a plan of care for a person experiencing crisis.
9. Explain the methods used to assist psychiatric-mental health nurses to deal with effects of providing crisis care.
NEED TO KNOW

1. Stress is a stimulus that increases an individual's level of arousal.
2. The three stages of stress response are: alarm, resistance and recovery, and exhaustion.
3. Crisis is a time-limited event that usually lasts no longer than 4 to 6 weeks in which the person is unable to relieve prolonged stress through adaptive coping mechanisms.
4. Crisis can have positive or negative results for a person.
5. Crisis is not an established psychiatric diagnosis. It is, however, associated with numerous psychiatric disorders classified by the DSM-IV-TR.
6. A crisis develops over four phases. If the crisis is not resolved during the second or third phase, panic or despair can occur in the fourth phase.
7. Crises may be categorized as maturational, situational, or social.
8. Crisis intervention is a strategy used to combat the immediate issue of the crisis and work to resolve it.
9. Nurses must remember to be flexible and set a professional example during crises.
10. It is imperative that crisis workers, including nurses, take care of their own emotional well-being to remain effective.

HYPERLINKS

Steps of Crisis Intervention, De escalation techniques to help avert a crisis in clients that may be escalating due to anxiety and a student made film of role playing crisis intervention.
1. http://www.youtube.com/watch?v=pBe4A32fpyI
2. http://www.youtube.com/watch?v=IUSHKNKSBi0

Films to Augment Chapter Material


ANSWERS TO NCLEX PREP QUESTIONS

1. a. The woman is describing the feelings of being overwhelmed due to her son leaving for college. This is an example of a maturational crisis. A situational crisis is one that occurs from an internal stress such as disease, or an external stress such as the death of a loved one, foreclosure on a home, or being fired from a job. A social or adventitious crisis is one that occurs from an unexpected and unusual social or environmental catastrophe, such as a natural or man-made disaster.
2. c. During the alarm stage of the stress response, respirations increase, pupils dilate, heart rate increases, and secretions from the sweat glands increase leading to diaphoresis.
3. d. Crisis is associated with several psychiatric diagnoses but it is not classified as a mental disorder by the DSM-IV-TR. Crisis is a time-limited event resulting in an acute response that will be resolved. A crisis occurs when there is a real or perceived threat to a person's physical, social, or psychological self.
4. c. Crisis begins with an exposure to a stressor that causes anxiety and the person attempts to cope using past coping mechanisms. In phase 2, the anxiety increases as past coping methods do not relieve the stress.
In phase 3, the individual tries every new idea and method that is possible to relieve the stress. In phase 4, distress and inability to cope occur as every method of coping fails.

5. a. In a community disaster, an individual's basic physiologic needs are the priority. These would include food, water and rest. Until these needs are met, the individual cannot focus elsewhere in a situation that is likely overwhelming. Once these needs are met, the focus shifts to safety and security needs, such as shelter and referrals to resources that can help meet the safety and security needs.
KEY TERMS

Broker case management: case management model in which single individuals (brokering case managers) are responsible for referral, placement, and monitoring of patients.

Case management: an outcome-oriented process that coordinates care and advocates for patients and patient populations across the health care continuum

Clinical case management: a worker-intensive, clinical case management model. The individuals commonly have the greatest need for services.

Colorado model: continuum of care model of psychiatric case management that combines focused therapy, assertive community treatment, and family centered interventions

In-patient psychiatric case management model: case management model involving the use of a managed care agent to perform the initial assessment and develop an initial treatment plan.

Managed care agent (MCA): individual who performs an initial assessment and initiates a treatment plan

Managed care organization: agencies providing case management, such as insurance companies

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:
1. Define case management.
2. Trace the historical evolution of psychiatric case management.
3. Identify the prominent case management models.
4. Describe the specific role case management has in mental health care.
5. Discuss the functions and activities involved in case management.
6. Identify the goals and principles associated with case management.
7. List the skills needed to function as a psychiatric-mental health nurse case manager.
8. Explain the roles assumed by psychiatric-mental health nurse case manager.
9. Correlate how the interpersonal process relates to case management.

NEED TO KNOW

1. Case management refers to an outcome-oriented process that coordinates care and advocates for patients and patient populations across the health care continuum. Although not exclusive to psychiatric-mental health nursing, it is an important component of psychiatric-mental health nursing.
2. Returning World War II veterans experiencing psychiatric conditions and the deinstitutionalization of chronic mentally ill patients are two key events that prompted the evolution of psychiatric-mental health case management.

3. Multiple case management models exist with the PMHN assuming the role of primary case manager or functioning as part of a case management team in collaboration with other health professionals. Services provided by the PMHN case manager can range from initiating the service to providing clinical case management.

4. Four models of psychiatric-mental health case management include: in-patient psychiatric case management model; continuum of care psychiatric case management model; the broker model; and clinical case management model.

5. The case management process requires an interactive relationship that views the patient holistically and fosters empowerment through advocacy and education.

6. A PMHN case manager must be skilled in critical thinking, communication, negotiation, and collaboration.

7. The case management process involves the functions of assessment, planning, implementation, coordination, monitoring, and evaluation.

8. The case management process closely resembles the steps of the nursing process and the stages of the therapeutic relationship.

9. When engaged in the case management process, the PMHN case manager can assume seven different roles: advocate, consultant, educator, liaison, facilitator, mentor, and researcher.

10. Case management services range in intensity from the most extensive support for individuals with the greatest need (Level One) to the least extensive support providing a basic link to crisis management services (Level Three).

11. At any level of service, case management must include the critical elements of coordination, consumer choice, determination of strengths and preferences, comprehensive, outcome-oriented service planning, collaboration with psychiatrists and other service providers, continuity of care, and family and kindred support.

12. The underlying premise of all case management is that everyone benefits when the patient reaches his or her optimum level of wellness and capability.

**HYPERLINKS**

*Nursing case management*, Brief film outlining the role of the nurse case manager.

1. [http://www.youtube.com/watch?v=5iYR_2IyUUU&feature=related](http://www.youtube.com/watch?v=5iYR_2IyUUU&feature=related)

**ANSWERS TO NCLEX PREP QUESTIONS**

1. c. Psychiatric-mental health case management is an outcome-oriented process that coordinates care and advocates for patients and patient populations across the health care continuum. It involves collaborative action among multiple disciplines for outcome achievement. Case management is not unique to nursing. Although case management does address cost-effectiveness, managed care is a method of care delivery and financing that is designed to control costs. It aims to reduce fragmentation of care across the health care continuum, not just when an illness occurs.

2. a. The broker case management model typically involves single individuals who are responsible for referral, placement, and monitoring of patients. These case managers usually have large caseloads (100 or more patients) and assess a patient’s needs and arrange for services from other providers to meet the needs.
With the clinical case management or intensive case management model, the case manager may work as a primary clinician or collaborate with other health professionals in the community setting. The patients commonly have 24-hour-a-day, 7-day-a-week access to a multidisciplinary staff. The continuum of care model (also known as the Colorado Model) involves focused therapy, assertive community treatment and family-centered interventions to rapidly transition hospitalized patients back into the community. The case manager guides the patient and family across the continuum of care, assisting the patient in accessing appropriate treatment. The case manager also coordinates the multidisciplinary team and monitors and documents the patient’s progress.

3. b. The nurse is demonstrating critical thinking as evidenced by the nurse’s analysis that additional information is needed. The nurse would demonstrate communication skills when interviewing the patient or others to obtain the information. The nurse would demonstrate negotiation when interacting with others to ensure that the needs of all parties involved are balanced objectively and fairly. Crucial to negotiation are mediation and compromise. The nurse demonstrates collaboration when working together cooperatively with all those involved on the team.

4. c. The role of a consultant is demonstrated by the nurse acting as a resource for members of the team during the course of treatment. The psychiatric-mental health nurse case manager would make recommendations about the suitability of vocational resources or training that may be incorporated into a patient’s goals and treatment. The nurse would be functioning in the role of an educator when instructing a patient about the need for adhering to a medication schedule. The nurse is functioning as an advocate when promoting patient access to the least restrictive treatment method. The nurse is functioning as a facilitator by proactively identifying barriers to care thereby ensuring that the plan of care moves in the proper direction.

5. d. Level two case management services are those that are supportive to promote recovery and rehabilitation. Crisis prevention is a priority for each level of case management. Level one case management services are those that are most extensive for individuals with the greatest need and disability. Level three case management services are those that are least extensive and provide a basic link to crisis management services for individuals who are more independent and self-managing with their lives.
KEY TERMS

Primary prevention: interventions that delay or avoid the onset of illness
Protective factor: characteristic, variable, or trait that guards against or buffers the effect of risk factors.
Psychomimetic disorders: medical disorders that mimic psychiatric disorders
Resilience: the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress
Risk factor: issues that increase an individual’s chance for developing an illness
Secondary prevention: interventions focusing on treatment including identifying persons with disorders and standardizing treatment for disorders
Stress-vulnerability-coping model: one way of understanding how risk factors are involved with the development of psychiatric-mental health disorders; identification of risk factors according to three categories: biological; personal; and environmental.
Temperament: innate aspects of personality that determine how a child tends to respond to the world; distinctive behavior involved with activity and adaptation.
Tertiary prevention: interventions focusing on maintenance including decreasing relapse or recurrence, and providing rehabilitation

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:
1. Define the term, risk factor.
2. Explain how risk factors may be grouped or categorized.
3. Describe the significance of protective factors.
4. Identify the major risk factors associated with schizophrenia, affective disorders, substance-related disorders, anxiety disorders, and personality disorders.
5. Describe interventions appropriate for primary and secondary prevention.
6. Integrate the interpersonal process with primary, secondary, and tertiary prevention activities.
NEED TO KNOW

1. Risk factors are characteristics, variables, or hazards that increase the probability that an individual will develop a disorder.

2. Risk factors may be classified in different ways. Possible categories include: individual, family, and community; biological and psychosocial; intrapersonal and environmental; or genetic, biological, psychological, social, and environmental. Many psychiatric disorders share risk factors that can be differentiated as biological and/or genetic or personal/social/environmental.

3. Individuals possess characteristics, variables, or traits that guard against or buffer the effect of risk factors. These are known as protective factors.

4. Resilience is a protective function that is learned over time.

5. Genetics/biology and temperament are two important intrapersonal risk factors for the development of psychiatric-mental health disorders occurring from infancy to adolescence.

6. Risk factors for schizophrenia include the interaction between genetics and environment. In addition, gestational and birth complications are associated biological risk factors.

7. Genetics is a risk factor for both depression and bipolar disorders. Gender, life stressors, substance abuse, and inadequate social supports are additional risk factors.

8. Substance use disorders are strongly linked to familial patterns. Genetics, biology, and learning from the environment are also thought to be intrinsically connected.

9. An optimistic outlook, social support, and resilience are protective factors for anxiety disorders.

10. In general, risk factors for personality disorders include a family history of personality disorders or other mental illness; verbal, physical, or sexual abuse, neglect, or trauma during childhood; a chaotic family life during childhood; diagnosis of a childhood conduct disorder; and death or divorce of parents during childhood.

11. Any medical disorder could be a risk factor for a psychiatric-mental health disorder. Any psychiatric-mental health disorder might place a patient at greater risk for a medical disorder.

12. Integrating the interpersonal process at the primary, secondary, and tertiary levels of prevention can help to minimize risk factors and enhance protective factors. Establishing a therapeutic nurse-patient relationship also acts as a protective factor.

13. Primary prevention interventions address and neutralize the influence of risk factors to avoid or delay the onset of illness.

14. Secondary prevention activities focus on early detection and intervention in an effort to reduce the possible duration of the disorder and its associated complications.

15. Tertiary prevention activities focus on minimizing complications and promoting the patient’s return to his or her maximum level of functioning.

HYPERLINKS

Risk factors for anxiety disorders, A psychiatrist discusses common risk factors thought to pre-dispose individuals to anxiety disorders.

1. http://www.youtube.com/watch?v=Orm_FoXKVdU
Films to Augment Chapter Material

Sybil. (1976). Film illustrates how childhood exposure to certain traumas/stressors could predispose an individual to mental illness.

ANSWERS TO NCLEX PREP QUESTIONS

1. c. Family risk factors include placement in foster care, a biological relative with a mental disorder, marital discord, social disadvantage, overcrowding, parental (father) criminality, and maternal mental disorder. Poverty and a high crime rate would be considered community risk factors. Temperament is an individual risk factor.

2. a, b, e. Protective factors include flexibility, average to better intelligence, varied supportive social relationships, engagement in recreational activities, and adequate economic resources.

3. d. Multiple medical disorders have been associated with the development of psychiatric-mental health disorders, of which, depression is a primary concern because it is associated with increased morbidity and mortality. Schizophrenia, acute stress disorder, and personality disorder are possible but depression is seen more commonly.

4. b. Secondary prevention requires the nurse to identify the existence of risk factors first and then assess for the presence of the disorder. If confirmed, then the nurse would initiate appropriate and immediate treatment to reduce the possible duration and severity of the disorder and associated complications. Conducting community screening and teaching about coping skills are examples of primary prevention activities. Making referrals for treatment would be completed once the nurse identifies the existence of the risk factors and determines that the disorder is present.

5. a. Resilience is a personal trait that serves as a protective mechanism. People are not born with it but learn it over time. Resilient people have a sense that they are able to cope with chronic stress or recover from trauma through skills such as communication and problem solving.
KEY TERMS

Curative factors: describe the patterns of interaction in a therapeutic group

Family therapy: as insight oriented therapy with the goal of altering interactions between or among family members, thus improving the functioning of the family as a unit or any individual within the family

Genogram: tool developed to show a map of the multigenerational family structure and process.

Group: to any collection of two or more individuals who share at least one commonality or goal, such that the relationship is interdependent

Group dynamics: forces that produce patterns within the groups as the group moves towards its goals.

Group process: interaction among group members

Group therapy: process by which group leaders with advanced educational degrees and experience

Lines of resistance: internal factors that an individual uses to help defend against stressors

Normal line of defense: usual response to stressors; represents the individual's usual state of wellness

System: any group of components related sufficiently to identify patterns of interaction

Therapeutic groups: groups used to promote psychologic growth, development, and transformation

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Describe systems theory, including the major concepts.
2. Discuss the relationship of general systems theory to nursing theories.
3. Apply systems theory thinking to psychiatric-mental health nursing.
4. Define group therapy.
5. Identify key concepts related to group therapy including those from systems theory.
6. Explain the eleven curative factors of a therapeutic group.
7. Describe the content of a supportive and insight-oriented group.
8. Discuss how family is considered a specialized type of group.
9. Describe the use of a genogram in family assessment.
10. Identify the relationship between interpersonal based therapy and group and family therapy.
NEED TO KNOW

1. A system is a group of components that interact, such that a change in one component affects the other components and the system overall. Using systems theory or systems thinking provides an opportunity to look at the “bigger picture” and promotes treatment planning that ultimately can lead to higher levels of functioning.

2. Systems thinking is not new to nursing. The environment has been a major component of many nursing theories.

3. Two or more people together functioning interdependently form a group. Family is a specialized type of group.

4. Groups may be classified by membership as open or closed, by purpose as insight-oriented or supportive, and by setting as in-patient or out-patient.

5. Yalom identified eleven curative factors that are interdependent within a group. They are the central core necessary for group survival.

6. Cohesiveness in a group reflects the solidarity of the group. It is a curative factor essential for ensuring the effectiveness of group therapy.

7. A group progresses through three phases of development: orientation, working, and termination.

8. The group leader or facilitator assumes different roles depending on the phase of the group’s development and in response to the members’ participation.

9. Group members can assume roles that keep the group on task and focused, that maintain the group, and that threaten curative factors and group functioning.

10. A psychoeducational group is one example of a group led by psychiatric-mental health nurses prepared at the basic (generalist) level.

11. Family therapy is a specialized form of group therapy that focuses on the family as an open system to alter the interactions between or among members.

12. Key concepts associated with the Bowen Family Systems include: differentiation of self, emotional triangles, and multigenerational transmission of anxiety.

HYPERLINKS

Yalom, First an interview with Irvin Yalom with demonstration of group concepts, then an overview of the Neuman systems model and its implications for nursing practice.

1. http://www.youtube.com/watch?v=C7FpVJs3Rbg

2. http://www.youtube.com/watch?v=rXrFTxv4IIU

Films to Augment Chapter Material

12 Angry Men. (1957). Film illustrates group dynamics amongst a jury of men.

ANSWERS TO NCLEX PREP QUESTIONS

1. a. Systems theory focuses on the interactions of the parts of the system and the nonlinear, dynamic pattern of those interactions. A closed system is one in which the components are isolated from the environment. An open system is one in which the components interact with the environment and with other components of the system. This system is dynamic and ever-changing. A system is more than the sum of its parts;
thus a change in any component leads to change in one or more other components of the system and in the system as a whole.

2. b. According to the Neuman Systems Model, the patient is a system that is a unique composite of factors and characteristics within a given range of possible responses. The central core includes basic survival factors common to all such as normal temperature, genetic structure, and organ functioning. Martha Rogers Science of Unitary Man describes person as an energy field inseparable from the environment with continuous and mutual interaction between the two. Florence Nightingale identified the need for creating the right environment for the patient's natural, reparative powers. Hildegard Peplau described the interpersonal process where the nurse and patient engage in a relationship to meet a desired goal.

3. c. Informal groups typically focus on casualness and personal needs, such as family, friends, and informal groups in the work setting. Formal groups include work-related groups such as a treatment team, professional organizations, or nurses working on the same unit.

