PSYCHIATRIC-MENTAL HEALTH NURSING

An Interpersonal Approach

Jeffrey S. Jones • Joyce J. Fitzpatrick • Vickie L. Rogers

SPRINGER PUBLISHING COMPANY
Chapter Feature Boxes:

**DIAGNOSTIC CRITERIA**
lists the key symptoms of a disorder for consideration when making a diagnosis. Features DSM-IV and NANDA-I guidelines.

**BOX 12-1: DIAGNOSTIC CRITERIA**

**MAJOR DEPRESSIVE DISORDER**

In addition to the depressed mood or loss of interest or pleasure in usual activities, at least four of the following must be present:

- Significant weight loss without dieting or weight gain or markedly decreased or increased appetite
- Hypersomnia or insomnia
- Psychomotor agitation or slowness
- Fatigue or energy loss
- Feelings of worthlessness or guilt
- Difficulty concentrating or indecisiveness
- Recurrent thoughts of death, either with or without suicide ideation
- Symptoms cause significant distress or impair social, occupational, educational, or other functioning
- Symptoms are not caused by a substance or a general medical condition.

**DYSHYMIC DISORDER**

In addition to the individual's chronic depressive symptoms, the individual has never been well...
Additionally, the person has:

1. Out at least two of the following symptoms for more than two months:
   - Difficulty concentrating or indecisiveness
   - Hypersomnia or insomnia
   - Excessive participation in pleasurable and often high-risk activities

2. Symptoms cause significant distress or impair social, occupational, educational, or important independent function.

3. Symptoms are not caused by a substance or a general medical condition.

4. Never been diagnosed with a manic, mixed, or hypomanic episode, and does not meet the criteria for hypomania.

5. Carol is a 24-year-old female being admitted to the acute care psychiatric unit. She has been diagnosed with Bipolar I disorder. Carol has no medical conditions or illnesses. During the nursing assessment, Carol states she was treated for Bipolar I disorder when she was 18 but did not require hospitalization. Carol was prescribed lithium but stopped taking it about a year ago. She reports that she recently moved to the city to teach secondary school, has a limited support system, and lives alone. Approximately three weeks ago, she experienced a burst of energy and wasn’t able to sleep for several days.

   - She states she then started feeling sad, worthless, hopeless, lonely, and guilty about leaving her parent’s home. Carol has a blunted affect, unkempt, and her clothes are dirty. She frequently bursts into tears during her intake.
   - Carol has lost 11 pounds over the past two weeks, has no appetite, and difficulty sleeping. She has missed several days of work this past week due to her not having the “energy to get out of bed.” Carol admits to recurrent thoughts of hanging herself but is afraid if she commits suicide she will “go to hell.” You are assigned to provide care to Carol.

   - **CRITICAL THINKING QUESTIONS**
     1. How would you describe what Carol is experiencing?

   - **PATHWAYS FOR CARE**
     1. **NURSING DIAGNOSIS:** Anxiety (severe); related to exposure to traumatic event; manifested by perceived threats and recurrent panic attacks. Ineffective coping; related to anxiety of perceived need to check and re-check things; manifested by participation in repeated ritualistic behavior to reduce anxiety.
     2. Patient will demonstrate participation in fewer ritualistic behaviors with an improved level of independent function.

   - **INTERVENTION**
     - **Assess the level of the patient’s anxiety; stay with the patient and provide for safety and security**
       - Determining the level of the patient’s anxiety provides a baseline from which to intervene.

   - **Maintain a calm, reassuring approach; keep verbal exchanges short and direct**
     - Maintaining a calm, reassuring approach prevents adding to the patient’s anxiety.

   - **Administering antianxiety agents helps to reduce or control feelings of anxiety**
     - Administering antianxiety agents provides the patient with options to manage symptoms of increasing anxiety.

   - **Employing breathing and relaxation techniques interferes with sympathetic nervous system**
     - Employing breathing and relaxation techniques provides information about possible maladaptive defense mechanisms.

   - **Using appropriate defense mechanisms can help to reduce anxiety**
     - Using appropriate defense mechanisms helps to reduce anxiety.

   - **Identifying precipitating factors can help to reduce anxiety**
     - Identifying precipitating factors helps to reduce anxiety.

   - **Work with the patient to determine usual methods of problem solving; identify effective and ineffective methods**
     - Work with the patient to determine usual methods of problem solving.

   - **Provides reassurance that you are there to empower the patient to learn a way to decrease her anxiety level**
     - Provides reassurance to the patient that you are there to empower the patient.

   - **How would you respond? presents case scenarios followed by critical thinking questions.**

   - **Therapeutic Interaction provides an exemplary therapeutic dialogue between nurse and patient with rationales for the nurse’s interaction methods.**
PATIENT AND FAMILY EDUCATION 13-1: COPING STRATEGIES FOR DEALING WITH ANXIETY

Use these tips to help deal with mild to moderate levels of anxiety:

- Decrease overwhelming stimuli in the environment by decreasing the noise level and dimming the lights.
- Create a relaxing environment with music, candles, or other aromatherapy (incense, diffusers, etc.).
- Practice diaphragmatic breathing.
- Go outside and breathe fresh air.
- Do stretching exercises.
- Exercise by taking a walk, walking your dog, walking around the yard, or going to a hiking trail.
- Distract yourself by focusing on a hobby.
- Call a friend or family member.
- Practice guided imagery.
- Practice progressive muscle relaxation.
- Take a warm bath.
- Watch or listen to comedy.

CONSUMER PERSPECTIVE 12-1: A PATIENT WITH BIPOLAR II DISORDER

There's an undeniable stigma associated with a psychiatric illness. It's never easy for someone with such a diagnosis to admit it or talk about it, but I feel that the only way healthcare professionals can truly understand and treat people with psychiatric illnesses is to hear from people like me directly. I have type II bipolar disorder and have been in treatment for twenty years. In that time, I've been on several medication regimens and have been both well-controlled and not so well-controlled. For the last ten years, I've been on one medication that keeps my bipolarity well-controlled. This medication, coupled with therapy, has allowed me to live as normal a life as someone with my diagnosis can. Over the past few years I've become quite comfortable and able discussing my illness and how I treat it.

EVIDENCE-BASED PRACTICE 13-1: CBT VERSUS PSYCHODYNAMIC THERAPY

STUDY:

SUMMARY:
This study compared the outcome of short-term psychodynamic psychotherapy with CBT in patients diagnosed with GAD. Patients with GAD were randomly assigned to receive either CBT (N = 29) or short-term psychodynamic psychotherapy (N = 28). Treatment included up to thirty weekly sessions. The primary outcome measure was the Hamilton Anxiety Rating Scale. Assessments were done at the completion of treatment and after six months. The study revealed that both therapies provided large, statistically significant improvements in anxiety symptoms. There were no significant differences in the Hamilton Anxiety Rating Scale between therapies or by two self-reported measures of anxiety. However, CBT was found to be superior in measures.
Drug Summary lists the common drugs used in the treatment of a disorder and their implications for nursing care. Expanded drug monographs are available for reference.

SUMMARY POINTS

- Anxiety disorders include panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), acute stress disorder, and phobias. Anxiety disorders were not officially recognized as a psychiatric illness until 1980. They are the most common and most costly psychiatric illness in the United States.
- The exact cause of anxiety disorders is not known. Psychodynamic, behavioral, and learning theories are prominent. Additionally, biological influences, including brain structures, neurotransmitters, and monoamine oxidase inhibitors (MAOIs), beta blocker propranolol, and anticonvulsants such as lamotrigine or topiramate.
- Individual psychotherapy involves a combination of supportive and insight-oriented therapy which is helpful for patients with PTSD. Eye movement desensitization and reprocessing (EMDR) is a new type of psychotherapy gaining popularity for treating PTSD. Cognitive behavioral therapy is considered the first line treatment strategy for patients with depression and anxiety disorders. Flooding or implosion therapy is a type of exposure therapy in which the

NCLEX-PREP

1. A patient with PTSD is exhibiting hypervigilance. Which statement would the nurse interpret as indicating this?
   a. “I'm having trouble sleeping at night.”
   b. “I've been really irritable and angry.”
   c. “I always have to watch my back.”
   d. “I just can't seem to relax.”

2. A group of nursing students is reviewing information about anxiety disorders. The students demonstrate a need for additional study when they identify which of the following as a compulsion?
   a. Hearing voices that tell a person he is the king
   b. Repetitive

3. A patient with a panic disorder is prescribed venlafaxine. The nurse identifies this agent as which of the following?
   a. Selective serotonin reuptake inhibitor (SSRI)
   b. Serotonin/norepinephrine reuptake inhibitor (SNRI)
   c. Benzodiazepine
   d. Atypical antipsychotic

4. A patient with a personality disorder is prescribed venlafaxine. The nurse identifies this agent as which of the following?
   a. Selective serotonin reuptake inhibitor (SSRI)
   b. Serotonin/norepinephrine reuptake inhibitor (SNRI)
   c. Acute stress disorder
   d. Specific phobia

5. A nursing instructor is preparing a class on anxiety disorders and the biological influences associated with this group of illnesses. Which statement best reflects this information?
   a. Anxiety disorders are primarily caused by genetic factors.
   b. Anxiety disorders are primarily caused by environmental factors.
   c. Anxiety disorders are primarily caused by a combination of genetic and environmental factors.
   d. Anxiety disorders are primarily caused by psychological factors.
JEFFREY S. JONES, DNP, PMHCNS, BC, LNC, is a board certified-psychiatric clinical nurse specialist, board certified sex therapist, legal nurse consultant, and entrepreneur. He is president and owner of Pinnacle Mental Health Associates, Inc. in Mansfield, Ohio. He received his doctorate from Case Western Reserve University in Cleveland, Ohio. He is currently fulltime visiting faculty at The University of Akron in Akron, Ohio. He was a contributing author on the role of the CNS is private practice in Foundations of Clinical Nurse Specialist Practice (Springer, 2009). He has served on the Richland County Mental Health Board, the Ohio Board of Nursing standards and practice committee, and as a content expert on psychiatric nursing for the American Nurses Credentialing Center. Dr. Jones has provided service to the mentally ill in hospital settings, out-patient clinics, prisons, and in private practice.

JOYCE J. FITZPATRICK, PhD, MBA, RN, FAAN, is the Elizabeth Brooks Ford Professor of Nursing, Frances Payne Bolton School of Nursing at Case Western Reserve University in Cleveland, Ohio, where she was Dean from 1982 through 1997. She has received numerous honors and awards including the American Journal of Nursing Book of the Year Award 18 times. Dr. Fitzpatrick is widely published in nursing and health care literature, and is senior editor for Springer’s revived Nursing Leadership and Management Series. Her most recent Springer books are The Doctor of Nursing Practice and Clinical Nurse Leader: Essentials of Program Development and Implementation for Clinical Practice and Giving through Teaching: How Nurse Educators Are Changing the World.

VICKIE L. ROGERS, DNP, RN, is an Assistant Professor at the University of Southern Mississippi where she teaches in the undergraduate and graduate nursing programs. She received a Doctor of Nursing Practice from Case Western Reserve University, Cleveland, Ohio, and a MS and BS in Nursing from the University of Southern Mississippi. Dr. Rogers has previously held faculty appointments at various schools of nursing in Mississippi and Connecticut. Additionally, Dr. Rogers has international teaching experience in the Caribbean. She is a contributing author of a chapter in the book, Giving through Teaching: How Nurse Educators Are Changing the World. She has worked in psychiatric clinical nurse specialist and management roles in the past. Research interests include the use of the Internet as a format to provide individual therapy to young adults. Dr. Rogers has presented her work internationally, and has published manuscripts on this topic.
PSYCHIATRIC-MENTAL HEALTH NURSING

An Interpersonal Approach

Jeffrey S. Jones, DNP, PMHCNS, BC, LNC
Joyce J. Fitzpatrick, PhD, MBA, RN, FAAN
Vickie L. Rogers, DNP, RN

SPRINGER PUBLISHING COMPANY
NEW YORK
This book is dedicated to
Hildegard Peplau and Joyce Travelbee.

Their models in structuring the practice of psychiatric nursing
from an interpersonal/relationship-based perspective are
timeless, relevant, and invaluable.

We are pleased to honor their legacy with this text
so that new generations of nurses can be inspired
and guided by their pioneering work.
1. Mental Health Trends and the Historical Role of the Psychiatric-Mental Health Nurse 3

Historical Overview of Mental Health and Mental Illness Care 4
The Earliest Years 4
The Eighteenth and Nineteenth Centuries 4
The Twentieth Century 5
Current Perspectives 6

Evolution of Psychiatric-Mental Health Nursing 8
Early Emergence of the Profession 8
Continued Evolution 9

Contemporary Psychiatric-Mental Health Nursing Practice 10
Scope and Standards of Practice 10
Phenomena of Concern 11
Levels of Psychiatric-Mental Health Nursing Practice 11
Roles and Functions of the PMHN 12

2. Interpersonal Relationships: The Cornerstone of Psychiatric Nursing 17

Hildegard E. Peplau 18
Biographical Background 18
Peplau’s Theory of Interpersonal Relationships 19
Phases of the Interpersonal Process 19
Roles 22
Application to Psychiatric-Mental Health Nursing Practice 22

Joyce Travelbee 23
Biographical Background 23
Travelbee’s Human to Human Relationship Theory 24
Application to Psychiatric-Mental Health Nursing Practice 26

3. Therapeutic Use of Self and Therapeutic Communication: From Self-Discovery to Interpersonal Skill Integration 31

The Concept of Self 32
Theoretical Foundations for Self and the Therapeutic Use of Self 32
Carl Rogers 33
Other Theorists 33

Development of the Therapeutic Use of Self 35
Self-Awareness 35
Self-Reflection 35

Therapeutic Use of Self and the Interpersonal Process 37
Importance of the Therapeutic Use of Self 37
Positive Components of the Self 40

Therapeutic Communication 41
Therapeutic Communication Techniques 43
Barriers to Effective Therapeutic Communication 46
Therapeutic Communication Within Challenging Nursing Situations 47

4. Boundary Management 53

Boundaries 54
Establishment of Professional Boundaries 54
Boundaries Within the Nurse-Patient Relationship 55

Boundary Issues 56
Boundary Testing 57
Boundary Crossing Versus Boundary Violation 59

Risk Factors for Unhealthy Nurse-Patient Boundaries 60

Strategies for Maintaining Boundaries 62
II. HEALTH PROMOTION AND ILLNESS PREVENTION  67

5. Critical Thinking, Clinical Decision Making, and the Interpersonal Relationship  67
   Critical Thinking and Clinical Decision Making  68
      Domains of Critical Thinking  68
      Elements Necessary for Critical Thinking  68
      Framework for Critical Thinking and Clinical Decision Making  70
   The Nursing Process  71
      The Nursing Process and the Interpersonal Relationship  71
      Planning and Implementation  74
      Evaluation  77
   Implications for Psychiatric-Mental Health Nursing  80