4. d. During the orientation phase, the group facilitator provides structure by describing the group purpose and expectations. Keeping the group on task and commenting on what is happening in the group typically occurs during the working phase. Reviewing group accomplishments is appropriate for the termination phase.

5. c. The member boasting about his accomplishments reflects the role of the recognition seeker, a person who attempts to have the group focus on his achievements by bragging. The encourager is one who praises others. The energizer is one who encourages group participation and action. The standard setter is own who verbalizes group standards.

6. b. Universality occurs when members begin to develop the belief that they are not alone and not so different from others in the group. Sharing of information by other group members to similar circumstances as the member arrested helps to make the person feel less distressed and also promotes a feeling of connectedness and safeness within the group. The instillation of hope is conveyed by statements, actions or behaviors that therapy will be helpful. Genuine enthusiasm and positive expectations from the group leader and encouragement from more experienced members help to foster the instillation of hope. Altruism is manifested by group members offering support, suggestions, insight and sharing of similar issues which lead to increased self-esteem. Imitative behavior involves picking up of behaviors, such as walking, talking, dressing, or thinking like others. A group member may try a new behavior to break old patterns.

7. b. The situation described reflects emotional triangles involving a three party system where two of the members are close with exclusion of the other. The two parties are the mother and her adult daughter. The mother then turns to her sister, placing the adult daughter on the outside. Differentiation of self involves being able to remain emotionally present, engaged and nonreactive in emotionally charged situations while also expressing one's own goals, values, and principles. Multigenerational transmission reflects the patterns of interaction transmitted or passed down from one generation to another.
KEY TERMS

Behavioral psychology theory: scientific approach that limits the study of psychology to measurable or observable behavior

Biological psychology theory: the study of human or animal psychology using a biological approach in order to understand human behavior; involving brain physiology, genetics, and evolution as means for understanding behavior

Classical conditioning: the learned associative behavioral stimulus-response discovered by Pavlov

Cognitive dissonance: the inability of the human mind to contain two disparate, conflicting thoughts or beliefs simultaneously. It also includes the process of how a person will engage in rationalization, change their beliefs or behavior to eliminate the tension or imbalance associated with cognitive dissonance, and restore cognitive or mental balance.

Cognitive psychology theory: the study of higher mental processes such as attention, language use, memory, perception, problem solving, and thinking

Ego defense mechanisms: conscious and unconscious tools used to protect and defend the ego

Gestalt: human experience of being whole

Grand theories: theories that are the most abstract and broad in scope

Humanistic psychology theory: a group of psychologies that include early and emerging orientations and perspectives, including Rogerian, existential, transpersonal, phenomenological, hermeneutic, feminist and other psychologies

Mental illness: mental disorders which are diagnosable conditions characterized by abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities.

Micro-level theories: theories that are the least abstract and narrow in scope.

Middle-range theories: theories that are less abstract than grand theories; more concrete.

Operant conditioning: also called instrumental conditioning; differing from Pavlov's classical

THEORIES OF MENTAL HEALTH AND ILLNESS: PSYCHODYNAMIC, SOCIAL, COGNITIVE, BEHAVIORAL, HUMANISTIC AND BIOLOGICAL INFLUENCES
Psychodynamic theories: theories that focus on the unconscious and assert that underlying unconscious or repressed conflicts are responsible for conflicts, disruptions, and disturbances in behavior and personality.

Self-efficacy: the beliefs a person holds about their ability to accomplish something and their belief about what the outcomes will be.

Social psychological theory: the study of the effect of social variables on individual behavior, attitudes, perceptions, and motives

Systematic desensitization: process in which a subject is gradually introduced to the source of the fear or anxiety, over the course of time under controlled conditions.

Theory: an organized set of concepts that explains a phenomenon or set of phenomena.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Describe how the definitions of mental illness have developed through the years.
2. Discuss the different disciplinary perspectives of mental illness.
3. Define six major grand theories used to explain mental health and illness.
4. Identify the major theorists associated with the psychodynamic, behavioral, cognitive, social, and humanistic theories of mental health and illness.
5. Discuss the concepts or beliefs associated with one theorist associated with the psychodynamic, behavioral, cognitive, social, and humanistic theories of mental health and illness.
6. Explain the current areas of research reflecting biological psychology theory.

NEED TO KNOW

1. No one simple definition of mental illness exists. The DMS-IV-TR and NANDA classifications offer widely accepted descriptions of mental illness.
2. Attempts to understand the human mind, body, and behavior can be traced as far back as Aristotle.
3. There are three main types of theory: grand, middle-range, and micro-level.
4. Psychodynamic theories focus on the unconsciousness involving repressed conflicts. Sigmund Freud developed the first psychodynamic theory called psychoanalytic theory.
5. Behavioral theory proposes that a person's behavior is the result of learning that is a response to a stimulus.
6. Classical and operant conditioning are two key behavioral theories.
7. Cognitive theories address a person's thinking about an event or situation as having an effect on his or her response to a stimulus (behavior).
8. Social theories focus on understanding the influences of and interaction between the environment, cognition, and a person's behavior.
9. Humanistic theories reflected the theoretical shift toward a more holistic, interpersonal, positive perspective.
10. Biological psychology theory includes brain physiology, genetics, and evolution as means for understanding behavior. Although numerous frameworks have evolved, they all address the effect of the mind on biological processes (or vice versa) on disease states and behaviors.
HYPERLINKS


1. http://www.youtube.com/watch?v=4KDP2v3lp08

Films to Augment Chapter Material

Dissociation and Second Life: Pathology or a State of Mind? Film available for viewing in class at http://vimeo.com/7573230 Film explores the blurred lines between reality and dissociation.

ANSWERS TO NCLEX PREP QUESTIONS

1. c. Beck is considered a cognitive theorist and is known as the founder of cognitive theory. Thorndike and Seligman are behavioral theorists. Bandura is considered a social theorist.

2. a. According to Freud, an individual’s personality develops over five stages, the first of which is the oral stage. This is followed by the anal, phallic, latency, and genital stages.

3. d. The person is transferring his feelings from the person to another less threatening object. This is called displacement. Suppression refers to intentionally blocking disturbing feelings from one’s awareness. Rationalization involves the use of incorrect explanations or excuses to explain unacceptable thoughts, actions or feelings. Denial is the refusal to acknowledge a reality or feelings associated with it.

4. c. Cognitive dissonance is a concept identified by Leon Festinger. It refers to the inability of the human mind to contain two disparate, conflicting thoughts or beliefs simultaneously. Reciprocal determination, behavior modeling, and self-efficacy are concepts associated with Bandura.

5. Maslow’s hierarchy of needs from most basic to highest level is: physiologic, safety, belongingness and love, esteem, and self-actualization.
KEY TERMS

Affective flattening: restricted range and intensity of emotion
Alogia: decreased production of speech
Anhedonia: inability to feel pleasure or joy from life
Anosognosia: poor insight
Avolition: diminished goal directed activity
Delusion: erroneous false, fixed beliefs; a misinterpretation of the an experience
Echolalia: parrot-like repetition of another’s words
Echopraxia: involuntary imitation of another’s movements and gestures
Erotomanic: delusions that another person, usually of higher status, is in love with the individual
Grandiose: delusions of inflated worth, power or knowledge; possibly involving special relationships with deity or famous person
Hallucination: most commonly auditory or visual, erroneous or false sensory perceptions
Neuroleptic malignant syndrome: a rare, but life-threatening, idiosyncratic reaction to a neuroleptic medication.
Psychosis: condition involving hallucinations, delusions, or disorganized thoughts, behavior or speech
Schizophrenia: diagnostic category within the group of schizophrenia spectrum disorders
Thought disorder: broad term applying to illnesses involving disordered thinking and disturbances in reality orientation and social involvement

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:
1. Define thought disorder.
2. Identify the disorders associated with Schizophrenia Spectrum Disorders (SSD).
3. Describe the history and epidemiology of thought disorders.
4. Discuss current scientific theories related to the etiology of thought disorders including relevant biological and psychosocial theories.
5. Distinguish among the diagnostic criteria for thought disorders as identified by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).
6. Describe common assessment strategies for individuals with thought disorders.
7. Explain treatment options for persons demonstrating thought disorders, emphasizing those that reflect evidence-based practices.

8. Apply the nursing process from an interpersonal perspective to the care of patients with thought disorders.

**NEED TO KNOW**

1. Schizophrenia was initially believed to be a type of early dementia. It was not until 1959 when it was defined with a specific list of symptoms by Kurt Schneider.

2. Initially, patients with schizophrenia were treated cruelly with banishment from society. The discovery of the antipsychotic agent, chlorpromazine, in the early 1950s marked the first time effective treatment was available for schizophrenia.

3. Schizophrenia occurs more commonly in men than in women, more often in immigrants than in the native-born population, and more often in those living in urban areas.

4. Schizophrenia is manifested by positive and negative symptoms. Positive symptoms are exaggerations of normal function; negative symptoms indicate decreased emotional expression.

5. The five subtypes of schizophrenia are: paranoid, disorganized, catatonic, undifferentiated, and residual. Each is associated with characteristic symptoms.

6. Other thought disorders include: schizoaffective disorder, delusional disorder, brief psychotic disorder, and shared psychotic disorder.

7. Early psychosocial theories identified a problematic maternal relationship as the cause of schizophrenia. Later, other theories addressed social context and unresolved family issues.

8. Biological theories suggest perinatal events, genetics, neuroanatomical abnormalities, and dysfunction of neurotransmitters as key risk factors for the development of schizophrenia.

9. Antipsychotic agents are typically classified as first- or second-generation agents. Both are associated with extrapyramidal symptoms: parkinsonism, akathisia, dystonias, and tardive dyskinesia. Second-generation antipsychotics are associated with the development of metabolic syndrome.

10. Cognitive behavioral therapy (CBT) is an effective treatment modality for schizophrenia because it focuses on the present, involves sessions requiring homework and exercises, and spans a limited time period.

11. Family psychoeducation involves teaching the patient and family about the disorder as well as showing concern and empathy for the family, helping to improve the relationships among family members, promoting adherence to the regimen, and instilling hope.

12. Patients with schizophrenia often have a substance abuse disorder that requires treatment.

13. Patients with schizophrenia may require social skills training, supported employment, illness self-management training, and supported housing.

14. When assessing a patient with schizophrenia, nurses need to be self-aware and to establish rapport with the patient to prevent the stigma associated with this disorder from interfering with the assessment and development of the therapeutic relationship.

15. The psychiatric-mental health nurse needs to use a broad opening statement to obtain information from the patient about his or her current status. Throughout the assessment, the nurse is vigilant in observing positive and negative symptoms of schizophrenia.

16. Patients with schizophrenia often present with a wide range of symptoms. Therefore, nursing diagnoses appropriate for a patient must reflect this variation.
17. An important consideration when implementing care for a patient with schizophrenia is to ensure adherence to the prescribed medications. Patient and family psychoeducation is a key intervention.

**HYPERLINKS**

*Hallucinate - a schizophrenic tale.* An interview with an actual client who suffers from hallucinations.

1. [http://www.youtube.com/watch?v=qWiTqDeTY7E](http://www.youtube.com/watch?v=qWiTqDeTY7E)

**Films to Augment Chapter Material**

*A Beautiful Mind.* (2001). Film illustrates schizophrenia from the lived experience.

*People Say I'm Crazy.* *People Say I'm Crazy* is the only film about schizophrenia ever made by someone with schizophrenia. Mental illness is viewed from the inside out as the audience becomes witness to a first-hand account of the symptoms of schizophrenia and the disease's effect on one man and his family. can be obtained at [http://www.peoplesayimcrazy.org/film](http://www.peoplesayimcrazy.org/film)

**CARE PLANNING PRACTICE**

Jerry’s condition is stabilized while on the in-patient unit and he is discharged to an out-patient mental health clinic for follow up. You are the nurse working with Jerry at the clinic. During the assessment he tells you that while his delusions are gone he adds “I don’t like taking these pills, they make me tired all the time”. Develop a care plan for Jerry using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. d. The shifting of conversation from one topic to another completely unrelated topic reflects loose association. Delusion is a false fixed belief, such as thinking that one is the king of the world, or that he or she is being followed by another. Hallucination is a sensory perception such as hearing voices, seeing insects or smelling a strange odor. Neologism is words made up by the patient that have no meaning.

2. b. The response of “okay” reflects alogia, or poverty of speech and is characterized by brief, bland minimalist replies. Affective flattening refers to a limited range of motion in conjunction with little interpersonal connection such as eye contact. Avolition refers to a limited ability to plan and organize goal direct activities. Anhedonia refers to a loss of interest in activities that previously were pleasurable for the patient.

3. c. Affective flattening is a negative symptom of schizophrenia. Delusions, hallucinations, and echolalia (an example of disorganized speech) are positive symptoms.

4. a, b, d. Symptoms of schizophrenia, catatonic type include motoric immobility, undirected excessive motor activity, extreme negativism, peculiar voluntary movement including stereotyped movements, prominent mannerisms, or grimacing, and echolalia or echopraxia. Odd beliefs and an absence of delusions suggest schizophrenia, residual type.

5. d. The priority for the initial encounter is to assess for suicidal or homicidal ideation, command hallucinations, current medications, and/or physical health problems or injuries. These are critical to ensure the patient’s safety. The nurse should approach the patient in a calm and reassuring manner but touch should be avoided because it could agitate the patient. Brief focused assessment may be necessary because the person may not be able to attend to the task of numerous questions. In addition, the questions can be uncomfortable for the patient, adding to his already agitated state. Determining the content of the delusions
would be important if the delusions were ones commanding the patient to do something. Focusing on the type however would not be a priority at this initial encounter.

6. d. Aripiprazole is an example of a second generation antipsychotic agent. Chlorpromazine, haloperidol and fluphenazine are examples of first generation antipsychotic agents.

7. a. Clozapine, a second generation antipsychotic, is associated with agranulocytosis. Therefore it is essential that a baseline white blood cell be done to evaluate for this effect with therapy. A high fever suggests neuroleptic malignant syndrome. This side effect typically occurs after the start of therapy, during the first two weeks or when the dosage increases. First generation antipsychotic agents are associated with anticholinergic effects such as dry mouth. Cogwheel rigidity would suggest parkinsonism related to drug therapy and would occur after the patient has been taking the medication.

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. The most appropriate diagnosis for Jerry is
   a. Brief psychotic episode
   b. Schizoaffective disorder
   c. Delusional Disorder
   d. Schizophrenia, paranoid type

2. Jerry has delusions which are fixed false beliefs. They are classified as
   a. Negative symptoms
   b. Ideas of reference
   c. Positive symptoms
   d. Erotomanic delusions

3. Jerry has a history of non adherence to medication. Because of that it may be indicated that
   a. Jerry will stay in the hospital for a year
   b. Jerry is an excellent candidate for ECT
   c. Jerry might benefit from long acting medication
   d. Jerry requires the use of a 2 antipsychotics simultaneously

4. Jerry's sister's risk of developing SSD is
   a. 40%
   b. 30%
   c. 20%
   d. 10%

5. Jerry's apparent lack of recognition of his illness is termed
   a. anosognosia
   b. alogia
   c. anhedonia
   d. arrogance

6. Since Jerry is potentially violent toward his parents and non adherent his medication regimen may include
   a. antidepressants
   b. mood stabilizer
c. antianxiety agent
d. anticholinergic

7. After several days of antipsychotic medication Jerry begins to discuss his life outside the hospital. He discusses his solitary existence and loss of contact with people his own age. An appropriate action would be:
   a. Invite Jerry to watch staff play softball after discharge
   b. Change the subject to something less threatening
   c. Refer Jerry to a peer support program
   d. Gently inform Jerry that loneliness is inevitable

8. Jerry currently has a BMI of 27.5. He is prescribed a second generation antipsychotic, olanzapine for his psychotic symptoms. Anticipatory guidance is appropriate in what area:
   a. Increased risk of akathisia
   b. Increased risk of metabolic syndrome
   c. Increased risk of agranulocytosis
   d. Increased risk of hypertension

9. Comorbidities complicate the clinical picture for persons with SSD and require active treatment. Because of this Jerry should be referred for:
   a. neurology assessment
   b. substance abuse assessment
   c. GI/hepatic assessment
   d. dental assessment

10. Jerry’s younger sister visits frequently. She describes to you the confusion she feels because she is angry with her brother about harassing her parents but she also is sad about the loss of “the big brother” Jerry used to be. Jerry’s family will likely benefit from:
    a. strategic family therapy
    b. a separation from Jerry
    c. family psychoeducation
    d. referral to Alanon

HOW WOULD YOU RESPOND CASE STUDY ANSWERS
1. Schizophrenia, paranoid type*
2. Positive symptoms*
3. Jerry might benefit from long acting medication*
4. 10%*
5. anosognosia*
6. mood stabilizer*
7. Refer Jerry to a peer support program*
8. Increased risk of metabolic syndrome*
9. substance abuse assessment*
10. family psychoeducation*
KEY TERMS

**Affective disorder**: a term frequently used interchangeably with depressive or mood disorders; predominantly involves a persistent disturbance in mood.

**Ambivalence**: a state of conflicting or opposing ideas, attitudes or emotions.

**Hypomania**: a less severe form of mania.

**Mania**: mental disturbances such as elevated mood, grandiosity, difficulty with attention span.

**Melancholia**: term used by Hippocrates to describe sad or dark moods noted in patients with depression and the term; literally, black bile.

**Mood**: a person's overall emotional status.

**Serotonin syndrome**: a life-threatening situation due to an overactivity of serotonin or disruption in the neurotransmitter's metabolism manifested by fever, sweating, agitation, tachycardia, hypotension, and hyperreflexia.