6. Crisis and Crisis Intervention  83
   Stress Response  84
      General Adaptation Syndrome  84
   Crisis  84
      Characteristics of a Crisis  86
      Factors Impacting an Individual’s Response to Crisis  87
   Development of Crisis  87
   Classification of Crises  89
   Crisis Intervention  89
      Nurses and Crisis Intervention: Historical Perspectives  90
      Nurses and Crisis Intervention: Current Perspectives  90
      Crisis Intervention and the Nursing Process  91
      Nurse’s Role During and After Community and Global Disasters  91
   Impact of Dealing With Crises on Psychiatric-Mental Health Nurses  96

7. Psychiatric Case Management  101
   Definition of Case Management  102
   Historical Evolution of Psychiatric Case Management  103
      Case Management Models  104
   Case Management Process  105
      Goals and Principles of Case Management  106
      Necessary Skills for Case Management  106
      Essential Functions of the Case Management Process  108
   Interpersonal Perspectives for Case Management  110
      Roles of the Psychiatric-Mental Health Nurse Case Manager  110
      Practice Guidelines  113
      Personal Practice Guidelines  115
   Measurement of Quality in Case Management  115

8. Known Risk Factors for Prevalent Mental Illness and Nursing Interventions for Prevention  121
   The Nature of Risk Factors  122
      Categories of Risk Factors  122
      Protective Factors  123
      The Stress-Vulnerability-Coping Model  124
   Risk Factors for Major Psychiatric-Mental Health Disorders  124
      Disorders of Infancy, Childhood, or Adolescence  124
      Schizophrenia  125
      Affective Disorders  126
      Substance-Related Disorders  127
      Anxiety Disorders  128
      Personality Disorders  129
   The Interface of Psychiatric-Mental Health Disorders and Medical Conditions  129
      Factors Influencing Risk  130
CONTENTS

9. Systems Concepts and Working in Groups 141
   General Systems Theory 142
   Systems Theory and Nursing Theory 142
   Systems Theory and Psychiatric-Mental Health Nursing 144
   Groups and Group Therapy 144
   Types of Therapeutic Groups 145
   Group Process and Group Dynamics 146
   Curative Factors of Groups 146
   Group Development 149
   Role of the Group Leader or Facilitator 149
   Roles of Group Members 151
   Examples of Group Therapy 152
   Family Psychotherapy 153
   Models of Family Therapy 154
   The Interpersonal Process and Group and Family Therapy 156

10. Theories of Mental Health and Illness: Psychodynamic, Social, Cognitive, Behavioral, Humanistic, and Biological Influences 163
    Mental Illness 164
    Evolution of Thinking About Mental Illness 164
    The Current State of Mental Illness 165
    Theories and Mental Illness 165
    Psychodynamic Theories 166
    Behavioral Theories 168
    Cognitive Theories 171
    Social Theories 172
    Humanistic Theories 173
    Biological Theories 175

11. Thought Disorders 181
    Historical Perspectives 182
    Epidemiology 183
    Incidence 183
    Prevalence 184
    Mortality 184
    Remission/Recovery 184
    Diagnostic Criteria 184
    Schizophrenia 184
    Schizophreniform Disorder 189
    Schizoaffective Disorder 189
    Delusional Disorder 189
    Brief Psychotic Disorder 189
    Shared Psychotic Disorder 189
    Etiology of SSD 190
    Psychosocial Theories 190
    Biological Theories 191
    Treatment Options 192
    Pharmacological Therapy 192
    Electroconvulsive Therapy 193
    Environmental Supports 194
    Psychological Therapies 195
    Assertive Community Treatment (ACT) 195
    Social Therapies 196
    Applying the Nursing Process From an Interpersonal Perspective 199
    Strategies for Optimal Assessment: Therapeutic Use of Self 199
    Self-Awareness 199
    Implementing Effective Interventions: Timing and Pacing 208
    Evaluation: Objective Critique of Interventions and Self-Reflection 210

12. Affective Disorders 217
    Historical Perspectives 218
    Epidemiology 218
    Diagnostic Criteria 219
    Major Depressive Disorder 219
    Dysthymic Disorder 219
    Bipolar I Disorder 222
    Bipolar II Disorder 222
    Cyclothymic Disorder 222
    Suicide 222
    Etiology of Affective Disorders 222
    Psychosocial Theories 222
    Biological Theories 222
    Treatment Options 223
    Psychopharmacology 223
    Electroconvulsive Therapy 230
    Cognitive Behavioral Therapy 230
    Applying the Nursing Process From an Interpersonal Perspective 231
    Strategies for Optimal Assessment: Therapeutic Use of Self 231
    Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 234
    Implementing Effective Interventions: Timing and Pacing 236
    Evaluating: Objective Critique of Interventions and Self-Reflection 238

IIII. ACUTE AND CHRONIC ILLNESS 181

11. Thought Disorders 181
   Historical Perspectives 182
   Epidemiology 183
   Incidence 183
   Prevalence 184
   Mortality 184
   Remission/Recovery 184
   Diagnostic Criteria 184
   Schizophrenia 184
   Schizophreniform Disorder 189
   Schizoaffective Disorder 189
   Delusional Disorder 189
   Bipolar II Disorder 189
   Bipolar Disorder 189
   Shared Psychotic Disorder 189
   Etiology of SSD 190
   Psychosocial Theories 190
   Biological Theories 191
   Treatment Options 192
   Pharmacological Therapy 192
   Electroconvulsive Therapy 193
   Environmental Supports 194
   Psychological Therapies 195
   Assertive Community Treatment (ACT) 195
   Social Therapies 196
   Applying the Nursing Process From an Interpersonal Perspective 199
   Strategies for Optimal Assessment: Therapeutic Use of Self 199
   Self-Awareness 199
   Implementing Effective Interventions: Timing and Pacing 208
   Evaluation: Objective Critique of Interventions and Self-Reflection 210

12. Affective Disorders 217
   Historical Perspectives 218
   Epidemiology 218
   Diagnostic Criteria 219
   Major Depressive Disorder 219
   Dysthymic Disorder 219
   Bipolar I Disorder 222
   Bipolar II Disorder 222
   Cyclothymic Disorder 222
   Suicide 222
   Etiology of Affective Disorders 222
   Psychosocial Theories 222
   Biological Theories 222
   Treatment Options 223
   Psychopharmacology 223
   Electroconvulsive Therapy 230
   Cognitive Behavioral Therapy 230
   Applying the Nursing Process From an Interpersonal Perspective 231
   Strategies for Optimal Assessment: Therapeutic Use of Self 231
   Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 234
   Implementing Effective Interventions: Timing and Pacing 236
   Evaluating: Objective Critique of Interventions and Self-Reflection 238
## 13. Anxiety Disorders 243

- **Historical Perspectives** 244
- **Epidemiology** 245
  - Incidence 246
  - Morbidity and Mortality 246
- **Diagnostic Criteria** 247
  - Panic Disorder 247
  - Obsessive-Compulsive Disorder (OCD) 247
  - Posttraumatic Stress Disorder (PTSD) 247
  - Generalized Anxiety Disorder (GAD) 247
  - Specific Phobia 251
  - Social Phobia 251
  - Acute Stress Disorder 251
- **Etiology** 251
  - Psychosocial Theories 251
  - Biological Theories 253
- **Treatment Options** 254
  - Pharmacological Therapy 254
  - Pre-emptive or Prophylactic Treatments 258
  - Herbal Preparations 258
  - Individual Psychotherapy 259
  - Eye Movement Desensitization and Reprocessing 260
  - Biofeedback 260
  - Functional Neurosurgery 260
  - Cognitive Behavioral Therapy 261
  - Exposure Therapies 262
  - Abdominal Breathing 263
  - Progressive Muscle Relaxation 263
  - Exercise 263
  - Guided Imagery 263
  - Music 263
  - Dietary Changes 264

### Applying the Nursing Process From an Interpersonal Perspective 264

- Strategies for Optimal Assessment: Therapeutic Use of Self 264
- Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 269
- Implementing Effective Interventions: Timing and Pacing 270
- Evaluating: Objective Critique of Interventions and Self-Reflection 270

## 14. Personality Disorders 277

- **Historical Perspectives** 278
- **Epidemiology** 279
- **Diagnostic Criteria** 279
  - Paranoid Personality Disorder 279
  - Schizoid Personality Disorder 283
  - Schizotypal Personality Disorder 283

### Antisocial Personality Disorder 283

### Borderline Personality Disorder 284

### Histrionic Personality Disorder 284

### Narcissistic Personality Disorder 284

### Avoidant Personality Disorder 284

### Dependent Personality Disorder 284

### Obsessive-Compulsive Personality Disorder 285

## 15. Addictive Disorders 305

- **Historical Perspectives** 306
- **Epidemiology** 307
- **Diagnostic Criteria** 307
- **Etiology** 309
  - Factors Related to Addiction and Substance Abuse 311

### Treatment Options 313

- 12-Step Programs 313
- Psychopharmacology 314
- Psychotherapy 314
- Detoxification and Rehabilitation 318

### Applying the Nursing Process From an Interpersonal Perspective 318

- Strategies for Optimal Assessment: Therapeutic Use of Self 318
- Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 326
- Implementing Effective Interventions: Timing and Pacing 326
- Evaluating: Objective Critique of Interventions and Self-Reflection 330
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td>Cognitive Disorders</td>
<td>337</td>
</tr>
<tr>
<td></td>
<td>Historical Perspectives</td>
<td>338</td>
</tr>
<tr>
<td></td>
<td>Epidemiology</td>
<td>339</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Criteria</td>
<td>339</td>
</tr>
<tr>
<td></td>
<td>Delirium</td>
<td>339</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td>342</td>
</tr>
<tr>
<td></td>
<td>Etiology</td>
<td>343</td>
</tr>
<tr>
<td></td>
<td>Neurobiological Influences</td>
<td>343</td>
</tr>
<tr>
<td></td>
<td>Treatment Options</td>
<td>344</td>
</tr>
<tr>
<td></td>
<td>Psychopharmacology</td>
<td>345</td>
</tr>
<tr>
<td></td>
<td>Herbal Remedies</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>Reality Orientation</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>Validation Therapy</td>
<td>348</td>
</tr>
<tr>
<td></td>
<td>Reminiscence Therapy</td>
<td>348</td>
</tr>
<tr>
<td></td>
<td>Person-Centered Care</td>
<td>348</td>
</tr>
<tr>
<td></td>
<td>Applying the Nursing Process From an Interpersonal Perspective</td>
<td>350</td>
</tr>
<tr>
<td></td>
<td>Strategies for Optimal Assessment: Therapeutic Use of Self</td>
<td>354</td>
</tr>
<tr>
<td></td>
<td>Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs</td>
<td>355</td>
</tr>
<tr>
<td></td>
<td>Implementing Effective Interventions: Timing and Pacing</td>
<td>357</td>
</tr>
<tr>
<td></td>
<td>Evaluating: Objective Critique of Interventions and Self-Reflection</td>
<td>362</td>
</tr>
<tr>
<td>17.</td>
<td>Impulse Control Disorders</td>
<td>371</td>
</tr>
<tr>
<td></td>
<td>Historical Perspectives</td>
<td>372</td>
</tr>
<tr>
<td></td>
<td>Epidemiology</td>
<td>372</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Criteria</td>
<td>373</td>
</tr>
<tr>
<td></td>
<td>Etiology</td>
<td>375</td>
</tr>
<tr>
<td></td>
<td>Psychodynamic Influences</td>
<td>375</td>
</tr>
<tr>
<td></td>
<td>Neurobiological Influences</td>
<td>376</td>
</tr>
<tr>
<td></td>
<td>Treatment Options</td>
<td>376</td>
</tr>
<tr>
<td></td>
<td>Nonpharmacological Therapies</td>
<td>376</td>
</tr>
<tr>
<td></td>
<td>Pharmacological Therapies</td>
<td>376</td>
</tr>
<tr>
<td></td>
<td>Applying the Nursing Process From an Interpersonal Perspective</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>Strategies for Optimal Assessment: Therapeutic Use of Self</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>Implementing Effective Interventions: Timing and Pacing</td>
<td>382</td>
</tr>
<tr>
<td></td>
<td>Evaluating: Objective Critique of Interventions and Self-Reflection</td>
<td>384</td>
</tr>
<tr>
<td>18.</td>
<td>Sexual Disorders and Dysfunctions</td>
<td>389</td>
</tr>
<tr>
<td></td>
<td>Historical Perspectives</td>
<td>390</td>
</tr>
<tr>
<td></td>
<td>Epidemiology</td>
<td>391</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Criteria</td>
<td>391</td>
</tr>
<tr>
<td></td>
<td>Etiology</td>
<td>393</td>
</tr>
<tr>
<td>19.</td>
<td>Eating Disorders</td>
<td>411</td>
</tr>
<tr>
<td></td>
<td>Historical Perspectives</td>
<td>412</td>
</tr>
<tr>
<td></td>
<td>Epidemiology</td>
<td>412</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Criteria</td>
<td>414</td>
</tr>
<tr>
<td></td>
<td>Anorexia Nervosa</td>
<td>414</td>
</tr>
<tr>
<td></td>
<td>Bulimia Nervosa</td>
<td>414</td>
</tr>
<tr>
<td></td>
<td>Binge Eating Disorder</td>
<td>414</td>
</tr>
<tr>
<td></td>
<td>Etiology</td>
<td>416</td>
</tr>
<tr>
<td></td>
<td>Biological Factors</td>
<td>416</td>
</tr>
<tr>
<td></td>
<td>Sociocultural Factors</td>
<td>416</td>
</tr>
<tr>
<td></td>
<td>Familial Factors</td>
<td>416</td>
</tr>
<tr>
<td></td>
<td>Psychological and Individual Factors</td>
<td>416</td>
</tr>
<tr>
<td></td>
<td>Treatment Options</td>
<td>417</td>
</tr>
<tr>
<td></td>
<td>Applying the Nursing Process From an Interpersonal Perspective</td>
<td>418</td>
</tr>
<tr>
<td></td>
<td>Strategies for Optimal Assessment: Therapeutic Use of Self</td>
<td>418</td>
</tr>
<tr>
<td></td>
<td>Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs</td>
<td>424</td>
</tr>
<tr>
<td></td>
<td>Implementing Effective Interventions: Timing and Pacing</td>
<td>425</td>
</tr>
<tr>
<td></td>
<td>Evaluating: Objective Critique of Interventions and Self-Reflection</td>
<td>427</td>
</tr>
<tr>
<td>20.</td>
<td>Psychological Problems of Physically Ill Persons</td>
<td>431</td>
</tr>
<tr>
<td></td>
<td>Suffering and the Therapeutic Use of Self</td>
<td>432</td>
</tr>
<tr>
<td></td>
<td>Theoretical Views of Suffering</td>
<td>432</td>
</tr>
<tr>
<td></td>
<td>Suffering and the Impact on Nurses</td>
<td>433</td>
</tr>
<tr>
<td></td>
<td>Special Issues Related to Mental Health and Physical Illness</td>
<td>434</td>
</tr>
<tr>
<td></td>
<td>Impact of Stress</td>
<td>434</td>
</tr>
<tr>
<td></td>
<td>Loss and Grief</td>
<td>437</td>
</tr>
<tr>
<td></td>
<td>Body Image Changes and Stigma</td>
<td>438</td>
</tr>
<tr>
<td></td>
<td>Pain and Other Physical Symptoms</td>
<td>438</td>
</tr>
<tr>
<td></td>
<td>Anxiety and Depression</td>
<td>438</td>
</tr>
<tr>
<td></td>
<td>Delirium</td>
<td>442</td>
</tr>
</tbody>
</table>
The Nurse’s Role in Breaking Bad News 442
End-of-Life Care 445
Conversations About Death and Dying 445
Conversations About Code Status 445
Conversations Involving a Shift From Cure-Driven Care to Palliative Care 446
Conversations About Hospice Care 446
The Role of the Mental Health Liaison/Consultation Nurse 446
Applying the Nursing Process From an Interpersonal Perspective 446
Strategies for Optimal Assessment: Therapeutic Use of Self 447
Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 447
Implementing Effective Interventions: Timing and Pacing 450
Evaluating: Objective Critique of Interventions and Self-Reflection 451