**Suicidal Ideation**: intruding thoughts of harming one's self.

**Suicide**: a behavior often resulting from an affective disorder; frequently described as an act of ambivalence or conflicting or opposing ideas, attitudes or emotions.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define affective disorders.
2. Identify the disorders classified as affective disorders.
3. Discuss the history and epidemiology of affective disorders.
4. Analyze current theories related to the etiology of affective disorders, including relevant neurobiological and psychodynamic theories.
5. Distinguish among the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR)* diagnostic criteria for affective disorders.
6. Discuss suicide and how it is related to affective disorders.
8. Demonstrate effective therapeutic use of self when communicating with a person diagnosed with an affective disorder or experiencing suicidal thoughts.
9. Explain various treatment modalities including those that are evidence based practice (EBP) for the person demonstrating signs and symptoms of an affective disorder and/or is suicidal.
10. Apply the nursing process from an interpersonal perspective to the care of patients with affective disorders or who are experiencing suicidal thoughts.

**NEED TO KNOW**

1. During the 1940s, electroconvulsive therapy was used to treat depression. The use of medications to treat affective disorders arose during the 1950s and continues through today.
2. Major depressive disorder is a leading cause of disability in the United States, affecting greater numbers of women than men.
3. The diagnosis of major depressive disorder must include depressed mood or loss of interest or pleasure in conjunction with at least four other symptoms: significant weight loss; hypersomnia or insomnia; psychomotor agitation or slowness; fatigue or energy loss; difficulty concentrating or indecisiveness; or recurrent thoughts of death.
4. Suicide is considered a behavior and not a disorder. The DSM-IV-TR does not identify diagnostic criteria for this behavior. Ambivalence is frequently the underlying theme involved with suicide.
5. Neurotransmitters, such as serotonin, dopamine, and norepinephrine, have been identified as playing a role in affective disorders.
6. Psychopharmacologic agents used to treat patients with affective disorders include antidepressants and mood stabilizers. Antidepressant agents target neurotransmitters to achieve their therapeutic effect. These neurotransmitters include dopamine, norepinephrine, and serotonin.
7. Patients taking lithium need to have their drug levels monitored closely to reduce the risk of toxicity.
8. The nurse needs to assess a patient for suicidal ideation by asking direct questions about suicidal thoughts and any previous attempts at suicide.
9. Nurses need to vigilantly monitor patients with suicidal thoughts for suicidal behavior as antidepressant medications begin to exert their effect, providing the patient with the necessary energy to follow through with the task.

**HYPERLINKS**

Bi-polar disorder, How to recognize the symptoms of bipolar disorder; a short film on common, basic criteria that may lead to diagnosis of this illness
1. [http://www.youtube.com/watch?v=wWem_VOIoR](http://www.youtube.com/watch?v=wWem_VOIoR)

**Films to Augment Chapter Material**

**Mr. Deeds Goes to Town.** (1936). Classic film that first introduced someone being considered to have manic-depressiveness (bi-polar disorder)

**Ordinary People.** (1980). Film that illustrates a familys dealings with depression and suicide

**CARE PLANNING PRACTICE**

Mr. Fry is a new patient in the psychiatrist office where you have just started to work. He has been diagnosed with Bi-Polar disorder type I. The psychiatrist recently started Mr. Fry on Lamictal and a low dose of Zyprexa. Mr. Fry stops in to see you for a quick nursing med check. During the visit he says “I didn’t like the Zyprexa so much, I noticed I didn’t have as much energy on it and I didn’t get as much done so I stopped it”. His voice
is loud and his speech is pressured. His mood is euphoric. Develop a care plan for Mr. Fry using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. b. Patients receiving lithium therapy require an adequate intake of salt to prevent disrupting the fluid and electrolyte balance than may lead to increased reabsorption of the drug by the kidneys with resultant toxicity. Adequate fluid intake also is necessary to maintain fluid and electrolyte balance. The drug may be taken with food to minimize gastrointestinal upset. Frequent laboratory testing of drug levels is necessary to prevent toxicity.

2. c. A patient with suicidal thoughts is at greatest risk when going into a depression and when coming out of one. The patient now has more energy, allowing her to be able to complete the task. Thus the nurse needs to be hypervigilant with the patient and maintain close supervision. Participating in group activities may or may not be appropriate.

3. b. The best response would be to ensure that each episode is treated individually so that all options could be explored. It would be inappropriate to refuse to see the patient. The patient most likely needs support but it is inappropriate to assume that he does not have support elsewhere. The nurse needs to demonstrate empathy and rapport to develop trust with the patient.

4. Sertraline is a selective serotonin reuptake inhibitor (SSRI) and thus exerts its action selectively on serotonin. It does not affect dopamine, GABA, or norepinephrine.

5. The manic patient is experiencing grandiosity thus the statement of being able to do their taxes better than the accountant is not uncommon. These patients often feel they are able to achieve tasks that are not in their normal life experiences.

6. The more specific and the more lethal the suicidal plan places the patient at a higher the risk of committing suicide.

7. d. To facilitate the interpersonal process, the nurse needs to assess the patient’s cognitive function to ensure that he is able to participate in his care. Collaboration with mutual goal setting is essential.

8. Any underlying physical cause must first be ruled out.

9. c. Dysthymic disorder is classified as a chronic depression that is milder than a major depressive disorder. Feelings of hopelessness or helplessness may be present predisposing the patient to suicidal thinking. Delusions typically are not present for either dysthymic disorder.
KEY TERMS

Agoraphobia: fear of being in a place or situation where escape might be difficult or help unavailable in the event of a panic

Anxiety: vague feeling involving some dread, apprehension or other unknown tension.

Biofeedback: also referred to as applied psychophysiological feedback; the process of displaying involuntary or subthreshold physiological processes, usually by electronic instrumentation, and learning to voluntarily influence those processes by making changes in cognition.

Compulsions: repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

Fear: feelings consistent with panic and phobias

Flooding: technique that exposes the patient to the anxiety-provoking or feared situation all at once

Hysteria: Greek for uterus used to describe anxiety and anxiety related disorders specifically in women in the 17th and 18th centuries

Obsessions: recurrent and persistent thoughts, impulses, or images experienced, at some time during the disturbance; intrusive and inappropriate, causing marked anxiety or distress

Panic disorder: individual experiences intense fear accompanied by physical symptoms such as chest pain, heart palpitations, dizziness, shortness of breath, and abdominal distress; possible inability to cooperate or collaborate with the nurse.

Phobia: intense fear about certain objects or situations

Systematic desensitization: process in which a subject is gradually introduced to the source of the fear or anxiety, over the course of time under controlled conditions.

Worry: term more indicative of symptoms such as anxious misery, apprehensive expectations, and obsessions.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define anxiety.
2. Identify the disorders classified as anxiety disorders.
3. Describe the historical perspectives and epidemiology associated with anxiety disorders.
4. Discuss current scientific theories related to the etiology of anxiety disorders, including relevant psycho-
dynamic and neurobiological influences.

5. Distinguish among the diagnostic criteria for anxiety disorders as outlined in the Diagnostic and Statistical

6. Explain the various treatment options available for anxiety disorders.

7. Apply the nursing process from an Interpersonal Perspective to the care of patients with anxiety
 disorders.

**NEED TO KNOW**

1. Anxiety is a vague feeling of discomfort. It can be a healthy response leading an individual to become
 more focused and able to cope with threatening situations, or it can become pathological and interfere
 with a person's ability to function.

2. Historically, terms such as hysteria, anxiety neurosis, and shell shock were used to identify anxiety
 disorders.

3. Anxiety disorders, the most common and most costly psychiatric diagnosis in the United States, com-
 monly occur with other conditions such as substance abuse and depression.

4. Anxiety disorders occur more commonly in women than in men and can contribute to illness and death
 through effects on the endocrine, immune, and nervous system.

5. Although panic disorder can occur spontaneously, it typically results after frightening experiences or
 prolonged stress. Patients with OCD use obsessions and compulsions to relieve anxiety. Patients with
 PTSD experience flashbacks and change behavior in an effort to avoid stimuli associated with a previous
 trauma.

6. Peplau identified four categories of anxiety: mild, moderate, severe, and panic.

7. Specific brain structures such as the amygdala and neurotransmitters such as GABA, norepinephrine, and
 serotonin have been associated with anxiety disorders. GABA is the primary neurotransmitter involved.

8. Various groups of medications can be used to treat anxiety disorders. SSRIs and SNRIs are the primary
 agents used. Benzodiazepines also may be used in conjunction with these agents.

9. Two herbal preparations are commonly used for self-medication with anxiety disorders. These include
 kava kava and valerian. Further research is needed to determine their effectiveness.

10. Although neurosurgery may be performed to treat OCD, deep brain stimulation (DBS), initially used for
 treating Parkinson's disease, is showing positive results for treating severe OCD.

11. Cognitive behavioral therapy requires that a patient focuses on the present and examines problem beliefs
 and thought patterns. The patient then learns through education, self-monitoring, and cognitive restruc-
turing how to replace these problematic thought patterns with more rational and realistic views.

12. Exposure therapy can occur in real situations (in vivo exposure) or through the imagination (imaginal
 exposure).

13. Patients with anxiety disorders can learn techniques such as abdominal breathing, progressive muscle
 relaxation, and guided imagery and can use exercise, music, and diet to assist in reducing anxiety.

14. Nurses need to be self-aware of feelings related to anxiety disorders and how they display anxiety during
 their interactions with patients to prevent adding to the patient's already heightened state.

15. Patients experiencing anxiety demonstrate physical, psychological, and social symptoms. The nurse needs
 to be vigilant in assessment because many medical conditions and medications can present with similar
 symptoms.
16. Nurses need to time and pace interventions appropriately based on the level of the patient’s anxiety to ensure that the most appropriate interventions are being used at the appropriate time.

**HYPERLINKS**

*Panic attack*, dealing with anxiety and panic attacks. A short film on what it’s like to experience a panic attack.

1. [http://www.youtube.com/watch?v=32K-rEIbBgE](http://www.youtube.com/watch?v=32K-rEIbBgE)

**Films to Augment Chapter Material**

*Vertigo. (1958).* Classic Hitchcock film dealing anxiety/panic disorder

*As Good as It Gets. (1997).* Film deals with main character struggling with obsessive-compulsive disorder

**CARE PLANNING PRACTICE**

Mr. Bower is admitted to a medical unit for severe lower back pain of unknown origin. A regimen of pain meds (vicoden) to help with pain is implemented and a CAT scan of the lower back is ordered to determine the cause. Knowing Mr. Bower’s mental health history and taking into account what lies ahead treatment wise, develop a care plan for Mr. Bower using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. Hypervigilance is best exemplified by the patient’s statement about always having to watch his back. This shows that the patient is constantly on the alert. The statements about trouble sleeping at night, being irritable and angry or not being able to relax are general statements that could indicate multiple issues or problems.

2. Compulsions are repetitive behaviors or mental acts, such as repeatedly washing one’s hands, touching a door know three times before leaving, or walking in a specific pattern. Hearing voices would be identified as an auditory hallucination.

3. d. The patient’s statement and symptoms suggest a specific phobia. He states clearly that he is afraid of needles and the anticipation of having laboratory testing sets off an anxiety reaction. A generalized anxiety disorder is reflected by excessive anxiety and worry occurring for more days than not for at least 6 months. There is no evidence to support the patient’s exposure to a traumatic event; therefore posttraumatic stress disorder would not be indicated. Acute stress disorder involves dissociative symptoms which are not evident here.

4. Venlafaxine is a SNRI. Escitalopram, fluoxetine, and sertraline are examples of SSRIs. Aprazolam, clonazepam, diazepam, and lorazepam are examples of benzodiazipines. Aripiprazole and onlanzipine are examples of atypical antipsychotics.

5. a. GABA is the main neurotransmitter involved in the anxiety response. It is an inhibitory neurotransmitter that plays a regulatory role in reducing the activity of many neurons, acting as the primary calming or peacemaker chemical. Serotonin and norepinephrine are also implicated in anxiety disorders but they are not considered the primary neurotransmitter involved. Dopamine is associated with psychotic disorders.

6. b. The patient is undergoing systematic desensitization, a type of imaginal exposure where the patient is asked to imagine certain aspects of the feared object or situation combined with relaxation. Flooding or
Implosion therapy is a technique that exposes the patient to the anxiety-provoking or feared situation all at once. In-vivo exposure is exposure treatment carried out in a real situation.

**HOW WOULD YOU RESPOND CASE REVIEW QUESTIONS**

1. Based on this presentation, Mr. Bower is experiencing symptoms of what anxiety disorder?
   a. Obsessive-Compulsive Disorder
   b. Generalized Anxiety Disorder
   c. Insomnia
   d. Post Traumatic Stress Disorder

2. What should be the next area explored in assessing Mr. Bower's current state of mind?
   a. Whether he is psychotic
   b. His nutritional status
   c. His feelings towards his family
   d. Whether he has suicidal thoughts

3. When providing medication education, what should be included? (select all that apply)
   a. a discussion about potential addiction and tolerance of Klonopin
   b. the need to take all medications with food
   c. potential side effects
   d. a discussion that medications are the only effective treatment for PTSD

4. Since Mr. Bower has refused individual psychotherapy based on not wanting to "dig up the past", what is the most appropriate response?
   a. I understand your concerns. Therapy is hard and you are not strong enough to engage in counseling.
   b. I am sure it is difficult to think about your past abuse. There are many therapies that can be done such as Cognitive Behavioral Therapy that deals with the present
   c. You are right. Talking about the past will produce more anxiety. You should consider EMDR.
   d. Individual psychotherapy is not for you. We should try to see if we can get your Klonopin increased to treat your symptoms.

5. Which of the following symptoms is most indicative hypervigilence?
   a. Insomnia
   b. Increased irritability and anger
   c. Feeling that he has to watch his back
   d. Inability to relax

6. Which of the following techniques would be appropriate during today's visit with Mr. Bower?
   a. music therapy
   b. massage
   c. systematic desensitization
   d. informational interventions

7. What is the best first approach in dealing with Mr. Bower's issue of insomnia?
   a. ask his prescriber for a sleeping pill
b. instruct him to take both doses of Klonopin at bedtime

c. discuss progressive muscle relaxation as a technique to assist in relaxing

d. encourage him to eat a large meal prior to going to sleep

8. When exploring the etiology of Mr. Bower's symptoms it is important to include which of the following (select all that apply):

a. an assessment of illicit drug and/or alcohol use

b. a review of recent physical exam, labs and test results

c. a review of socioeconomic status and ability to pay for services

d. an assessment of over the counter and herbal medication use

9. Based on Mr. Bower's diagnoses, which neurotransmitters are most likely involved in his symptoms (select all that apply):

a. melatonin

b. serotonin

c. gamma-amino-butyric acid (GABA)

d. galantamine

10. Which part of the brain is most likely involved in Mr. Bower's symptoms:

a. pineal gland

b. amygdale

c. cerebellum

d. cerebrum

HOW WOULD YOU RESPOND CASE REVIEW ANSWERS

1. Post Traumatic Stress Disorder*

2. Whether he has suicidal thoughts *

3. a discussion about potential addiction and tolerance of Klonopin*, & potential side effects*

4. I am sure it is difficult to think about your past abuse. There are many therapies that can be done such as Cognitive Behavioral Therapy that deals with the present*

5. Feeling that he has to watch his back*

6. informational interventions*

7. discuss progressive muscle relaxation as a technique to assist in relaxing*

8. an assessment of illicit drug and/or alcohol use*, a review of recent physical exam, labs and test results*, & an assessment of over the counter and herbal medication use*

9. serotonin*, gamma-amino-butyric acid (GABA)*, & galantamine*

10. amygdale*
KEY TERMS

Cognitive restructuring techniques: strategy that helps a person recognize how his or her thoughts and feelings are contributing to the behavior and then assists the patient in reshaping this thinking to result in more appropriate behaviors and emotions.

Confrontation: technique used to help the patient take note of a behavior and examine it.

Dialectical behavior therapy (DBT): cognitive-behavioral therapy which helps individuals take responsibility for their own behavior and problems; teaches individuals how to cope with conflict, negative feelings, and impulsivity, thereby enhancing the patient's capabilities and improving his or her motivation, which leads to a decrease in dysfunctional behavior.

Limit setting: specific parameters for what a person can and cannot do.

Magical thinking: belief that thoughts are all-powerful.

Personality: who a person is and how that person behaves; influences individual's thoughts, feelings, attitudes, values, motivations, and behaviors.

Personality disorders: a long term maladaptive way of thinking and behaving that is ingrained and inflexible.

Personality traits: distinct set of qualities demonstrated over an extended period of time that characterize an individual.

Splitting: individual tends to view reality in polarized categories.

Time out: a situation in which the nurse allows the patient to get away from the area and go to a safe, non-stimulating place to regain emotional control.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define personality.
2. Describe personality traits.
3. Identify the major personality disorders, including common components.
4. Describe the historical and epidemiologic perspectives related to personality disorders.
5. Distinguish among the characteristic behaviors for Clusters A, B, and C based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).
6. Discuss the behaviors of individuals with different types of personality disorders.
7. Explain current psychosocial and biologic theories related to the etiology personality disorders.
8. Apply the nursing process from an interpersonal perspective to the care of patients with personality disorders.