IV. GROWTH AND DEVELOPMENT AND MENTAL HEALTH CONCERNS ACROSS THE LIFE SPAN 455

21. Working With Children 455
Growth and Development Theories 456
Piaget’s Theory of Cognitive Development 456
Erikson’s Theory of Emotional and Personality Development 457
Freud’s Theory of Psychological Development 458
Sullivan’s Theory of Interpersonal and Personality Development 459
Behavioral Theories of Pavlov and Skinner 460
Overview of Disorders of Childhood 460
Pervasive Developmental Disorders 460
Autistic Disorder 461
Asperger’s Disorder 462
Attention-Deficit and Disruptive Behavior Disorders 464
Attention-Deficit Hyperactivity Disorder 464
Conduct Disorder 465
Oppositional Defiant Disorder 468
Mood Disorders 468
Depression 468
Adjustment Disorder 469
Post-Traumatic Stress Disorder 469
Feeding and Eating Disorders 470
Pica 470
Rumination Disorder 470
Feeding Disorder of Infancy or Early Childhood 471
Treatment Options 472
Play Therapy 472
Behavioral Therapy 472
Cognitive Behavioral Therapy 473
Family Therapy 474
Psychopharmacology 474
Applying the Nursing Process From an Interpersonal Perspective 474
Strategies for Optimal Assessment: Therapeutic Use of Self 476
Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 479
Implementing Effective Interventions: Timing and Pacing 479
Evaluating: Objective Critique of Interventions and Self-Reflection 480

22. Mental Health Concerns Regarding Adolescents 485
Adolescent Development 486
Puberty and Self-Esteem 486
Peer Relationships 486
Adolescent Assessment 487
Common Mental Health Problems in Adolescence 488
Depression 489
Mania 489
Self-Harm 489
Suicide 490
Eating Disorders 491
Substance Misuse and Abuse 491
Attention Deficit Hyperactivity Disorder 492
Conduct Disorders 492
Obsessive-Compulsive Disorder 493
Social Phobia 493
Treatment Options 493
Cognitive Behavioral Therapy 493
Family Therapy 494
Parent Training 494
Group Work 494
Inpatient Care 495
Psychopharmacology 495
Applying the Nursing Process From an Interpersonal Perspective 496
Strategies for Optimal Assessment: Therapeutic Use of Self 496
Diagnosing and Planning Appropriate Interventions: Meeting the Adolescent’s Focused Needs 496
Implementing Effective Interventions: Timing and Pacing 496
CONTENTS

Epidemiology 530
  Child Abuse 530
  Intimate Partner Violence 531
  Elder Abuse 531
Etiology 531
  Child Abuse 532
  Intimate Partner Violence 532
  Elder Abuse 533
Patterns of Violence 533
  The Cycle of Violence 533
  Cycle of Abuse 534
  The Power and Control Wheel 534
Nursing Responsibilities From an Interpersonal Perspective 534
  Child Abuse 535
  Intimate Partner Violence 537
  Elder Abuse 543

V. MENTAL HEALTH CARE SETTINGS 549

23. Issues Specific to the Elderly 503
  Overview of the Elderly Population 504
    Quality of Life 504
    Medicare 504
  Factors influencing Mental Health in the Aging Population 504
    Physical Changes 505
    Chronic Illness 505
    Pain 505
    Insomnia 506
    Disabilities and Handicaps 507
    Stress and Change 507
    Loss 507
    Family Coping 507
    Loneliness 508
    Abuse and Neglect 509
    Culture and Spirituality 509
  Common Mental Health Problems
    Associated With the Elderly 509
      Depression in the Elderly 509
      Generalized Anxiety Disorder in the Elderly 513
      Mood Disorders in the Elderly 514
      Substance Use and Abuse and the Elderly 514
  Palliative and End-of-Life Issues With Mentally Impaired Elders 514
  Trends in Mental Health Care for the Elderly 515
    Acute Care 515
    Outpatient Services 516
  Applying the Nursing Process From an Interpersonal Perspective 517
    Strategies for Optimal Assessment: The Therapeutic Use of Self 517
    Diagnosing and Planning Appropriate Interventions: Meeting the Patient’s Focused Needs 518
    Implementing Effective Interventions: Timing and Pacing 520
    Evaluating: Objective Critique of Interventions and Self-Reflection 520

24. Victims andVictimizers 527
  Types of Abuse 528
    Physical Abuse 528
    Sexual Abuse 528
    Emotional or Psychological Abuse 528
    Economic Abuse 529
  Historical Perspectives 529
CONTENTS  xiii

26. Vulnerable Populations and the Role of the Forensic Nurse  567

Children and Mental Health and Illness  568

Nurse’s Role When Working With Children  569

Aging Individuals and Mental Health and Illness  569

Nurse’s Role When Working With the Elderly  569

Minority Groups and Mental Health and Illness  570

Nurse’s Role When Working With Minority Groups  571

Individuals With Intellectual Disabilities and Mental Health and Illness  571

Nurse’s Role When Working With Individuals With Intellectual Disabilities  571

The Homeless and Mental Health and Illness  571

Impact on Mental Health  572

Nurse’s Role When Working With the Homeless Population  572

Individuals Who Are Incarcerated and Mental Health and Illness  573

Impact of Incarceration on Mental Health  573

Nurse’s Role When Working With Incarcerated Patients  573

Forensic Nursing  575

Educational Preparation  575

Roles of the Forensic Nurse  576

27. Cultural, Ethnic, and Spiritual Concepts  581

Core Concepts  582

Globalization and Health Care Disparities  582

Race, Ethnicity, and Culture and Mental Health  583

Racial, Ethnic, and Cultural Diversity  583

Language Variations  584

Gender Roles and Expectations  584

Immigration  585

Mental Health, Mental Illness, and Mental Health Service Use Among Ethnic, Racial, and Cultural Groups  585