NEED TO KNOW

1. Personality disorders are not synonymous with personality traits. A personality disorder occurs when personality traits become maladaptive, rigid, and persistent such that the person experiences distress or impaired functioning.
2. Currently there are 10 specific personality disorders, all of which are classified as a separate axis in the DSM-IV-TR.
3. Personality disorders often occur along with another major mental disorder. They are also associated with alcoholism. Violence or violent acts are linked to the development of antisocial and borderline personality disorders.
4. Cluster A personality disorders include paranoid, schizoid, and schizotypal personality disorders characterized by odd or eccentric behavior. Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders characterized by dramatic, emotional, or erratic behavior. Cluster C personality disorders include avoidant, dependent, and obsessive-compulsive personality disorders characterized by anxious or fearful behavior.
5. Psychodynamic theories related to the etiology of personality disorders focus on an individual becoming fixated in a specific phase of psychosexual development, and thus are unable to advance to the next phase.
6. Genetics, a smaller-sized limbic system, and decreased levels of a metabolite of serotonin are being linked to the development of personality disorders.
7. Cognitive behavioral therapy (CBT) helps patients with personality disorders focus on their distorted patterns of thinking. Dialectical behavior therapy (DBT) focuses on helping individuals cope with conflict, negative feelings, and impulsivity.
8. Psychopharmacology as a treatment strategy for personality disorders treats the symptoms of the disorder but not the maladaptive personality traits.
9. Establishing a therapeutic relationship with a patient diagnosed with a personality disorder can be difficult because the patient can exhibit intense feelings that evoke strong emotions in the nurse. Nurses need to be self-aware and cognizant of these responses to prevent them from interfering with the therapeutic relationship and the therapeutic use of self.
10. A common priority nursing diagnosis for a patient with a personality disorder is risk for self-directed or other-directed violence.
11. Establishment of boundaries, time out, and limit setting are effective interventions for patients diagnosed with antisocial or borderline personality disorders.

HYPERLINKS

Borderline personality disorder. A client with borderline personality disorder is interviewed. Diagnostic criteria is discussed.
1. http://www.youtube.com/watch?v=eOphgCJX1FY
Films to Augment Chapter Material

Girl Interrupted. (1999). Film deals with a girl's struggle with borderline personality disorder

CARE PLANNING PRACTICE

You are working in the an ER one night and Dave is brought in for treatment after getting into a violent fight at a local bar. He has several lacerations on his face and hands. He appears to also be intoxicated. The attending needs to get an x-ray of the face and jaw as well as obtain a urin drug tox screen and a blood alcohol level. You remember Dave from his recent stay on the mental health unit. Develop a care plan for Dave using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

ANSWERS TO NCLEX PREP QUESTIONS

1. b, d. Cluster A disorders include paranoid, schizoid, and schizotypal personality disorders. Borderline, narcissistic, and antisocial personality disorders are classified as Cluster B disorders. Avoidant personality disorder is classified as a Cluster C disorder.

2. b. With a borderline personality disorder, the patient is impulsive and makes frenzied attempts to prevent genuine or imagined abandonment. Demonstrating behaviors to get attention would be associated with a histrionic personality disorder. Involvement with law enforcement is commonly linked to antisocial personality disorder. An extreme suspiciousness of others suggests a paranoid personality disorder.

3. a. Time out refers to a technique in which the nurse allows the patient to get away from the area and go to a safe, non-stimulating place to regain emotional control. Limit setting identifies for the patient what he or she can or cannot do. Confrontation helps a patient take note of a behavior and examine it. Cognitive restructuring involves having a patient recognize how his or her thoughts and feelings are contributing to the behavior and then assisting the patient to reshape his or her thinking in more appropriate ways.

4. c. The most appropriate intervention would be to confront the patient about his behavior to help the patient identify the behavior and examine it. Telling the patient's primary nurse or obtaining an order for an antipsychotic agent would be inappropriate. The patient with an antisocial personality disorder has a pervasive disregard for the rights of others and such encouraging him to discuss his feelings would be ineffective.

5. d. For a patient with schizotypal personality disorder, nursing interventions would be directed at improving self-care skills, improving community functioning, and improving social skills because the patient has difficulty forming close relationships. Boundary setting and problem solving techniques would be appropriate for a patient with antisocial personality disorder. Fostering decision making skills would be appropriate for a patient with avoidant, dependent, or obsessive-compulsive personality disorder.

6. A patient with an obsessive-compulsive personality disorder demonstrates a preoccupation with details, rules, lists, order, organization or schedules. Suspiciousness of others is associated with a paranoid personality disorder. An exaggerated sense of self-importance reflects a narcissistic personality disorder. An unwillingness to get involved with others suggests an avoidant personality disorder.

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. The nurse doing the initial nursing assessment with Dave would expect to find what common psychosocial assessment finding:
   a. Impulsivity, need for immediate gratification
   b. Fear of abandonment
c. Perfectionism, rigidity

2. Which nursing diagnosis is appropriate for Dave?
   a. Risk for self-directed violence related to unpredictable and erratic behavior as evidence by impulsivity
   b. Risk for other-directed violence related to pervasive disregard for the rights of others related to absence of empathy
   c. Chronic low self esteem related to identity disturbance as evidenced by fear of abandonment
   d. Impaired social interaction related to rigid perfectionism as evidenced by preoccupation with rules, details

3. Which nursing outcome would be appropriate for Dave? Client will:
   a. Refrain from injuring self
   b. Demonstrate reality-based thoughts
   c. Demonstrate self restraint with others
   d. Verbalize positive statements about self and life

4. Which nursing intervention is the first priority with Dave?
   a. Encourage client to keep a diary or log of his rituals
   b. Identify a specific social skill that will be the focus of training
   c. Interrupt paranoid thinking by changing the subject or responding to the feeling rather than the content
   d. Develop rapport and trust

5. Given Dave's recent aggressive behavior on the unit, which intervention would be most appropriate?
   a. Be alert for possible trigger or factors that may precipitate anger
   b. Encourage verbalization of feelings and fears
   c. Attempt to determine the content of hallucinations
   d. Provide simple tasks and activities that he can realistically complete

6. Dave will need to learn appropriate outlets for his anger and tension. The nurse will know more teaching is necessary when Dave says:
   a. “Just put me in restraints if I get out of control.”
   b. “I will practice my deep breathing to help calm me.”
   c. “Taking time-outs from stressful situations may help me regain control.”
   d. “If the other interventions aren't working I can take a PRN medication as ordered by my nurse practitioner.”

7. Dave is observed taking other client’s belongings. Which initial nursing intervention is appropriate?
   a. Tell the client’s primary nurse what happened
   b. Obtain an order for tranquillizing medications
   c. Confront the client about the behavior
   d. Encourage discussion of angry feelings

8. Dave demands at 2 AM to speak with the nurse practitioner about his treatment plan. Which nursing statement is therapeutic?
   a. “Please be quiet and go back to bed. You are waking the other clients.”
   b. “I can give you medication to help your anxiety.”
c. “I can see that you are angry. However, this is not an appropriate time to address your issues.”

d. “I will try to page her for you.”

9. The nurse meets with Dave’s family. Which of the following statements by the family indicate that education has been effective?

a. “This is a long term problem and change will be slow.”

b. “I am so happy that there is a medication for personality disorders.”

c. “I feel bad that our family life has caused his problems.”

d. “We could not have avoided this from developing as it directly caused by his genetic make-up.”

10. Problem solving will be a useful intervention for Dave. The nurse will know that the client requires more teaching based on which of the client’s following statements:

a. “The first step for me will be to figure out what the problem is.”

b. “I will try not to focus on the consequences as that is negative.”

c. “I will try to come up with alternative ways to deal with situations.”

d. “I will evaluate how I did with my new way of coping.”

HOW WOULD YOU RESPOND CASE STUDY ANSWERS

1. Impulsivity, need for immediate gratification*

2. Risk for other-directed violence related to pervasive disregard for the rights of others related to absence of empathy*

3. Demonstrate self restraint with others*

4. Develop rapport and trust*

5. Be alert for possible trigger or factors that may precipitate anger*

6. “Just put me in restraints if I get out of control.”*

7. Confront the client about the behavior*

8. “I can see that you are angry. However, this is not an appropriate time to address your issues.”*

9. “This is a long term problem and change will be slow.”*

10. “I will try not to focus on the consequences as that is negative.”*
KEY TERMS

Abuse: the initial stage where the individual may have recurrent substance use that leads to failure to meet obligations, puts the individual in hazardous situations, causes legal problems or results in social, interpersonal or professional problem

Addiction: chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences

Dependency: the final stage and refers to a maladaptive pattern of behavior characterized by progression, tolerance, withdrawal, preoccupation with the behavior regardless of any consequences, and has the potential to be fatal


Intoxication: reversible substance-specific syndrome with central nervous system response and related behavioral and psychological changes after exposure or ingestion of a substance

Substance abuse: recurrent substance use that leads to failure to meet obligations, puts the individual in hazardous situations, causes legal problems or results in social, interpersonal or professional problems

Substance dependence: maladaptive pattern of behavior characterized by progression, tolerance, withdrawal, preoccupation with the behavior regardless of any consequences, and has the potential to be fatal

Tolerance: need for markedly increased amounts of substance to achieve effect or markedly diminished effect with continued use of same amount

Withdrawal: substance-specific syndrome with significant physical and psychological distress and impairment in areas of functioning that occurs after reducing or stopping heavy and prolonged use of the substance

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define addiction.
2. Describe the historical perspective and epidemiology of addictive disorders.
3. Distinguish among the characteristic behaviors for disorders involving addiction based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR).
4. Discuss current theories of addiction and other problems related to substance use.
5. Explain the various treatment options available for addiction disorders, including evidence-based strategies.

6. Apply the nursing process from an interpersonal perspective to the care of patients with anxiety disorder.

**NEED TO KNOW**

1. Compulsive drug seeking and use that leads to harmful consequences is termed addiction.

2. Addiction is a disease affecting the brain and its chemistry. Both substances and behavioral or process addictions activate the same neurotransmitters and use the same reward pathways.

3. The *DSM-IV-TR* classifies substance disorders as substance use and substance-induced disorders. Substance use disorders are further classified as substance abuse and substance dependence. Substance-induced disorders are further classified as substance intoxication and substance withdrawal.

4. Psychological, environmental, and neurobiological influences and shared experiences play a role in whether or not a person develops an addiction.

5. Alcoholics Anonymous is the oldest and most notable of the 12-step programs. Confidentiality, anonymity, and a desire to remain sober are key components of AA.

6. Numerous medications are used to treat addiction. Some medications are used to control the symptoms that occur during detoxification and withdrawal. Other medications are used to promote continued abstinence.

7. During assessment, the nurse must be ever vigilant in monitoring him- or herself for conflicts and countertransference. The nurse also uses active listening to gain an understanding of the patient’s experience.

8. The nurse uses reliable and validated screening tools to provide for early detection of substance disorders.

9. Although nursing diagnoses may vary, a common nursing diagnosis for a patient with addiction is defensive coping.

10. Detoxification involves evaluation, stabilization, and entry into treatment.

**HYPERLINKS**

*Cocain, A teenager discusses his struggles with cocain addiction.*

1. [http://www.youtube.com/watch?v=hwweEf_Okx](http://www.youtube.com/watch?v=hwweEf_Okx)

**Films to Augment Chapter Material**

*Clean and Sober. (1988).* Film deals with main charachter coming to terms with his addiction and subsequent recovery.

**CARE PLANNING PRACTICE**

Mr. Smith is a long standing patient at the doctors office where you are working. His wife has called in several times recently to reports that “he’s drinking again, please tell the doctor to do something about it”. Mr. Smith comes in for his regular blood pressure check up one afternoon and you detect a faint odor of alcohol on his breath. His blood pressure is in normal limits and he says he’s having no problems with his medicin. You ask him about his alcohol intake and he laughs and says, “I hardly drink at all”. Develop a care plan for Mr. Smith using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.
ANSWERS TO NCLEX PREP QUESTIONS

1. a. Substance use disorders include substance abuse and substance dependence. Substance-induced disorder is one of the two major categories of addictive disorders based on the DSM-IV-TR and this category include substance intoxication and substance withdrawal.

2. b. With Alcoholics Anonymous (AA), a 12-step program, everyone is welcome and all that is needed is a desire to quit drinking. Using the support of other members and the 12 steps, individuals learn how to be sober one day at a time. Sponsors serve as the guide to the person completing the tasks associated with the 12 steps. Sponsors are not selected by the group leader but rather by the participant.

3. c. Clonidine most likely would be used to control hypertension due to heroin withdrawal. Phenobarbital and diazepam would be used to treat seizures associated with alcohol withdrawal. Acamprosate is used to manage alcohol cravings.

4. b. Cognitive behavior therapy addresses thinking patterns and assists patients to identify potentially flawed core beliefs, identify dysfunctional thought processes and redirect them. Motivational enhancement therapy involves the process of change from use/abuse behavior to abstinence. Mindfulness and meditation focus on learning to be present. Community reinforcement focuses on reactivating or establishing supportive relationships, employment, and educational activities.

5. b, c, d. With a blood alcohol level between 101 to 200 mg percent, signs of withdrawal would include obvious trembling of the hands and arms, increased pulse rate (greater than 100 beats per minute), hypy or sensitivity to noise and light, brief auditory and visual hallucinations, and fever greater than 101 degrees F. Restlessness is noted during withdrawal for a blood alcohol level between 20 to 100 mg percent. Seizures occur with withdrawal when blood alcohol level is between 201 to 300 mg percent.

6. b. Oxycodone is an opioid. Pinpoint pupils would suggest opioid intoxication. Tachycardia, rhinorrhea, and gooseflesh are signs of opioid withdrawal.

7. a. The statement about drinking when stressed supports the nursing diagnosis of defensive coping where the patient is denying the problem with alcohol. The statement about losing his job would support a nursing diagnosis of ineffective role performance. The statement about not being able to do anything right and being a failure suggests a nursing diagnosis of chronic low self-esteem. The statement about the family falling apart suggests a nursing diagnosis of dysfunctional family processes.

8. c. When using the CAGE assessment tool, the nurse would first ask the patient if he or she ever felt the need to cut (C) down on drinking. Next, the nurse would ask if people annoyed (A) him or her by criticizing about the drinking. Then, the nurse would ask if the patient ever felt bad or guilty (G) drinking and finally, ask if the person ever had a drink the first thing in the morning (eye opener [E]).

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. The diagnosis of alcohol dependency is met with this individual because ________, tolerance, withdrawal and relapse are present.
   a. Desire
   b. Compulsion
   c. Craving
   d. All of the above

2. This individual is a part of the ________ individuals said to have comorbid or co-occurring disorders.
   a. Fifty two million
   b. Twenty million
3. Researcher now believe that co-occurring mental health and substance disorders are a(n) ___________.
   a. Exception
   b. Expectation
   c. Coincidence
   d. None of the above
   e. All of the above

4. The background of this individual demonstrates the presence of a shared __________ vulnerability.
   a. Neurobiological
   b. Psychological
   c. Environmental
   d. All of the above
   e. None of the above

5. Alcohol is classified as a depressant. This individual may have begun drinking because it managed her anxiety and then became dependent because she
   a. had a genetic predisposition.
   b. was bored when she retired.
   c. liked the taste.
   d. None of the above.
   e. All of the above

6. The brain responds to substances of abuse
   a. with a blockage of neurotransmitters that protects it.
   b. Neither a nor c.
   c. with a predictive pattern of neuroadaptive changes.
   d. Both a and c.
   e. By ignoring them

7. Treatment for addiction
   a. consists of taking medication that corrects the disease.
   b. is the same for everyone.
   c. has immediate results.
   d. can take a long time and requires a combination of medication and therapy.
   e. All of the above

8. Individuals with the disease of addiction experience cravings and triggers to use their substances or behaviors of abuse. This is due to
   a. the establishment of reward pathways that activate in certain situations.
   b. dopamine depletion and the attempt by the brain to attain balance.
   c. reinforcement of learned behaviors.
   d. All of the above.
   e. None of the above.
9. The plan of care is developed by the nurse and relies heavily on the _______________ that is established in the initial assessment.
   a. patient/client's history.
   b. mutually identified patient/client needs.
   c. therapeutic relationship.
   d. All of the above.
   e. None of the above

10. No plan of care is complete without taking into consideration
   a. the patient's wishes.
   b. the diagnosis based best practice evidence.
   c. the input of the multidisciplinary team.
   d. All of the above.
   e. None of the above

**HOW WOULD YOU RESPOND CASE STUDY ANSWERS**

1. Compulsion*
2. Eight million*
3. Expectation*
4. All of the above*
5. had a genetic predisposition.*
6. with a predictive pattern of neuroadaptive changes.*
7. can take a long time and requires a combination of medication and therapy.*
8. All of the above.*
9. All of the above.*
10. All of the above.*
KEY TERMS

Delirium: an acute disruption in consciousness and cognitive function

Dementia: a group of conditions that involve multiple deficits in memory and cognition

Enriched model of dementia: A model that acknowledges that the primary cause of problems for the person with dementia stems from the person's neurological impairment.

Malignant social psychology: the damaging effects of the negative attitudes and prejudices of other people on someone's personhood

Neurofibrillary tangles: are thick clots of protein which reside inside damaged neurons and are made from a protein called tau (τ).

Positive person work: means of how one could uphold the personhood of an individual with dementia

Progressively lowered stress threshold (PLST): model that proposes that a person has a stress threshold firmly established by adulthood but which can be temporarily altered during times of illness, or permanently altered during episodes of brain damage such as in dementia.

Reality orientation: technique used to improve the quality of life of confused older adults by assisting them to gain a more accurate understanding of their surroundings; people who are confused are regularly presented with information about time, place and person in an effort to orientate them to the here and now.

Reminiscence therapy: the discussion of past activities, events and experiences, with another person or group of people.

Senile dementia: memory loss as part of normal aging

Validation therapy: a popular psychosocial intervention involving the affirmation of the person's feelings, and the adoption of a non-judgemental approach on the part of the caregiver.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define cognitive disorders.
2. Identify the major cognitive disorders.
3. Describe the historical perspectives and epidemiology of cognitive disorders.
4. Discuss current scientific theories related to the etiology and pathophysiology of cognitive disorders, specifically dementia of the Alzheimer’s type.
5. Identify the diagnostic criteria for cognitive disorders.
6. Explain the pharmacological and non-pharmacological treatment options for persons with cognitive disorders.
7. Describe common assessment strategies for individuals with cognitive disorders.

8. Apply the nursing process from an interpersonal perspective to the care of patients with cognitive disorders, demonstrating an appreciation of the challenges that face family caregivers in caring for someone with Dementia.

**NEED TO KNOW**

1. **Delirium** occurs suddenly and is the result of an underlying medical condition. **Dementia** occurs gradually and involves multiple problems of memory and cognition.

2. Delirium is the most commonly occurring cognitive disorder. Dementia of the Alzheimer's type accounts for more than half of all dementias globally.

3. Although signs and symptoms may vary in patients with dementia of the Alzheimer's type, often progressive memory loss is noticed first.

4. Frontotemporal dementia is manifested by changes in behavior and language.

5. Pathologic changes involved with dementia of the Alzheimer's type include neurofibrillary tangles, beta-amyloid plaques, and apolipoprotein E. Acetylcholine deficiency, referred to as the cholinergic hypothesis, is also implicated in the etiology of dementia of the Alzheimer's type. Other neurotransmitters, such as a deficiency of serotonin and dopamine also may be involved.

6. Cholinesterase inhibitors are used to treat dementia of the Alzheimer's type. These agents do not cure the disease; rather, they are believed to slow the progression of cognitive decline.

7. Validation therapy focuses on the premise that past conflicts can be resolved by validating the person's reality.

8. Reminiscence therapy can be formal, using a structured activity, or informal, using a specific event to stimulate discussion of past events.

9. The Enriched Model of Dementia focuses on minimizing the damaging negative social and psychological environment (termed “malignant social psychology”) and maximizing the supportive aspects (termed “positive person work”).

10. A person with dementia experiences a diminished stress threshold. The PLST Model focuses on modifying the environment to reduce stress for the patient with dementia who is nearing his or her stress threshold.

11. Assessment of a patient with dementia requires patient, family, and caregiver involvement to ensure that enough information is collected to develop a complete picture of the patient's status.

12. Providing care for a family member with dementia can be highly stressful and overwhelming. Family caregivers need to receive adequate preparation and support when caring for the individual.

**HYPERLINKS**

*Alzheimers*, A nurse who is experienced in dealing with Alzheimers patients is interviewed, then two cases of individuals who have been diagnosed with Alzheimers is presented.

1. http://www.youtube.com/watch?v=ICNLwa-Q6kY
2. http://www.youtube.com/watch?v=K52tHgJICQkc
Films to Augment Chapter Material

On Golden Pond. (1981). Film that deals with an elderly man's emerging dementia and his family's struggle in coming to terms with this

CARE PLANNING PRACTICE

Mr. Fitzgerald is admitted to the day out patient surgery area for a laparoscopic procedure. He is 69 years old and is accompanied by his wife. He is very pleasant and cooperative but during the preoperative teaching you notice that he doesn't seem to be able to recall any of the information you are presenting. His wife says “his memory is really getting bad”. He then begins asking why he is there and “what's going on”? Develop a care plan for Mr. Fitzgerald using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

ANSWERS TO NCLEX PREP QUESTIONS

1. b. Delirium is a disturbance in consciousness that occurs suddenly and is usually the result of an underlying medical condition. It tends to fluctuate during the course of the day. Dementia has a gradual onset. Typically, treatment focuses on eliminating or managing the cause. Medications such as cholinesterase inhibitors are used to slow the progression of dementia, specifically, dementia of the Alzheimer's type.

2. d. Atorvastatin is a lipid lowering agent that may be used in the treatment of dementia of the Alzheimer's type because of the effect on cholesterol. Donepezil, rivastigmine, and galantamine are examples of cholinesterase inhibitors.

3. c. With frontotemporal dementia, the patient experiences behavioral changes and problems with language. However, his or her memory remains intact. Shorter life expectancy and mini-strokes are associated with dementia of the vascular type. A risk for falls due to muscle rigidity is associated with dementia with Lewy bodies.

4. b. The priority nursing diagnosis at this time would be risk for injury because the patient's behavior is impacting her safety and that of her caregiver. Although chronic confusion may be appropriate, the current situation involving the patient's safety is the priority. Deficient knowledge would be inappropriate. Although the patient's sleep pattern is disturbed, her risk for injury is the priority.

5. a. Validation therapy involves confirming the patient's or going with the patient to his or her reality. Placing cards on the bathroom and bed room doors and repeatedly telling the patient what day it is are examples of reality orientation. Having the patient discuss past events reflects reminiscence therapy.

6. c, e, f. Types of positive person work which foster a patient's personhood include: acceptance, collaboration, and recognition. Intimidation, labeling, and objectification are examples of malignant social psychology which would deny or interfere with personhood.

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. Regarding the scenario, what medical diagnosis best describes Catherine's behaviour?
   a. Depression.
   b. Dementia of the Alzheimer's type.
   c. Frontotemporal dementia.
   d. Delirium.
2. Which two of the following models/theories are useful in explaining the behaviours exhibited by Catherine?
   a. The Health Seeking Behaviour Model.
   b. The Theory of Reasoned Action.
   c. The Progressively Lowered Stress Threshold Model.
   d. The Frustration-Aggression Hypothesis.
   e. Orem’s Self Care Model.

3. Which of the following therapies could help Catherine?
   a. Cognitive behaviour therapy.
   b. Cholinesterase Inhibitors.
   c. Validation Therapy.
   d. Attending a support group for people with Dementia of the Alzheimer’s type at a local day hospital.

4. What is a priority nursing diagnosis for Catherine?
   a. Sleep pattern disturbance.
   b. Impaired communication.
   c. Chronic Confusion.
   d. Risk for self-harm.

5. What is a priority nursing diagnosis for George?
   a. Ineffective coping.
   b. Situational low self esteem.
   c. Knowledge deficit.
   d. Fatigue.

6. Which three of the following according to Kitwood, are factors associated with malignant social psychology?
   a. Mockery
   b. Surprise
   c. Intimidation
   d. Celebration
   e. Disparagement.

7. Which three of the following according to Kitwood, are factors associated with positive person work?
   a. Warmth.
   b. Empathy.
   c. Infantalisation.
   d. Empowerment.
   e. Including.

8. Identify three limitations to the use of reality orientation therapy when caring for someone such as Catherine:
   a. Can cause frustration, anger and anxiety in the person with dementia as it contradicts their perceived reality.
   b. Can make the person with dementia feel like they are being tested.
c. Can erode the person’s self esteem.
9. What is a priority intervention for Catherine?
   a. Ensure she engages in all group activities.
   b. De-stress the environment of care.
   c. Commence a programme of behaviour modification.

HOW WOULD YOU RESPOND CASE STUDY ANSWERS

1. Dementia of the Alzheimer’s type.*
2. The Progressively Lowered Stress Threshold Model.*
3. Cholinesterase Inhibitors.* & Validation Therapy.*
4. Risk for self-harm.*
5. Ineffective coping.*
7. Warmth*, Empowerment.* & Including.*
8. Can cause frustration, anger and anxiety in the person with dementia as it contradicts their perceived reality.*, Can make the person with dementia feel like they are being tested. * & Can erode the person’s self esteem.*
KEY TERMS

Impulse control disorder (ICD): characterized by the inability to control or suppress acting on an impulse that has the potential for harm to one’s self or others.

Intermittent explosive disorder (IED): failure to resist aggressive impulses leading to serious property destruction or assaults.

Kleptomania: recurrent failure to resist the impulse to steal.

Pathological gambling (PG): persistent maladaptive gambling behavior.

Pyromania: fire-setting for pleasure and gratification.

Trichotillomania (TTM): recurrent pulling out of one’s hair for pleasure or tension relief.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify the disorders that can be described as impulse control disorders.
2. Discuss the history and epidemiology of impulse control disorders.
4. Describe possible theories related to the etiology of impulse control disorders.
5. Explain various treatment options for persons experiencing impulse control disorders.
6. Discuss common assessment strategies for individuals with impulse control disorders.
7. Apply the nursing process from an interpersonal perspective to the care of patients with impulse control disorders.

NEED TO KNOW

1. Impulse control disorders are characterized by the inability to control or suppress acting on an impulse that has the potential for harm to one’s self or others.
2. Intermittent explosive disorder and pyromania are more common in males; kleptomania and trichotillomania are more common in females. Two-thirds of those with pathological gambling are male.
3. The impulse response follows a predictable pattern: an increase in stress followed by an increase in arousal, which leads to the act and subsequent experience of pleasure, gratification, and release of tension followed by feelings of regret, self-reproach, or guilt.
4. Alterations in neurotransmitter levels, such as serotonin, are associated with the etiology of impulse control disorders.
5. SSRIs are commonly used to treat impulse control disorders
6. A common priority nursing diagnosis for a patient with an impulse control disorder is risk for other-directed violence.

HYPERLINKS

Intermittent explosive disorder, A short film describing intermittent explosive disorder and how it is diagnosed.
1. http://www.youtube.com/watch?v=zs0ltqR3dY

Films to Augment Chapter Material

One Last Ride. (2005). Film regarding one's mans struggle with a gambling addiction

CARE PLANNING PRACTICE

Stella is a 19 year old female college freshman. She has been court ordered into treatment due to shoplifting. You are the nurse working at the clinic and perform an intake on her. She shares with you during the assessment that she first started stealing when she was 9 “on a dare’ and she felt such “a rush” when she did it and got away with it that she has been unable to stop since then. Only recently has she started getting caught. She is at risk of being expelled from college and losing her job. Develop a care plan for Stella using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

ANSWERS TO NCLEX PREP QUESTIONS

1. a. The impulse response arises from an increase in tension that leads to heightened arousal and commission of the act. Immediately following the act, the person experiences a sense of pleasure, gratification, and tension relief. Afterwards, the person experiences regret, self-reproach or guilt.
2. Trichotillomania is characterized by recurrent pulling out of one’s hair. Pyromania is associated with fire setting. Kleptomania is associated with stealing. Intermittent explosive disorder is characterized by aggressive actions often resulting in serious property destruction or assaults.
3. d. With kleptomania, the person steals objects that are not required for personal use or to fulfill a monetary need.
4. a, b, d, e. The patient statements about going back to get even, using increasing amounts to gamble, focusing on hitting the jackpot again, and lying to his wife all support the diagnostic criteria for pathological gambling. An occasional bet of $5 does not meet the diagnostic criteria.
5. c. Intermittent explosive disorder, by its definition, results in serious assaultive acts leading to injury. Fear of discovery which can lead to ineffective health maintenance is associated with trichotillomania. Intermittent explosive disorder is not due to the physiological effects of a substance.

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. In the case just described, which diagnosis best describes Tonya?
   a. OCD
1. What are two possible therapies that could be helpful for Tonya?
   a. Treat with a SSRI
   b. Teach relaxation techniques
   c. Give 10 mg Valium q.i.d.
   d. Hypnosis
2. What is the priority nursing diagnosis for Tonya?
   a. Knowledge deficit = - R/T medication side effects
   b. Potential Injury – Others directed
3. What is a priority intervention for Tonya?
   a. Safety for Tonya & Others
   b. Work on relaxation techniques
   c. Continue to encourage healthy communication
4. What makes Tonya’s Diagnosis IED and not another axis 1 diagnosis? _______________
   _______________
5. _______________ 9. _______________
   a. Behavior is planned and she is able to stop if she desires.
   b. Failure to resist the impulse to act.
   c. Increased tension or arousal before committing the act.
   d. Often experience pleasure, a sense of gratification or release at the time of the commission of
      the act.
   e. Medications have not been shown to be effective.
6. ______________
   ______________
7. ______________
   a. Anger Management
   b. Relaxation Techniques (meditation, physical/ exercise)
   c. Cognitive restructuring (time-out)
   d. Yoga
8. ______________
   ______________
   a. Encourage exercise and healthy diet
   b. Re-explain potential SSRI medication side effects.
   c. Monitor her weight gain and if trend continues beyond 6 weeks encourage discussion with her pre-
      scriber about alternative medication.
HOW WOULD YOU RESPOND CASE STUDY ANSWERS

1. IED
2. Treat with a SSRI & Teach relaxation techniques
3. Potential Injury – Others directed
4. Safety for Tonya & Others
5. Failure to resist the impulse to act.
6. Increased tension or arousal before committing the act.
7. Often experience pleasure, a sense of gratification or release at the time of the commission of the act.
8. Relaxation Techniques (meditation, physical/ exercise)
9. Cognitive restructuring (time-out)
10. Encouraging exercise and healthy diet, re-explaining potential SSRI medication side effects, & monitoring her weight gain and if trend continues beyond 6 weeks encourage discussion with her prescriber about alternative medications are all appropriate nursing interventions.
KEY TERMS

Chemical castration: a hormone medication, which reduces testosterone and therefore sexual urges

Human sexuality: how people experience themselves as sexual beings

Paraphilias: sexual disorders; recurrent, intense sexual urges, fantasies, or behaviors involving unusual objects, activities or situations

Sensate focus: therapy involving a progression of sexual intimacy typically over the course of several weeks, eventually leading to penetration and orgasm

Sexual disorders: also called paraphilias; recurrent, intense sexual urges, fantasies, or behaviors involving unusual objects, activities or situations

Sexual dysfunctions: conditions characterized by a disturbance in the processes involved in the sexual response cycle

Sexual functioning: the actual act of then expressing yourself sexually either for pleasure or for reproductive purposes with others.

Sexual health promotion: nurses provide care for the young as well as the old and need to be comfortable in incorporating sexual health assessments and development of a treatment plan

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define sexuality.
2. Differentiate between a sexual dysfunction and sexual disorder.
3. Discuss the history and epidemiology of sexual disorders and dysfunctions.
4. Identify diagnoses that constitute a sexual disorder. Identify diagnoses that constitute a sexual dysfunction.
5. Describe the major diagnostic criteria for sexual disorders and dysfunctions.
6. Discuss possible theories related to the etiology of sexual disorders and dysfunction.
7. Explain the various treatment options available for persons experiencing sexual disorders and dysfunctions.
8. Discuss the common assessment strategies for individuals with sexual disorders and dysfunctions, identifying the importance of assessing sexual functioning as part of the nursing assessment.
9. Describe the role of the nurse in promoting sexual health for patients.

10. Apply the nursing process from an interpersonal perspective to the care of patients with sexual disorders and dysfunctions, with an emphasis on boundary management when dealing with sexual health promotion of patients.

**NEED TO KNOW**

1. Difficulties with sexual functioning typically are classified as sexual disorders or sexual dysfunctions. Sexual disorders involve intense sexual urges, fantasies, or behaviors, whereas sexual dysfunctions involve disruptions in the sexual response cycle.

2. Sexuality is viewed on a continuum from exclusively heterosexual to exclusively homosexual.

3. Sexual problems occur in approximately 31% of men and 43% of women.

4. Emotional stressors, such as anxiety or depression, medical illnesses, and medications that alter the brain's chemistry, have been linked to development of sexual disorders and dysfunctions.

5. Nurses need to be aware of the messages they are sending—verbally and nonverbally—when assessing patients about their sexual functioning.

6. The nurse needs to obtain permission from the patient before proceeding with an assessment of sexual functioning.

7. Psychoeducation and acting as a patient advocate are two key nursing interventions for patients with sexual dysfunction.

**HYPERLINKS**

*Compulsive sexual behavior*, How to know if you’re a sex addict is a brief film describing warning signs of this compulsive problem.

1. [http://www.youtube.com/watch?v=-s0cAPXoPRk&feature=fvwrel](http://www.youtube.com/watch?v=-s0cAPXoPRk&feature=fvwrel)

**Films to Augment Chapter Material**


*Kinsey*. (2004). Biographical film about the legendary sex researcher

**CARE PLANNING PRACTICE**

You are assigned to a local OB/GYN practice as part of your clinical rotation. You have the opportunity to assess a 24 year old female client who is there for her first visit. During the assessment she reports to you that she is not sexually active because she is not married and because of her religious beliefs. The only reason she is there today is because her internist insisted she come for an evaluation due to constant menstrual irregularity. She reveals that she never looks at herself nude in the mirror, she does not perform self breast exams and she wears sanitary pads rather than tampax because “sticking things up there is nasty”. She is visibly uncomfortable regarding the pending pelvic exam. Develop a care plan for her using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.
ANSWERS TO NCLEX PREP QUESTIONS

1. b. Dypareunia is characterized by recurrent or persistent genital pain usually with sexual intercourse. Female sexual arousal disorder is characterized by an inability to attain or maintain until completion of sexual activity adequate lubrication in response to sexual excitement. Hypoactive sexual desire disorder is characterized by deficient or absent sexual fantasies and desire for sexual activity. Sexual aversion disorder is characterized by persistent or recurring aversion or avoidance of sexual activity.

d. After determining that it is appropriate to move on to assessing a patient's sexual history, the nurse must first obtain the patient's permission to do so. The nurse would have already determined the need for privacy before asking permission to question him about his sexual history. Making sure that the patient and nurse are alone may not be appropriate. The patient's partner or family members may need to be present depending on the patient's preference and his ability to accurately report information. Asking the patient if he is sexually active would be an initial question once permission is obtained. During the discussion, the nurse would question the patient about any abuse.