Implications for Psychiatric-Mental Health Nursing  587

Spirituality, Religion, and Mental Health  588

Influence on Coping  588

Influence on the Etiology of Mental Illness  588

Influence on Mental Illness Symptomatology  589

Barriers to Mental Health Services  589

Overcoming Barriers  589

Correlation to Other Cultures  591

Implications for Psychiatric-Mental Health Nursing  591

Culturally Competent and Congruent Care  591

28. Ethical and Legal Principles  597

Ethics  598

Ethical Theories and Principles  598

Model for Ethical Decision Making  600

Legal Issues  602

Bill of Rights for Mental Health Patients  602

Voluntary and Involuntary Admission  602

Competency  603

Least Restrictive Environment  604

Restraints and Seclusion  605

Nursing Responsibilities  606

Confidentiality  607

Legal Liability  607

29. Policy, Policy Making, and Politics for Professional Psychiatric Nurses  611

An Overview of How Policy Is Made  612

Theory Building and Policy Generation  613

Nursing’s Political Roots  614

Ideologies, Facts, and Politics  614

The Politics of Communication  615

Federal Legislators, New Laws, and Health Policies  616

Legislation, Law, and Regulations  617

The Future of (Psychiatric) Nursing  619

The Future of Baccalaureate Education for Psychiatric Nurses  620

Appendix: NANDA-I Nursing Diagnoses 2009–2011  625

Glossary  629

NCLEX Review  639

Index  00
Carolyn A. Baird, DNP, MBA, RN-BC, CARN-AP, ICCDPD
Waynesburg University
Waynesburg, PA

Audrey Marie Beauvais, DNP, MBA, RN-BC
Sacred Heart University
Fairfield, CT

Katherine R. Casale, MS, RN
Bridgeport Hospital School of Nursing
Bridgeport, CT

Angela Supplee Chesser, PhD, RN, PMHCNS-BC
The Ohio State University Medical Center
Columbus, OH

E. J. Ernst, DNP, MBA, APRN, FNP-BC, CEN
California State University Dominguez Hills
Carson, California

Joyce J. Fitzpatrick, PhD, MBA, RN, FAAN.
Case Western Reserve University
Cleveland, OH

Lorain Fleming, MA, APRN, PMHNP-BC
Hawaii Pacific University
Honolulu, Hawaii

Patricia Ann Galon, PhD, PMHCNS-BC
The University of Akron
Akron, OH

Marianne Goldyn, MSN, PMHCNS- BC
Community Support Services, Inc.
Akron, Ohio

Vicki P. Hines-Martin, PhD, CNS, RN, FAAN
University of Louisville,
Louisville, KY

Áine Horgan, RPN, BNS, MSc
University College Cork
Cork, Ireland

Emily K Johnson, DNP, PMHNP-BC, RN
Mayo Clinic
Rochester, MN

Jeffrey Schwab Jones, DNP, PMHCNS- BC, LNC.
Pinnacle Mental Health Associates, Inc.
Mansfield, OH

Betty Jane Kohal, DNP, PMHCNS- BC
Cumberland University
Lebanon, TN

Melanie S. Lint, MSN, PMHCNS-BC.
New Horizons Youth & Family Center
Lancaster, OH

Patricia Smythe Matos, DNP, RN
Mount Sinai Medical Center
New York, NY

Declan McCarthy, MA HDip (Integ. Psychother.)
RPN
South Lee Mental Health Services
Cork, Ireland

Geraldine McCarthy, RGN, RNT, MEd, MSN, PhD
University College Cork
Cork, Ireland
Kimberly S. McClane, RN, MBA, PhD  
International University of Nursing  
St. Kitts, West Indies

Vickie L. Rogers, DNP, RN  
University of Southern Mississippi  
Hattiesburg, MS

Lori Neushotz, DNP, PMHCNS-BC, NPP, CASAC  
Private practice  
New York, NY

Shirley A. Smoyak, PhD, MPhil, MS  
Rutgers University  
New Brunswick, NJ

James O’Mahony, MSc, PgDip Cog Psych, BSc, RPN  
North Lee Mental Health Services  
Cork, Ireland

John F. Sweeney, PhD, MSc DipANS RNID RPN RNT CNT T.Nur  
University College Cork  
Cork, Ireland

Patti Hart O’Regan, DNP, ARNP, ANP-C, PMHNP-BC, LMHC  
Village Health, LLC  
Port Richey, FL

Amanda Alisa Townsend DNP, APRN, FNP-C  
Gulf Coast Mental Health Center  
Gulfport, MS

Kathleen L. Patusky, MA, PhD, RN, CNS  
University of Medicine and Dentistry of New Jersey  
School of Nursing  
Newark, NJ

Kathleen Tusaiie, PhD, PMHCNS-BC  
The University of Akron  
Akron, OH

Patrice Ellen Rancour, MS, RN, PMHCNS-BC,  
The Ohio State University Medical Center  
Columbus, OH

Mark P. Tyrrell, RGN, RPN, RNT, BNS, Med  
University College Cork  
Cork, Ireland
There is an old saying: “what goes around comes around.” This textbook returns to life the promise of Hildegard’s Peplau’s pioneering work. When, in 1952, Peplau wrote *Interpersonal Relations in Nursing*, she was clear that the relationship between the nurse and the patient was the core of all nursing practice. In that book she demonstrated the key elements of that practice. Herein were also the roots of all specialty practice in psychiatric mental health nursing. Some years after she published her work, I once asked Peplau if she had ever considered revising and publishing a new edition. Her answer was direct and to the point. She said that if and when there was something new to be added she might consider it but nothing had appeared on the horizon to contradict the material presented in the book. She went on to say that if the concepts and ideas presented in the book had merit they would still be relevant even after 50 years. And she was right of course; they still have merit. In this textbook, the editors and contributors have eloquently and persuasively rendered much of the wisdom found in the 1952 book. They also use the complementary work of Joyce Travelbee, who in the same time period pursued very similar ideas to those of Peplau.

I have been a nurse for more than 50 years. I have witnessed the shifting sands of my profession as it follows fads and trends. For us in psychiatric nursing, we have typically followed the trends in psychiatry. So in the late 1960s when what was thought to be the “magic bullet” for the treatment of serious mental illness was discovered, with the advent of Thorazine and the subsequent explosion of interest in and demand for psychotropic drugs, Nursing followed. Then when the “decade of the brain” was announced in the 1990s, Nursing followed. Now, when current research informing best practices suggest the “talk therapies” are equal too and often have better outcomes than biophysical regimens, Nursing is rediscovering its power, precisely in the practice of the relationships that help and heal.

This textbook is a major step in that direction. The editors and contributors are to be congratulated for their clear effort to bring some degree of correction to the singular emphasis on pharmacotherapy found in many advanced practice work roles as well as in general psychiatric care. While it is clear that pharmacotherapy has a role to play in treatment, it is equally clear that the use of relationships as therapy has an equal if not more important role to play. It is just this point that this text makes in compelling fashion.

However, a word of caution to the reader is in order on this point. One should not try too hard to impose the phases on the relationship as Peplau described them. The stages are merging and overlapping and often can take place in a short interval of time. Or they may take place over a long period of time, in which case they are often more easily discernable. What was most important was that the nurse and the patient began as strangers and would be engaged for a time limited period and that the limits inherent in their engagement should be understood by both the nurse and the patient.

There are several other features of this text that commend it to the student and to the nurse seeking a review or a refresher course. First, the authors have done an excellent job in noting historical context. Understanding where and how these ideas and practices have had their origin allows the reader to appreciate the growth and development of information. Information when tested in practice/experience leads to knowledge. Hopefully, it also encourages the idea that there is more to know as well as to appreciate the developmental nature of information.

Second, the authors have made extensive use of the current research literature and have well used the nursing research literature. The embedded web-links will allow
the reader to easily explore the treasure trove to be found inside the wonderful world of the www.