3. b, c. Exhibitionism and pedophilia are examples of sexual disorders. Vaginismus, premature ejaculation, and male erectile disorder are examples of sexual dysfunctions.

4. a. Sexual masochism involves intense sexually aroused fantasies, urges, or behaviors in which the individual is humiliated, beaten, bound, or made to suffer in some way. Sexual sadism involves intense sexually aroused fantasies, urges, or behaviors in which the individual is sexually aroused by causing humiliation or physical suffering of another person. Frotteurism involves intense sexual arousing fantasies, urges, or behaviors in which the individual touches or rubs against a non-consenting person in a sexual manner. Fetishism involves intense sexually arousing fantasies, urges, or behaviors in which the individual uses a nonliving object in a sexual manner.

5. b, d, c, a. The classic male sexual response cycle begins with desire, followed by excitement, orgasm, and then finally, resolution.

HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. What would be the first area of interest warranting further exploration during the sexual health part of the assessment given Mr. Rittenour's history?
   a. Her change of sexual function along with her change in menstrual cycle
   b. Her troubled marriage.
   c. Her history of depression.
   d. Her suicidality.

2. What would be the next most appropriate line of questioning during this interview?
   a. Did you try artificial lubricants to ease the pain during intercourse?
   b. Did the decreased interest in sexual activity coincide with the onset of menopause and/or the starting of escitalopram (Lexapro)?
   c. Do you plan on divorcing your husband or trying to save the marriage?
   d. Were you sexually active with your husband before marriage?

3. It is possible Ms. Rittenour blames her lack of sexual desire on the troubled marriage. What question would help her explore this with you?
   a. Did your husband leave you for a younger woman?
   b. Have you thought about what you will do if the marriage ends?
c. Would you like to talk about the role sexual intimacy played in your marriage?
d. Did you ever have an affair?

4. Ms. Rittenour asks you what you would do regarding the marriage if you were in her situation. The best answer would be.
   a. I am not married so I don't know.
   b. We are not allowed to talk about our personal life with patients so I can't answer that.
   c. I would get a lawyer ASAP and find out where I stand.
   d. That is a complicated question. Are you asking because you are having trouble deciding what to do?

5. During the another part of the sexual health assessment Ms. Rittenour reveals that she was never orgasmic, even before menopause, and states she just thought “most woman aren't anyway.” The most helpful response would be.
   a. Were you sexually abused as a child?
   b. Do you think you have ever had an orgasm?
   c. You are right, that's why men like sex more than woman.
   d. I can give you a book on masturbation that will show you how to achieve orgasm.

6. When discussing practices to maintain sexual health with this patient she reports rarely performing breast exams or regular mammograms. The best next step for you would be.
   a. To assess if she understands the importance of these practices and explore why she hasn't participated in them.
   b. To make a note of this and develop a treatment plan problem around knowledge deficit related to sexual health practices.
   c. Report this to her psychiatrist as this is further evidence of her depression.
   d. Make an appointment for a mammogram to be obtained after she is discharged.

7. On the 2nd day of her stay her husband visits. You speak with her afterwards and she indicates he is willing to hold off on the divorce for now to “think about things”. She says “I'm going to work hard to win him back, you'll see”. Your best response would be.
   a. You really would want him back after what he's done to you?
   b. You see, you really weren't as depressed as you thought after all. Life is really worth living.
   c. What do your kids want you to do?
   d. Sounds as though you really want the marriage to work. What plans have he and you made to address what happened?

8. After several more days her mood seems to stabilize and the treatment team decides to discharge her to home. Given the information obtained during your time with her, it would be appropriate to suggest which referral for after discharge?
   a. Job and Family services to assess her level of employability and eligibility for benefits.
   b. The local Parents without Partners group.
   c. A therapist who specializes in couples counseling and sex therapy.
   d. The local breast cancer survivors group so that she can see the benefit of early detection from breast exams.

9. When working with this patient you at times felt yourself getting angry and frustrated with her. This seemed to occur primarily when she discussed with you she was interested in reconciling with her husband. Since
your father frequently left your mother and then would come back when you were young, you were most likely experiencing:

a. Transference
b. Countertranferance
c. Conversion reaction
d. Depersonalization

10. Mr. Rittenour stops at the nurses' station one day on the way out and asks "have they changed any of my wife's medication"? Your most appropriate answer would be;

a. That's really none of your concern, Mr. Rittenour.
b. You'll need to call the psychiatrist for that information.
c. Did your visit go well with your wife?
d. I'll need to check the chart to see if she signed a release of information allowing us to discuss her treatment with you.

**HOW WOULD YOU RESPOND CASE STUDY ANSWERS**

1. Her change of sexual function along with her change in menstrual cycle *
2. Did the decreased interest in sexual activity coincide with the onset of menopause and/or the starting of escitalopram (Lexapro)? *
3. Would you like to talk about the role sexual intimacy played in your marriage?*
4. That is a complicated question. Are you asking because you are having trouble deciding what to do?*
5. Do you think you have ever had an orgasm?*
6. To assess if she understands the importance of these practices and explore why she hasn't participated in them.*
7. Sounds as though you really want the marriage to work. What plans have he and you made to address what happened?*
8. A therapist who specializes in couples counseling and sex therapy.*
9. Countertranferance*
10. I'll need to check the chart to see if she signed a release of information allowing us to discuss her treatment with you. *
KEY TERMS

Anorexia nervosa: refusal or inability to maintain a minimally normal body weight

Binge eating disorder: characterized by episodes of binge eating [eating in a discrete period of time an amount of food that is larger than most other people would eat in a similar period under comparable circumstances]

Bulimia nervosa: repeated episodes of binge eating followed by compensatory behaviors

Eating disorder: a serious disturbance in behaviors associated with eating

Obesity: a body mass index greater than or equal to 30 (kg/m²)

Overweight: a body mass index (BMI) ≥25 (kg/m²)

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define eating disorders.
2. Discuss the history and epidemiology of eating disorders.
3. Identify the different eating disorders.
5. Discuss possible theories related to the etiology of eating disorders, differentiating the biological, sociocultural, familial influences, psychological and individual risk factors associated with these disorders.
6. Explain various treatment options for persons experiencing eating disorders.
7. Apply the nursing process from an interpersonal perspective to the care of patients with eating disorders.

NEED TO KNOW

1. Numerous factors affect an individual’s eating patterns. Eating provides nutrition but also other functions.
2. Anorexia is more commonly found in females than in males. It occurs more frequently in adolescents and young adults, usually under the age of 25 years. Bulimia, also more common in females, occurs more frequently in individuals between the ages of 14 and 40 years.
3. Anorexia is characterized by a low body weight (less than 85% of minimally normal weight for age and height), intense fear of gaining weight or becoming fat, disturbed perception of the body, and amenorrhea for at least three consecutive menstrual cycles.
4. CBT is the treatment of choice for individuals with bulimia nervosa.
5. Nurses need to perform a comprehensive physical assessment of individuals with eating disorders because acute and chronic complications can occur that can affect any body system.
6. A key component of assessment is determining how motivated the patient is to change and his or her readiness to change.
7. When implementing interventions, a strong trusting interpersonal relationship between the nurse and individual experiencing the eating disorder is necessary to ensure effective outcomes.

**HYPERLINKS**

*Anorexia*, A student's video about the illness and main diagnostic features.
1. http://www.youtube.com/watch?v=N1GOVpCfFEG

**Films to Augment Chapter Material**

*Kate's Secret*. (1986). Film about one young girl's struggle with anorexia

**CARE PLANNING PRACTICE**

Sheila Rank is a 17-year-old morbidly obese female. She has been referred to the local endocrinologist, where you are working, for evaluation. During the assessment, she breaks down crying and reveals to you that she “can't stop eating.” She describes her eating almost as an addiction, further stating she uses it to self-regulate her mood. She says when she doesn't eat certain things, such as cheeseburgers, she begins to feel anxious and depressed. When she tries to stop or goes on a diet, she gets irritable and there is much disruption in the home. Develop a care plan for Sheila using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. d. The patient's minimal acceptable weight is 125 pounds. According to the DSM-IV-TR criteria, weight loss leading to maintenance of body weight less than 85% of expected would be suggestive of anorexia nervosa. In this case, 85% of 125 pounds is 106.25 pounds. Thus a weight of 100 pounds would meet this criterion.
2. c. Bulimia nervosa is more common in females between the ages of 14 to 40, rarely occurring before the age of 13. Fasting rituals are associated with anorexia nervosa, restricting type. Binge eating disorder is associated with overweight and obesity.
3. d. Antiemetics are medications use to control vomiting and would interfere with purging behavior. Diuretics, enemas, and laxatives are commonly used for purging behaviors.
4. c. Complications associated with eating disorders include postural hypotension, decreased muscle mass and strength, cold intolerance, and bradycardia.
5. a. The statement about looking at the patient and how 'fat' she is suggests a distorted perception of herself. The statement about a menstrual cycle 6 weeks ago indicates that the patient is having menstrual cycles and thus amenorrhea is not a problem. Losing 5 lbs to fit into a prom dress does not signify a fear of gaining weight or attempts at dramatic weight loss. Swimming three times a week does not suggest excessive exercise.
HOW WOULD YOU RESPOND CASE STUDY QUESTIONS

1. What eating disorder is Ann experiencing?
   (i) AN  (ii) BN  (iii) BED
2. Which type of _____ is Ann experiencing?
   (i) Restrictive Type  (ii) Binge-eating/ purging type
3. To be diagnosed with AN the individual must be experiencing amenorrhea.
   (i) True  (ii) False
4. From the literature individuals such as Ann come from middle/ upper socio economic groups?
   (i) True  (ii) False
5. A body mass index (BDI) of ≥ 30.0 (kg/m²) indicates:
   (i) Overweight  (ii) Obesity
6. List the factors that contribute to Eating Disorders:
   (i) (ii) (iii) (iv) (v)
7. Using reflective practice helps us to evaluate nursing practice when caring for individuals with ED’s?
   (i) True  (ii) False
8. The Transtheretical model of change has how many stages of change?
   (i) 4  (ii) 5  (iii) 6  (iv) 7
9. CBT is identified as the gold standard treatment according to the NICE guidelines for BN.
   (i) True  (ii) False
10. “All or nothing thinking” is considered a cognitive distortion in ED’s?
    (i) True  (ii) False

HOW WOULD YOU RESPOND CASE STUDY ANSWERS

1. BN (Bulimia Nervosa)
2. Binge-eating/ purging type
3. True
4. True
5. Obesity
7. True
8. 5
9. True
10. True
CHAPTER 20

PSYCHOLOGICAL PROBLEMS OF PHYSICALLY ILL PERSONS

KEY TERMS

Assisted suicide: providing a person with an available means for death such as pills or weapons, with the knowledge of the person's intent to use those means to die but without acting as the direct agent for the death.

Bad news: any new information that the patient interprets as representing significant loss.

Compassion fatigue: the emotional and physical burnout that may interfere with caring.

Courageous conversations: conversations held at certain turning points so that the patient and family are able to successfully navigate the predictable and sometimes not-so-predictable pitfalls that accompany illness journeys.

Critical incident debriefing: a formally recognized program with trained staff that allows staff to vent and process feelings in a structured way after particularly stressful patient contacts.

Delirium: an acute disruption in consciousness and cognitive function.

Endorphins: chemicals in the body that are responsible for increasing the sense of well-being; potent mood elevators.

Psychoneuroimmunology: study of the connection between the immune, nervous, and endocrine systems.

Suffering: feeling of displeasure which ranges from simple transitory mental, physical, or spiritual discomfort to extreme anguish, and to those phases beyond anguish, namely, the malignant phase of despairful not caring, and the terminal phase of apathetic indifference.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Describe how mental and physical health are intertwined.
2. Define suffering.
3. Identify the key concepts of suffering.
4. Explain how compassion fatigue can impact the nurse.
5. Describe issues related to mental health that impact physically ill individuals, applying mental health care concepts to other physically ill patient populations.
6. Demonstrate understanding of the nurse's role in addressing end-of-life issues.
7. Describe the role of the mental health liaison/consultation nurse.
8. Apply the nursing process from an interpersonal perspective to a physically ill patient with mental health issues.

**NEED TO KNOW**

1. According to Travelbee, suffering must be explored as part of the nurse-patient relationship.
2. The therapeutic use of self places nurses at risk for compassion fatigue because they are directly involved in the patient's experience of suffering.
3. Adverse childhood events have been shown to lead to unhealthy lifestyle behaviors.
4. The mind-body interaction is demonstrated by research showing that stress can disrupt the functioning of the nervous, immune, and endocrine systems and with the study of complementary and alternative medicine therapies.
5. Grief and loss affect not only the patient but the family as well. Active listening skills are important to help patients and families identify their feelings and put them into words.
6. Changes in body image and the stigma attached to the change can elicit a grief response. Nurses need to help the patient reframe his or her relationship to the change.
7. Nurses need to assess a patient's pain and understand that pain is highly subjective.
8. Depression differs from grief and complicated grief. It requires active treatment, whereas grief requires facilitation and complicated grief requires intervention.
9. Nurses can use the SPIKES protocol to deliver bad news therapeutically. The SPIKES protocol addresses setting, perception, invitation, knowledge, emotions and empathy, and summary and strategy.
10. Nurses involved in end-of-life care need to be prepared to have courageous conversations about death and dying, code status, palliative care, and hospice care.
11. The therapeutic use of self is an important skill used throughout the nursing process when dealing with mental health issues in patients with physical illnesses.

**HYPERLINKS**

*Therapeutic communication in the medical surgical unit.* Brief film highlighting the importance of interpersonal relationships in the medical surgical population.
1. http://www.youtube.com/watch?v=Nipj7PwCjtC

**Films to Augment Chapter Material**

*Caring for Dying: The Art of Being Present.* (2008). Film that discusses the complex art of caring for a terminally ill person.

**CARE PLANNING PRACTICE**

While working in the ER one eve you participate in the care of a patient who was brought in from an industrial accident. He was working maintenance at a local factory when one of the boilers exploded severely scalding his face and damaging his eyes. He is conscious and his pain is presently being managed well. The specialist has examined him and decided to take him to surgery to try to save at least one of his eyes but the chances are slim. The patient is aware of the high probability that he will be blind. Develop a care plan for him using a diagnosis from the NANDA list in the Appendices that would best address the priority intervention.
ANSWERS TO NCLEX PREP QUESTIONS

1. c. Travelbee described suffering as ranging from a simple mental, physical or spiritual discomfort to extreme anguish. She also described phases beyond anguish such as despairful not caring and apathetic indifference. She viewed suffering as a key element in any illness and therapeutic communication as the vehicle to relieve suffering. Viktor Frankl, a key influence on Travelbee, believed that the way a person chooses to respond to his or her experience determines whether and how that person survives.

2. c, a, e, d, b. According to Bailey’s model, loss occurs. This is followed by protest, searching, despair, reorganization, and finally reinvestment.


4. d. Acupuncture is classified as an energy biofield therapy. Meditation and visualization are mind-body therapies. Aromatherapy is considered a biologically based practice.

5. b. Grief is considered a normal response, that although painful, is a healing experience. Adverse childhood events have been identified as leading to unhealthy lifestyle behaviors in adults. Psychoneuroimmunology is the study of the connection between the immune, nervous and endocrine systems based on the action of neuropeptides. Pain stimulates high levels of circulating stress hormones, most importantly cortisol, which disrupt the immune system function.
KEY TERMS

**Autism:** Literally, “living in self”; inability to relate to people and situations, and failure to learn to speak or convey meaning to others through language

**Circular reactions:** motor reflexes, such as thumb sucking and hand grasping that then develop into object manipulation that invokes a response from people or the environment (rattle shaking).

**Classical conditioning:** the learned associative behavioral stimulus-response discovered by Pavlov

**Cognitive development:** one's ability to understand the world, including interaction with stimuli and objects in the environment, social interactions related to thinking patterns, and how one receives and stores information

**Conservation:** the ability to recognize that despite something changing shape, it maintains the characteristics that make it what it is (clay)

**Echolalia:** parrot-like repetition of another's words

**Libido:** the id; driving force behind specific behavior

**Magical thinking:** belief that thoughts are all-powerful

**Object permanence:** the ability of the child to realize that an object is no longer visible despite the fact that it still exists

**Operant conditioning:** also called instrumental conditioning; differing from Pavlov's classical conditioning; addresses consequences (or responses) and the modification of future behavior based upon the (positive or negative) reinforcement, punishment or extinction associated with the consequence (response)

**Pica:** persistent eating of one or more nonnutritive substances for a period of at least one month

**Play therapy:** a method of psychotherapy that uses fantasy and symbolic meanings expressed during play as a medium for communicating and understanding a child's behavior

**Reversibility:** concept in which a child realizes that certain things can turn into other things and then back again, such as water and ice

**Symbolic play:** the child's ability to separate behaviors and objects from their actual use and instead use them for play

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Discuss the major theories related to growth and development in children.
2. Identify normative versus non-normative behavioral patterns in relation to developmental milestones.
3. Describe the major mental health disorders found in children.
4. Identify the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR)* diagnostic criteria for the major childhood mental disorders.
5. Identify the primary treatment options available for mental disorders found in children.
6. Apply the nursing process from an interpersonal perspective that addresses the developmental needs of children experiencing mental health disorders.

**NEED TO KNOW**

1. According to Piaget, a child's cognitive development occurs over four developmental stages from infancy through adolescence: sensorimotor, preoperational, concrete operational, and formal operational.
2. According to Erikson, the majority of an individual's emotional and personality development occurs during the first 20 years of that person's life. This development forms the foundation for continued development in adulthood.
3. According to Freud, if an individual does not resolve issues in an early stage, he or she becomes fixated in that stage. Fixation results in unhealthy behavior.
4. According to Sullivan, children develop a self-system from infancy through late adolescence based on their interactions with others.
5. The behavioral theories of Pavlov and Skinner form the basis for many of the therapies used for childhood disorders.
6. Genetics, environment, structural and functional alterations of the brain, and prenatal and postnatal problems have been linked to autism.
7. Asperger's disorder is similar to autism but the symptoms are less severe. Early cognitive and language skills are not significantly delayed and preoccupation with objects and rituals are less often noted.
8. Inattention and/or hyperactivity-impulsivity are characteristics of ADHD, which is not diagnosed until after the child starts school.
9. Conduct disorder involves behavior that violates the rights of others or major societal norms or rules. It typically involves aggressive behavior toward individuals or animals, property destruction, deceitfulness or lying, or serious violations of rules.
10. Oppositional defiant disorder involves negative, hostile, or defiant behavior usually noted before the child reaches 8 years of age.
11. Adjustment disorder and PTSD both result from exposure to a stressor. However, with PTSD, the stressor is extreme and traumatic.
12. Pica involves the ingestion of substances such as clay, soil, chalk, soap, flour, starch, ice cubes, or salt, none of which are considered to have any nutritional value.
13. The vomiting associated with rumination disorder is not self-inflicted and is not under the individual's voluntary control, making it different from the vomiting associated with bulimia nervosa.
14. Play therapy provides children with a means of communicating thoughts and feelings that they are unable to put into words.
15. Central nervous system stimulants are used as treatment for ADHD.
16. A thorough understanding of childhood development is necessary when conducting an assessment of a child with a mental health disorder.

**HYPERLINKS**

*Sighs of mental illness in children,* Film highlights ways to begin recognizing symptoms that may be due to mental illness in children.


**Films to Augment Chapter Material**


**ANSWERS TO NCLEX PREP QUESTIONS**

1. a. The child is demonstrating circular reaction which involves initiating behavior to produce an outcome rather than eliciting a response. Object permanence is reflected by the ability of a child to realize that an object is no longer visible despite that it still exists. Symbolic play involves the use of an object for another purpose instead of its actual use. Magical thinking results from the child's belief that a circumstance or event may be brought on by wishing for it or thinking about it.

2. d, b, f, c, e, a. According to Sullivan's theory, the developmental tasks beginning in infancy and progressing through late adolescence are as follows: oral gratification; delayed gratification; formation of peer relationships; same-sex relationships; opposite-sex relationships; and development of self-identity.


4. d. A child with conduct disorder demonstrates a repetitive and persistent pattern of behavior that violates the rights of others or society's norms. Aggression, such as bullying behaviors would be an example. Repetitive stereotypical movements may be noted with autistic disorder. Difficulty organizing tasks and lacking follow through with directions reflect ADHD.

5. b. Difficulty engaging in quiet leisure activities reflects hyperactivity which is related to ADHD. Exposure to a traumatic event would be related to PTSD. Frequent losses of temper would be associated with oppositional defiant disorder. A previous diagnosis of oppositional defiant disorder would be related to conduct disorder.

6. a. The stressor associated with adjustment disorder results in significant or behavioral symptoms. However, witnessing the death of a parent would be considered an extreme stressor that would be most commonly associated with PTSD. Stressors associated with adjustment disorder could include the moving away of a close friend, parental divorce, or bullying by a classmate.
KEY TERMS

**Binge drinking**: copious amounts of alcohol are consumed over a short period of time

**Compulsions**: repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

**Obsessions**: recurrent and persistent thoughts, impulses, or images experienced, at some time during the disturbance; intrusive and inappropriate, causing marked anxiety or distress

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Discuss the major concepts associated with adolescent development.
2. Identify normative versus non-normative behavioral patterns in terms of developmental milestones for an adolescent.
3. Describe the major areas to address when assessing an adolescent.
4. Identify the common mental health problems found in the adolescent population.
5. Apply the nursing process from an interpersonal perspective that addresses the care of adolescents with mental health problems.

NEED TO KNOW

1. The development of self-esteem and identity are important developmental tasks in adolescence. Peer relationships play a major role in achieving these tasks.
2. Assessment of an adolescent requires sensitivity and use of appropriate language to determine the adolescent's view of the problem from his or her frame of reference.
3. Adolescents often experience mental health disorders that are the same as those in adults. Depression, mania, self-harm, suicidal ideation, alcohol and drug use, eating disorders, and anxiety disorders, such as obsessive compulsive disorder, are common in adolescence.
4. An adolescent who engages in self-harm behaviors may or may not be experiencing suicidal ideation. Self-harm behaviors without suicidal intent result from a multitude of reasons and are not attempts to gain attention.
5. Typically, warning signs of suicide are present before an adolescent attempts suicide. Assessment focuses on the lethality of the method, location, motive, evidence of suicidal communication, previous attempts, and information related to a continued wish to die.
6. Alcohol is the most common mood-altering drug used by adolescents. Cannabis and amphetamines are the most common illicit substances used.

7. Social phobia can lead to the development of poor social skills and low self-esteem, thus affecting the adolescent's development.

8. Ability to interact in a group environment, suitability for a group, and level of group functioning must be considered when determining if group work would be appropriate for an adolescent.

9. Psychopharmacology is considered only as a last resort when treating adolescents because of the increased risk for suicide.

10. Therapeutic communication skills including active listening are essential to the development of the therapeutic relationship with an adolescent. The adolescent needs to be treated as an individual whose input is valued.

**HYPERLINKS**

Teenage issues, 4 part series from Dr. Phil on common concerns related to teens.

1. http://www.youtube.com/watch?v=berxf5t1H9w
2. http://www.youtube.com/watch?v=czoS-zSa5M
3. http://www.youtube.com/watch?v=635Moor7fTw
4. http://www.youtube.com/watch?v=L0l0507–1VY

**Films to Augment Chapter Material**

Secret Cutting (also known as Painful Secrets). (2000). Film that portrays a teenager's struggle with self-mutilation

**ANSWERS TO NCLEX PREP QUESTIONS**

1. b. Mental health problems that occur during adolescence can continue into adulthood if appropriate treatment is not instituted. There is a perception that time will heal mental health problems in adolescents and that they will "grow out" of the problem as they mature into adulthood. However, this is not the case. Adolescents experience similar mental health disorders as adults do. The stigma associated with mental health problems is particularly evident in adolescents as they are searching for self-identity and acceptance by their peers.

2. a. The statement about not worrying and not being around to bother anyone anymore suggests hopelessness and is a strong warning sign of suicide. The statement about the adolescent's parents requires further investigation about exactly what the patient means. The statement about finding music more relaxing and the preference for sports over school indicate an interest in something and desire to engage in life.

3. c. Alcohol is the most commonly used and abuse substance in adolescents. Cannabis and amphetamines are the most commonly used and abused illicit substances with cocaine becoming increasingly popular.

4. a, b, e. Possible triggers for self-harm behaviors include rejection by peers, substance misuse, feelings of powerlessness and worthlessness, and parental divorce.

5. a, b, c, e. When applying the therapeutic use of self with an adolescent during assessment, the nurse must be genuine, honest, respectful, empathetic, and flexible.
KEY TERMS

Activities of daily living: activities include personal hygiene, dressing, eating, mobility, and toileting.

Emotional loneliness: loneliness associated with loss of intimacy with a partner, family member, or friend who can no longer support the emotional needs of the elder

Geropsychiatry: the study of psychiatric and mental illness in the aging population

Insomnia: difficulty initiating or maintaining sleep

Loneliness: an unnoticed inability to do anything while alone

Polypharmacy: defined as the use of multiple medications beyond the clinically identified needs of the individual

Quality of life: a state of complete physical, mental, and social well-being and not the absence of disease or infirmity

Social loneliness: loneliness due to loss of contact with peers, friends or groups that have shared and supported the needs of the elderly individual.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Describe the current demographics of the elderly population.
2. Identify the impact of physical, emotional, and sociocultural issues influencing the mental health of the elderly patient.
3. Discuss the most common mental health disorders associated with the elderly.
4. Identify trends affecting mental health services provided to the elderly.
5. Apply the nursing process from an interpersonal perspective for the care of an elderly patient with a mental health disorder.

NEED TO KNOW

1. Quality of life is a key indicator of an individual’s overall health, but especially the overall health of an elderly individual.

2. Typically, physical changes in the elderly are dismissed as normal, age-related changes. However, they can significantly impact the person’s mental health, leading to social isolation, anxiety, and depression.
3. The presence of pain, its effect on functioning, and the associated treatment can predispose the elderly patient to mental health problems such as changes in cognition, mood, and sleep patterns.

4. Elderly individuals experience a wide range of losses, both physical and emotional, that can occur as single or multiple events, placing them at risk for decreased self-esteem and depression.

5. Loneliness, an individual response to unfulfilled needs for intimacy or social contacts, occurs in two forms: social loneliness, which is related to a loss of contact with peers, friends, or groups that have shared and supported the elderly individual's social needs; and emotional loneliness, which is associated with the loss of intimacy with a partner, family member, or friend who can no longer support the elderly individual's emotional needs.

6. Depression in the elderly is reaching epidemic proportions, with estimates indicating depression as the major underlying cause for the increased cost of health care in this population.

7. Treatment of generalized anxiety disorder in the elderly typically involves psychotherapy with psychopharmacology, or cognitive behavioral therapy followed by psychopharmacology if not successful.

8. Polypharmacy is a major problem with the elderly population with the use of multiple medications commonly used to treat unresolved pain, depression, or anxiety.

9. Factors influencing the elderly individual's use of mental health services in the community include: the person's belief in and desire for the services, the ability to pay for the services, the ability to physically access the services, and the availability of programs to meet the changing needs of the elderly.

10. When assessing the elderly individual, the nurse interacts with the patient on a humanistic level to promote trust and foster an atmosphere of genuine interest, acceptance, and positive regard.

**HYPERLINKS**

*Loneliness and depression in the elderly.* A series of films highlighting the issues of loneliness, depression, and suicide in the elderly.

3. http://www.youtube.com/watch?v=c_XyFGFr29c&feature=related

**Films to Augment Chapter Material**

*Harry and Tonto.* (1974). Film that follows one elderly man's life as he attempts to adjust to isolation.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. a. The patient is describing a new onset of insomnia. The patient's history reveals the addition of an antihypertensive agent which could contribute to insomnia. A history of arthritis may be a contributing factor for chronic insomnia. Eating large meals close to bedtime and not establishing a consistent bedtime can contribute to insomnia. However, the patient's large meal is consumed long before he goes to bed and he has a consistent bedtime.

2. b. Prolonged stress increases the physical and mental aging processes and has been associated with decreased immune function and altered health status. Depression and anxiety are to major mental health problems associated with increased stress.

3. a. Social loneliness is related to the loss of contact with peers, friends, or groups that have shared and supported the needs of the elderly individual. Emotional loneliness is associated with the loss of intimacy with
a partner, family member, or friend who can no longer support the emotional needs of the elder. Loss of support would be associated with emotional loneliness. Loss of independence is not associated with either social or emotional loneliness.

4. c. Based on the scenario, the patient is most likely experiencing delirium related to the abrupt onset and underlying infection and treatment such as the oxygen therapy and antibiotics which may be contributing to the patient’s changes in cognition. Dementia involves a slowly progressive change in cognitive abilities. Depression can occur rapidly however the cognitive changes are usually associated with changes in mood and the cognitive confusion is related to specific rather than global activities. General anxiety disorder is more commonly associated with physical symptoms.

5. d. Aripiprazole is an antipsychotic agent that would not be used to treat depression. Escitalopram, paroxetine, and duloxetine are approved by the Food and Drug Administration (FDA) for treating depression in the elderly.

6. b. Typically, polypharmacy is related to unresolved pain and depression or anxiety which leads the patient to go to more than one physician for more than one prescription and have the medication filled at different pharmacies. Fear typically is not involved.
KEY TERMS

Abuse: acts of commission or omission that result in harm, potential for harm, or threat of harm

Battering: striking someone repeatedly with violent blows

Domestic violence: causing or attempting to cause physical or mental harm to a family or household member; placing a family or household member in fear of physical or mental harm; causing or attempting to cause a family or household member to engage in involuntary sexual activity by force, threat of force, or duress; engaging in activity toward a family or household member that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested

Honor killings: killings based on the belief that women are the property of male relatives and embody the honor of the men to whom they “belong.”

Intimate partner violence: violence among spouses or domestic partners

Statutory rape: Sexual intercourse with an adolescent between the ages of 13 and 18

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify the various types of abuse.
2. Discuss the historical perspectives and epidemiology related to abuse.
3. Explain the psychodynamics influencing the victims as well as the abusers, across the life span.
4. Describe the signs and symptoms indicative of abuse and neglect.
5. Describe the models used to explain abuse, including the Cycle of Violence and the Power and Control Wheel.
6. Identify possible barriers faced by the nurse during the assessment process especially those related to the emotional responses that may be experienced when working with victims of abuse as well as with the abusers.
7. Describe the legal and ethical responsibilities of the nurse in reporting suspected abuse or neglect.

NEED TO KNOW

1. Abuse reflects a means for exerting power and control over another person.
2. The four types of abuse are physical, emotional or psychological, sexual, and economic (or financial) abuse.
3. Domestic abuse historically was viewed as a family problem. However, increasing public pressure has led to legislation, recognizing domestic violence as a crime.

4. Anyone can be a victim or perpetrator of abuse. However, victims most often are females and victimizers are most often males.

5. The common belief surrounding abuse is that it is a learned behavior, occurring most commonly in households where individuals have grown up being exposed to violence.

6. The cycle of violence consists of three phases: tension-building phase, acute battering (or explosive) phase, and the honeymoon (or love-contrition) phase.

7. The Power and Control Wheel emphasizes the responsibility of the individual abuser and the community for controlling the abuser.

8. Nurses typically provide care for both the victims of abuse and their victimizers. Therefore, self-awareness of feelings and responses for victims of abuse and victimizers is crucial to ensuring the development of a therapeutic relationship.

9. Nurses are legally mandated to report suspicions of child abuse, usually within 24 hours.

10. When assessing a victim of intimate partner violence, the nurse interviews the victim separately from the victimizer.

11. A nurse must never force or coerce a victim of intimate partner violence to leave an abusive relationship. This decision is entirely the victim's choice.

HYPERLINKS

Domestic violence, Two films regarding domestic violence with relevant statistics.

1. http://www.youtube.com/watch?v=rt7JZSrDJA


Films to Augment Chapter Material

The Burning Bed. (1984). Film concerns a woman's struggle in living in an abusive relationship

ANSWERS TO NCLEX PREP QUESTIONS

1. d. Abuse comes in many forms and frequently the abuser will use more than one method to achieve the goal of power and domination. Abuse occurs across all socioeconomic status, age, gender, culture, races, religion, and marital status. Most childhood victims of abuse are between the ages of 3 to 5 years. Abuse reflects behavior designed to gain or maintain power and control over another.

2. b. The statement about the spouse being sorry and not doing it again indicates the honeymoon phase where the abuser tries to make amends often promising that the violence will never happen again. The statements about walking on eggshells, not wanting to make him angry or blaming herself because dinner was late indicate the tension-building phase as the victim attempts to appease the victimizer.

3. c. Destroying property or making the victim feel afraid reflects intimidation. Calling the victim names and making the victim feel guilty reflect emotional abuse. Controlling who the victim talks to reflects isolation.

4. b, c, a, d, f, e, g. According to this model, the victimizer fantasizes and then plans the abuse. Next, the abuser will set up the scenario to perpetrate the abuse. This is followed by the actual abuse, then guilt, rationalization, and lastly a return to normal.
5. a. The nurse interviews the older adult and caregiver together to evaluate the patient-caregiver interaction which provides clues to possible issues that may lead to abuse. The patient and caregiver are interviewed separately to evaluate for inconsistencies and allow the elder patient an opportunity to discuss the possible abuse. The joint interview is not done to confirm the patient’s level of alertness or determine the need for adult protective services.

6. c. With child abuse, the perpetrator is commonly someone the child knows. Nurses and physicians are responsible for reporting suspected child abuse. Child abuse can involve physical, emotional, and/or sexual abuse. When a child fails to disclose the truth about abuse, he or she experiences revictimization.
KEY TERMS

Continuum of care: integrated system of settings, services, healthcare clinicians, and care levels spanning illness to wellness states

Forensic nursing: application of forensic science combined with the biopsychological education of registered nurse in scientific investigation, evidence collection, preservation, and analysis, and prevention and treatment of trauma and/or death related medical-legal issues.

Least restrictive environment: the safest environment with the minimum restrictions on personal liberty necessary to maintain safety of the patient and the public and to allow the patient to achieve independence in daily living as much as possible.

Telehealth: psychiatric intervention via telecommunications such as phone or video conferencing.

Therapeutic milieu: a climate and environment that is therapeutic and conducive to psychiatric healing

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Define the continuum of care.
2. Describe available treatment options and community-based resources for psychiatric-mental health patients.
3. Correlate the adequacy of care settings as they relate to patient acuity and needs.
4. Explain how the psychiatric-mental health nurse (PMHN) applies the nursing process throughout the diverse settings within continuum of care.
5. Discuss the specialized roles that PMHNs may assume within the continuum of care.

NEED TO KNOW

1. The continuum of care covers the range from illness to wellness and requires coordination of care and services for the patient to achieve optimal health.
2. Like medical emergency care, psychiatric emergency care, often involves life and death situations. The safety of the patient and those around him or her is the priority.
3. A partial hospitalization program provides a structured treatment program during the day, with the patient returning to his or her living environment at night.
4. Residential services are used for patients experiencing seriously persistent mental illness, such as persistent and unremitting psychotic or mood disorders.