In short, I would wish that this text, your experience, the teachers who will guide that experience, the excellent role models you will see in your experience will give you an appreciation for the rewards of practicing in this field. If not that, I am certain that the knowledge gained from these experiences will be a central part of your practice in all other areas of Nursing. I am often asked, what is the one thing I would say about my many years of experience.

My reply is always the same; “I have never been bored, not even for a minute!”

May you never be bored and have fun with the challenges!

Grayce M. Sills, PhD, RN, FAAN
Emeritus Professor
College of Nursing
Ohio State University
This textbook is the result of our belief in the need to reaffirm and strengthen interpersonal relationships as the core component of psychiatric–mental health nursing practice. Throughout the book we have used the interpersonal theories of Hildegard Peplau and Joyce Travelbee so that the student can develop an understanding of the nature of the nurse/client relationship in care of persons with psychiatric illnesses. Prevailing curricular guidelines were used in the text’s construction and thus the book is divided into six key areas of foci.

SECTION I: THE PRACTICE OF PSYCHIATRIC- MENTAL HEALTH NURSING lays the groundwork for understanding the history and nature of this specialty area. The theories of Peplau and Travelbee are introduced. Additional chapters in this section focus on therapeutic use of self and boundary management in nursing practice. SECTION II: HEALTH PROMOTION AND ILLNESS PREVENTION continues to build the fundamental skill set by presentation of topics such as critical thinking, clinical decision making, and counseling interventions. Also, crisis intervention and the case management role are discussed. System and group dynamics are emphasized as key to understanding various mental health treatment modalities. This section also provides an overview of theories of mental health disorders, information about known risk factors for select illnesses, and related nursing interventions.

SECTION III: ACUTE AND CHRONIC ILLNESS provides detailed discussion of the most common psychiatric disorders utilizing the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) to describe criteria and enrich understanding. This section also includes important content related to mental health care of the medically ill person. Key to this section and unique to this book is the integration and application of the Peplau/Travelbee theories to the four step Assessment, Planning/Diagnosing, Implementation, and Evaluation (APIE) nursing process. The North American Nursing Diagnosis Association (NANDA 2009–2011) approved diagnoses are utilized in examples for care planning practice. Case study questions augment the chapter’s content with reflective questions both in the text and in the digital adjunct companion. SECTION IV: GROWTH AND DEVELOPMENT AND MENTAL HEALTH CONCERNS ACROSS THE LIFE SPAN covers essential nursing concerns related to care for children, adolescents, the elderly, and victims of abuse. SECTION V: MENTAL HEALTH CARE SETTINGS details psychiatric nursing across the continuum of care with special content on vulnerable populations and alternate settings and roles for the psychiatric mental health nurse. SECTION VI: CULTURAL, ETHICAL, LEGAL, AND PROFESSIONAL ASPECTS OF MENTAL HEALTH CARE covers integral aspects to providing competent care from a culturally sensitive perspective. Essential ethical and legal components are delineated for safe practice. Prevailing curricular guidelines for psychiatric-mental health nursing education are discussed.

The text contains features such as NCLEX preparation questions, clinical scenarios with “what would you do” questions, and consumer perspectives on what it is like to live with a specific illness. Also included are evidence based practice summaries from the psychiatric mental health nursing and related research literature. A student digital adjunct component contains carefully selected hyperlinks that compliment and augment the chapters themes, supplemental case study questions and answers, and review of key terms. A faculty digital adjunct contains power point highlights of each chapter and recommends films that further illustrate major diagnostic concepts.
This book will assist the beginning professional nurse in the development of knowledge of the interpersonal relationship, the importance of self reflection and discovery, and the skill in using these processes to assist patients in their journey toward mental health. The role of the professional psychiatric nurse and the power to heal individuals’ suffering from mental illness from an interpersonal relationship perspective remains timeless and relevant. This textbook intentionally guides curricula toward interpersonal relations in nursing as being the key fundamental practice skill set in psychiatric – mental health nursing, and thus serves as a testimony to the original architects of relationship-based care.
CHAPTER CONTENTS

Historical Overview of Mental Health and Mental Illness Care

Evolution of Psychiatric-Mental Health Nursing

Contemporary Psychiatric-Mental Health Nursing Practice
CHAPTER 1
MENTAL HEALTH TRENDS AND THE HISTORICAL ROLE OF THE PSYCHIATRIC-MENTAL HEALTH NURSE

Joyce J. Fitzpatrick
Jeffrey S. Jones

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 relationships as being the foundation for clinical practice.
5. Delineate between the roles and functions of basic and advanced practice in psychiatric-mental health nursing.

KEY TERMS

Asylums
Deinstitutionalization
Interpersonal models
Milieu management
Process groups
Psychopharmacology
Psycho-educational groups
Somatic
Therapeutic communication
Professional nursing originated from the work of a visionary leader, Florence Nightingale, who identified a need to organize the profession into a respectable discipline with its own body of knowledge and practice skill sets. As professional nursing evolved, so too did the practice of psychiatric-mental health nursing. This evolution paralleled the development in the field of mental health care. Subsequently, mental health care and psychiatric-mental health nursing practice have evolved from a poorly understood and poorly organized area of concern to a highly specialized area of health care.

This chapter provides an overview of the key historical events associated with the evolution of mental health care and their influences on psychiatric-mental health nursing. It also describes the current status of psychiatric-mental health nursing, focusing on the scope of practice for the two levels of psychiatric-mental health nursing practice: basic and advanced. This chapter emphasizes the interpersonal models of practice as the standard of care across the full range of settings and client groups. Relationships, interactions, and environment are important components of these models. This focus was selected to enhance this crucial element of nursing practice, the nurse-patient relationship, and, in particular, to establish interpersonal relations as the cornerstone of psychiatric-mental health nursing practice to assist patients in meeting their needs.

HISTORICAL OVERVIEW OF MENTAL HEALTH AND MENTAL ILLNESS CARE

History reveals that mental illness has been around since the beginning of time. However, it was not until the late eighteenth century when the view of mental illness became that of a disease requiring treatment and humane care. Overall, the views of mental health and mental illness closely reflect the sociocultural climate of the time.

The Earliest Years

Mental illness is a complex experience, with different values and meanings worldwide. While some cultures considered mental illness in a negative light, attributing it to possession by spirits or demons, other cultures considered mental illness somewhat differently, even as an exceptional state; one that would prepare that person to become a healer as, for example, in shamanism. However classified or viewed, the complexity of mental illness has prompted treatment, from ridding the person of spirits or demons to enabling the person to explore the possibility that he or she is a potential healer. For the former, magical therapies such as charms, spells, sacrifices, and exorcisms were used. For the latter, various initiation rituals were used.

In the West, however, the prevailing view of mental illness involved possession. A person who exhibited an odd or different kind of behavior without identifiable physical injury or illness was seen as possessed, specifically by an evil spirit or demon and the patient’s behavior was the result of this state of possession. In response, treatments such as magical therapies were commonplace. Physical treatments such as bleeding, blistering, and surgically cutting into the skull to release the spirit also were done. If the patient was not disruptive, he or she could remain in the community. However, if the patient’s behavior was violent or severe, the patient often was ostracized and driven from the community.

During the Middle Ages and the Renaissance period, the view of mental illness as demonic possession continued. Witch hunts and exorcisms were common. In addition, the strong religious influences at that time led to the belief that mental illness was a punishment for wrong doings. Persons with mental illness were inhumanely treated, being placed in dungeons or jails and beaten.