5. With outpatient care, the patient's symptoms are managed as he or she is integrated back into the community.

6. Primary care is often used to treat uncomplicated cases of depression, anxiety, and substance abuse.

7. Personal care homes are most often used for patients who are elderly, have physical or mental disabilities, or cannot care for themselves but would not require medical or nursing home care.

8. Behavioral ambulatory care is classified into three levels, with Level 1 being appropriate for patients experiencing disabling to severe symptoms.

9. Telehealth includes services provided by telephone, computers, email, and interactive video sessions.

**HYPERLINKS**

Overview of different levels of mental health care. A mental health professional describes the various levels of mental health care available to consumers.

1. [http://www.youtube.com/watch?v=fG8kACiNvYI](http://www.youtube.com/watch?v=fG8kACiNvYI)

**Films to Augment Chapter Material**


A discussion of current state of affairs with regard to mental illness in the United States.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. d. Milieu is considered a service variable. Risk/dangerousness, social system support and level of functioning are patient variables.

2. b. Assertive community treatment is a level 2 ambulatory behavioral service. Partial hospitalization and day treatment programs would be level 1 services. A clubhouse program is a level 2 service.

3. a. The nurse is engaging in forensic nursing when working with incarcerated patients with psychiatric-mental health disorders. Disaster response involves working in man-made and environmental disasters such as hurricanes and earthquakes. Case management involves coordinating multiple care activities for patients to decrease fragmentation and ensure access to appropriate, individualized, and cost-effective treatment along the continuum of care. Telehealth involves using electronic means of communication to establish and maintain a therapeutic relationship with patients.

4. c. The patient is experiencing acute symptoms and is a threat to himself. Therefore emergency psychiatric care would be most appropriate. After evaluation and emergency treatment, the patient would be referred to another level of care. The level of care would be dependent on the situation. Acute inpatient care is used to stabilize symptoms and then discharge the patient to a safe and therapeutic living environment with the appropriate level of outpatient treatment. Partial hospitalization would be appropriate for a patient who requires a structured treatment program during the day but is stable enough to return to his or her living environment at night. Residential services are appropriate for patients who are seriously persistently mentally ill that require a place to stay along with supervised care over a 24-hour period.

5. b. Housing services include halfway houses, personal care homes, supervised apartments, and therapeutic foster care. Home care is a type of housing service.
KEY TERMS

Developmental disability: a diverse group of severe chronic conditions that are due to physical and/or mental impairments.

Disparity: lack of equality, usually in reference to health and health care

Forensic nursing: specialty practice that provides services to the legal and criminal system

Intellectual disability: mental retardation; term used when a person’s ability to learn at an expected level and function in daily life are limited.

Transinstitutionalization: the transfer of this care to jails and prisons where there are three times more patients with mental health problems than in mental hospitals and where one in six detainees is diagnosed with a mental illness.

Vulnerable populations: groups of individuals defined by race/ethnicity, socio-economic status

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:
1. Identify certain populations as being legally classified as vulnerable.
2. Describe the role of nurses in working with these populations.
3. Demonstrate understanding of the challenges experienced by vulnerable populations related to care access and provision.
4. Explain the specialty practice of forensic nursing.

NEED TO KNOW

1. When working with vulnerable populations, nurses function as advocates for those populations and work to ensure the safety of all involved.
2. Populations at the opposite ends of the age spectrum, that is, children and the elderly, are considered vulnerable.
3. Access to and availability of mental health services is limited for many minority groups.
4. Individuals with intellectual disabilities vary in their functional ability. Regardless of the severity of the disability, the nurse advocates for the individual and works to protect the rights of the individual.
5. Veterans account for a significant number of homeless individuals. These veterans often experience the
effects of posttraumatic stress disorder.
6. PMHNs working in correctional facilities administer psychopharmacology, engage in groups, perform
medical functions such as drawing specimens for testing, follow up with individuals with chronic illnesses,
perform treatment, and provide education.
7. Forensic nurses typically require a graduate level education and work as forensic psychiatric nurses, cor-
rectional nurses, legal nurse consultants, forensic sexual assault nursing examiners, nurse attorneys, nurse
 coroners, death investigators, and clinical nurse specialists in trauma, transplant, and emergency, and
critical care.

**HYPERLINKS**

*Mentally ill incarcerated,* Documentary regarding housing of the vulnerable mentally ill in prison systems.
1. [http://www.youtube.com/watch?v=bPUsdxMBEQ](http://www.youtube.com/watch?v=bPUsdxMBEQ)

**Films to Augment Chapter Material**

*What's Eating Gilbert Grape.* (1993). Film about trying to raise and care for a mentally ill person outside of
an institutional setting.

**ANSWERS TO NCLEX PREP QUESTIONS**

1. b. With vulnerable populations, the nurse plays a major role in advocating for the patient because they may
be unable to do so for themselves. Vulnerable populations are at an increased risk for any type of mental
health disorder, not just depression. The nurse allows vulnerable patients to what they can for themselves,
and intervenes appropriate to address the patient's limitations. Children and the elderly are both vulner-
able, each with their own risks.
2. c. African Americans tend to somaticize or manifest physical illnesses related to mental health. They are
less likely to receive diagnoses for mental illnesses, experience higher rates of suicide, and receive higher
doses of psychotropic medications.
3. b, c, d, e. Risk factors associated with suicide in the elderly include: male gender; living along; recently
widowed; multiple chronic illnesses (diabetes, arthritis and stroke); and use of multiple medications
(polypharmacy).
4. a. Nurses working in correctional institutions must be open-minded, nonjudgmental, and self aware.
Prejudice and cultural bias would interfere with the nurse-patient relationship. The nurse needs to be able
to adapt to the setting and the patient situation. Therefore the nurse needs to be flexible, not inflexible.
5. a, b, c, d, e. Factors contributing to homelessness include: foreclosures on homes; poverty eroding work
opportunities; decline in public assistance; lack of affordable housing and limited scale of housing assis-
tance programs; lack of affordable health care; and domestic violence, addiction disorders; and mental
illness.
KEY TERMS

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency or those professionals to work effectively in multicultural situations and with diverse social groups.

Cultural congruence: distance between the cultural competence characteristics of a health care organization and the patient's perception of those same competence characteristics as they relate to the patient's cultural needs.

Culture: An integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, lifestyles, and institutions of racial, ethnic, religious or social groups.

Diversity: reality created by individuals and groups from a broad spectrum of demographic and philosophical differences; narrowly, includes age, race, gender, ethnicity, religion and sexual orientation.

Enculturation: Process by which a person learns the requirements of the culture by which he or she is surrounded, and acquires values and behaviors that are appropriate or necessary in that culture.

Ethnicity: Selected cultural characteristics used to classify people into groups or categories considered to be significantly different from others.

Linguistic competence: Capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons with limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities that impair communication and comprehension.

Race: Biological characteristics and variations within humans, originally consisting of a more or less distinct population with anatomical traits that distinguish it clearly from other races.

Religiosity: Specific behavioral and social characteristics that reflect religious observance within an identified faith.

Spirituality: Cognitions, values and beliefs that address ultimate questions about the meaning of life, God and transcendence which may or may not be associated with formal religious observance.

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify the core concepts associated with culture.
2. Describe the impact of ethnic and cultural factors on the delivery of mental health care.
3. Explain the concept of spirituality as it relates to health, including mental health.
4. Integrate concepts of cultural competence into interpersonal modes of practice.
5. Demonstrate culturally sensitive and congruent care to different patient populations.

**NEED TO KNOW**

1. Ethnic, racial, cultural, and social minorities use mental health services to a lesser degree and, when used, the services tend to be poorer in quality.
2. Despite potential increased risks for emotional distress and mental illness among diverse ethnic, racial, and cultural groups, protective factors such as family, group identity, mutual support, and closely held beliefs help to reduce these risks.
3. Differences in language as well as gender roles and expectations can influence how mental health and illness are discussed and how decisions are made in this area.
4. Risk factors for mental illness in immigrant populations include: social exclusion due to low English language proficiency, decreased interaction with the new culture, culture shock, family or social isolation, employment difficulties, prejudice and discrimination, and feelings of persecution due to prior trauma.
5. Stigma is often an important barrier affecting whether an individual from another racial or ethnic group seeks mental health services.
6. Religion and spirituality can influence an individual’s coping methods, beliefs about the causes of mental illness, and how symptoms are manifested.
7. Barriers to mental health services occur at three levels: individual, environmental, and institutional.
8. Regardless of the population involved, overcoming barriers to accessing mental health care is a priority.
9. Provider and organizational cultural competence is necessary to meet the needs of the diverse populations being served.

**HYPERLINKS**

*Cultural issues in nursing.* A student video regarding incidents of “cultural crappy care” and a documentary on cultural competence of healthcare providers.

1. [http://www.youtube.com/watch?v=qDuXR-_m67o&feature=related](http://www.youtube.com/watch?v=qDuXR-_m67o&feature=related)
2. [http://www.youtube.com/watch?v=dNLtAj0wy6I&feature=related](http://www.youtube.com/watch?v=dNLtAj0wy6I&feature=related)

**Films to Augment Chapter Material**

*Worlds Apart: A Series on Cross-Cultural Health Care* - can be found at [http://www.youtube.com/watch?v=K5d_iPaUrWw](http://www.youtube.com/watch?v=K5d_iPaUrWw)

Film is about care givers awareness of the need to provide culturally competent care

**ANSWERS TO NCLEX PREP QUESTIONS**

1. c. Environmental obstacles include family and social networks, thus availability of family support would be an example. Lack of a translator would reflect an institutional barrier. Knowledge about mental health problems and beliefs that mental illness is caused by demons reflect individual barriers.
2. b. The patient is demonstrating enculturation, in which the person learns the requirements of the culture by which he or she is surrounded and acquires values and behaviors appropriate or necessary in
that culture. Ethnicity refers to the selected cultural characteristics used to classify people into groups or categories considered to be significantly different from others. Spirituality refers to specific behavioral and social characteristics that reflect religious observance within an identified faith. Spirituality refers to cognitions, values, and beliefs that address the ultimate questions about the meaning of life, God, and transcendence.

3. b. A risk factor for mental health problems related to immigration is the lack of interface with the new culture. Therefore, interaction with the new culture would not be a risk factors. Other risk factors include social isolation, feelings of persecution, and stress of acculturation.

4. d. Providing culturally competent care requires that the needs and help-seeking behaviors of the individuals and families are understood and identified; that services are tailored to meet the unique needs of those being served; that services are driven by the patient preferred choices, not by culturally blind or culturally free interventions; and delivery recognizes mental health as an integral and inseparable aspect of primary health care.

5. a. Cognitive styles reflect how individuals organize and process information. Negotiation strategies reflect what individuals accept as evidence for change. Value systems reflect the basis for behavior such as the locus of decision making and sources of anxiety and anxiety reduction.
CHAPTER 28

ETHICAL AND LEGAL PRINCIPLES

KEY TERMS

Autonomy: capacity to make decisions and act on them
Beneficence: ethical principle involving doing what is best
Competence: the degree to which a patient possesses the cognitive ability to understand and process information
Ethics: collection of philosophical principles that examine the rightness and wrongness of decisions and conduct as human beings.
Fidelity: ethical principle focusing on acting as promised
Involuntary commitment: involuntary admission; the patient admitted against his or her wishes.
Justice: ethical principle focusing on fair and equal treatment
Kantianism: ethical theory focusing on performing one's duty rather than the "rightness" or "wrongness" of the act
Nonmaleficence: ethical principle focusing on doing no harm
Seclusion: placement of the patient in a safe room alone
Self-determination: freedom to make decisions without consulting others
Utilitarianism: ethical theory in which decisions should be based on producing the best outcome or the greatest happiness for the greatest number of people.
Veracity: ethical principle focusing on honesty and truthfulness
Voluntary admission: patient agrees or consents to admission

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify ethical theories that may be used when providing care to psychiatric-mental health patients.
2. Analyze the steps of the ethical decision-making process, applying them to nursing process.
3. Describe the rights and responsibilities of psychiatric-mental health patients across the continuum of care.
4. Compare the similarities and differences between voluntary and involuntary admission for mental health care.
5. Describe the concepts of competency and self-determination as they apply to psychiatric-mental health patient.
6. Explain the methods for ensuring patient safety when implementing restraint and seclusion.
7. Discuss the responsibilities of the psychiatric-mental health nurses (PMHN) in providing ethical and legal nursing care.

NEED TO KNOW

1. Ethics involves the principles that address right and wrong.
2. Ethical theories and principles provide the foundation from which the PMHN integrates the nursing process to make an ethical decision when faced with an ethical dilemma.
3. The Bill of Rights for Mental Health Patients is designed to protect the rights of any mentally ill patient who is unable to speak for him- or herself. Each patient has the right to the most supportive care in the least restrictive environment.
4. A patient who is admitted voluntarily can ask to leave at any time. Conversely, a patient who is involuntarily admitted cannot. If this admission restricts the patient's rights, the court assumes responsibility to ensure that the patient is protected and decisions made are in his or her best interests.
5. Consent and the right to self-determination are based on a person's competency.
6. Restraints and seclusion are used only when there is an emergency and it is determined that the patient's behavior is unsafe and there is imminent danger.
7. If restraints are used, they must be applied so that circulation is not restricted and the patient cannot slip out of them. Ongoing monitoring is necessary to ensure the patient's safety.
8. Maintaining confidentiality is a priority. However, if a patient clearly threatens violence to another, a nurse is legally responsible to report this information.

HYPERLINKS

*Ethical issues in nursing*, a film describing ethical issues in nursing with an introduction to concepts, values, and decision making.

1. [http://www.youtube.com/watch?v=9VRPMJUyE7Y](http://www.youtube.com/watch?v=9VRPMJUyE7Y)

Films to Augment Chapter Material

*N.W.O.-Psychiatry Exposed* can be viewed at [http://youtu.be/5zhu8rsumBw](http://youtu.be/5zhu8rsumBw)

ANSWERS TO NCLEX PREP QUESTIONS

1. d. Utilitarianism involves decision based on producing the best outcome or the greatest happiness for the greatest number of people. Honesty reflects veracity; fair and equal treatment reflects justice; and doing no harm reflects beneficence.

2. a. Advocacy is reflected by the principle of beneficence in which the nurse is doing what is best for the patient and not doing anything that will harm him or her. Fidelity would be reflected in activities involving faithfulness. Kantianism focuses on the “rightness” or “wrongness” of an outcome. Veracity involves honesty.

3. c. The patient with depression in need of treatment would most likely be voluntarily admitted. Patients being involuntarily committed include those who are a danger to self or others, who are mandated by a court order to receive treatment, or who are experiencing deterioration or severe persistent mental illness that limits the patient’s ability to understand the importance of complying with treatment.
4. a, c, b, d. Applying the concepts of the least restrictive environment, first talk therapy would occur, then behavioral therapy, then involuntary medication administrations, and lastly seclusion.

5. b. When a situation arises, several trained employees converge slowly as a unit to the patient. As they approach, they explain that they are there to help. If this does not de-escalate the patient’s behavior, the team then carefully and safely takes down the patient to apply the restraints. Within an hour of initiating restraints, a physician’s order must be obtained.

6. c. Breaching a patient’s confidentiality via sharing of the information in written form indicates libel. Slander refers to an oral breach. Medical battery occurs when a mentally ill patient is touched without his or her permission other than for routine nursing care. Assault occurs if the nurse indicates an intent to touch a patient without permission.
KEY TERMS

Lobbying: any action undertaken by an individual or group to influence the thinking and decision-making (e.g. voting on bills) of an elected official, at any level of government

Policy: in institutions, agencies and governments, means the sets of rules, guidelines, procedures and processes, which allow workers or officials to know how to go about conducting their daily tasks

Policy making: a broad term, which embodies all the processes in political action

Political action: a group of people organizing themselves to influence others to make changes

Politics: simply means the process of influencing the allocation of scarce resources, whether these are time, money, energy, services, and so on

EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Demonstrate understanding of key terms related to political forces affecting health care.
2. Describe how health care policy is made.
3. Identify milestones in policy impacting undergraduate nursing curricula.
4. Delineate current issues affecting psychiatric nursing education.

NEED TO KNOW

1. Political action is accomplished by a group of people organizing themselves to influence others to make changes.
2. Theory building and policy making are very similar processes.
3. Florence Nightingale not only influenced change in hospital systems but also in how the mentally ill were cared for.
4. All nurses, regardless of their preparation, can become politically active and influence legislative and regulatory processes if they understand how the game is played in specific sectors.
HYPERLINKS
Debbie Burton discusses the role of the nurse and politics
http://www.youtube.com/watch?v=4HMww5ma06w

Brief film of how nurses became involved in the 2008 campaign and influenced outcomes.
1. http://www.youtube.com/watch?v=Rd9OjW40EkY

ANSWERS TO NCLEX PREP QUESTIONS
1. a. Political Action is a group of people organizing themselves to influence others to make changes.
2. c. The best lobbying is done in a person-to-person manner, with live interaction.
3. b. The three primary concerns targeted by health care reform are quality, access, and value.
4. a. Influencing means using one’s persuasive powers. Nurses do this work of influencing as part of their daily tasks. In fact, psychiatric nursing might be defined as influencing people to change their views, consider new options, have new perspectives and open their minds to new ideas. The essence of psychotherapy is introducing new ideas and options to replace paranoia, delusional thinking, or depression.
5. d. The roots of theory building and policy generation are very similar. Both start with observation of repeated instances of things which are puzzling or processes which seem to be wrong or in need of repair.