The Eighteenth and Nineteenth Centuries

The early to middle eighteenth century laid the groundwork for future developments in the latter half of this century and the next, especially in the United States. Society was beginning to recognize the need for humane treatment, which led to a gradual reshaping of the view of mental illness. Treatment, rather than punishment, exorcisms, and magical therapies, was becoming the focus. During this time, public and private asylums, buildings specially constructed to house persons with mental illness, were developed. Individuals with mental illness were removed from their homes and placed in these institutions.

This need for treatment prompted the development of institutions where care could be provided. For example, in 1751, Benjamin Franklin established Pennsylvania Hospital in Philadelphia. This was the first institution in the United States to provide treatment and care for individuals with mental illness. As the late eighteenth century approached, medicine began to view psychiatry as a separate branch. At the time, mental illness embraced only such medical interventions as bloodletting, immobilization, and specialized devices such as the tranquilizer chair both in the United States and abroad. These practices continued until the very late eighteenth and early nineteenth centuries. Through the work of Dr. Benjamin Rush in the United States, the focus of treatment began to shift to supportive, sympathetic care in an environment that was quiet, clean, and pleasant. Although humane, this
care was primarily custodial in nature. Moreover, individual states were required to undertake financial responsibility for the care of people with mental illnesses, the first example of government-supported mental health care.

A key player in the evolution of mental health and mental illness care during the nineteenth century was Dorothea Dix. A retired school teacher, Dix was asked to teach a Sunday school class for young women who were incarcerated. During her classes, she witnessed the deplorable conditions at the facility. In addition, she observed the inhumane treatment of the women with mental illness. As a result, she began a crusade to improve the conditions. She worked tirelessly for care reform, advocating for the needs of the mentally ill through the establishment of state hospitals throughout the United States (Mental Health America, 2009). Unfortunately, these state institutions became overcrowded, providing only minimal custodial care. Although she was a nurse, her impact on the evolution of mental health and mental illness may be overlooked because her work was primarily humanitarian.

**Dorothea Dix was instrumental in advocating for the mentally ill. She is credited with the development of state mental hospitals in the United States.**

### The Twentieth Century

The twentieth century ushered in a new era about mental health and illness. Scientific thought was coming to the forefront. In the beginning of the 1990s, two schools of thought about mental illness were prevalent in the United States and Europe. One school viewed mental illness as a result of environmental and social deprivation that could be treated by measures such as kindness, lack of restraints, and mental hygiene. The other viewed mental illness as a result of a biologic cause treatable with physical measures such as bloodletting and devices. This gap in thinking—deprivation on one end of the spectrum and biologic causes on the other end—led to the development of several different theories attempting to explain the cause of mental illness.

One such theory was the psychoanalytic theory developed by Sigmund Freud. His theory focused on a person’s unconscious motivations for behaviors, which then influenced a person’s personality development. Freud, a neuropathologist, examined a person’s feelings and emotions about his or her past childhood and adolescent experiences as a means for explaining the person’s behavior. According to Freud, an individual develops through a series of five stages: oral, anal, phallic/oedipal, latency, and genital. He considered the first three of these five stages (oral, anal, and phallic) to be the most important. If the person experiences a disruption in any of these stages, experiences difficulty in moving from one stage to the next, remains in one stage, or goes back to a previous stage, then that individual will develop a mental illness. Freud’s views became the mainstay of mental health and mental illness care for several decades.

The development of **psychopharmacology**, the use of drugs to treat mental illness and its symptoms, also revolutionized treatment for mental illness. The control of symptoms through the use of drugs allowed many individuals to be discharged from institutions and return to the community where they could live and function. Subsequently, the numbers of persons requiring hospitalization dramatically decreased. Moreover, psychopharmacology provided a lead-in to the future for deinstitutionalization and for addressing the underlying biologic basis for mental illness.

Research into the causes or factors associated with mental illness exploded during the 1990s, which became known as the “the decade of the brain.” Information about neurotransmitters and their role in influencing mental illnesses grew. New medications were developed from a greater understanding of how medications could regulate neurotransmitter reuptake. This era led to a major shift away from therapy as the main psychiatric treatment to one involving medical-somatic options as first line intervention.

### Governmental Involvement and Legislation

Governmental involvement in mental health care took on an expanded role during the twentieth century. In the United States at the time of World War II, individuals were rejected for military service due to psychological problems. Additionally, those returning from combat often were diagnosed with emotional or psychological problems secondary to the effects of the war. The view that anyone could develop a mental illness was beginning to take root. As a result, the National Mental Health Act was passed in 1946. This 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. It also called for the establishment of a National Advisory Mental Health Council and a National Institute of Mental Health (NIMH), which was formally established in 1949. NIMH focused its activities on research and training in mental health and illness.
In 1955, the Mental Health Study Act was passed, which called for a thorough analysis of mental health issues in the nation. This resulted in a Joint Commission on Mental Illness and Health which prepared a major report titled “Action for Mental Health.” The report established a need for expanded research and training for personnel, an increase in the number of full-time clinics as well as supplemental services, and enhanced access to emergency care and treatment. In addition, the report recommended that consumers should be involved in planning and implementing the delivery systems and that funding would be shared by all levels of government.

The impact of psychopharmacology coupled with the social and political climate of the 1960s led to the passage of the Mental Retardation Facilities and Community Mental Health Centers Act. This act was designed to expand the resources available for community-based mental health services. It called for the construction of mental health facilities throughout communities to meet the needs of all those experiencing mental health problems. The result was to ease the transition from institutionalized care to that of the community. The ultimate goal was to provide comprehensive humane treatment rather than custodial care. This legislation was part of President John F. Kennedy’s New Frontier program and led to the Deinstitutionalization (the movement of patients in mental health institutions back into the community) of many who had been in state-run and other mental health facilities that had provided long-term mental health care and treatment.

At this time, the NIMH expanded its service role and assumed responsibility for monitoring the community mental health centers programs (National Institutes of Health [NIH], 2010). Unfortunately, the number of community mental health centers grew slowly and often were understaffed. Care was fragmented and inadequate. Thus, the demands resulting from deinstitutionalization became overwhelming.

In the late 1960s, care of the mentally ill began to shift to community clinics.

The overwhelming demands faced by the community mental health centers continued. In addition, society was changing. Population shifts, a growing aging population, changes in family structures, and increased numbers of women in the workforce further complicated the system. In 1980, the Mental Health Systems Act was passed in response to the report findings of the President’s Commission on Mental Health. This act was designed to establish research and training priorities and address the rights of patients and community mental health centers. However, the election of a new president led to dramatic changes in focus. In 1981, the Omnibus Budget Reconciliation Act (OBRA) was passed, which provided a set amount of funding for each state. Each state would then determine how to use these funds. Unfortunately, mental health care was not a priority for the majority of states and, subsequently, mental health care suffered. Individuals with chronic mental illness often were placed in nursing homes or other types of facilities. In an attempt to address the issues associated with OBRA, Congress passed the Omnibus Budget Reconciliation Act of 1987, which was to provide a means for ensuring that the chronically mentally ill would receive appropriate placement for care. However, the political climate of concern for an ever-widening federal budget deficit led to a significant decrease in funding for mental health care.

In 1992, NIMH joined the National Institutes of Health (NIH) as one of the institutes that continues today to fund research on mental health and illness. NIMH also serves as a national leadership organization for mental health issues (NIH, 2010).

As a result of the changes in society and the political climate of the times, mental health care suffered once again. In response, Surgeon General David Satcher issued The Surgeon General’s Report on Mental Health in 1999. This was the first national report that focused on mental health. The report included recommendations for broad courses of action to improve the quality of mental health in the nation as follows: continuing the research on mental health and illness to build the science base; overcoming the stigma of mental illness; improving public awareness of effective treatment; ensuring the supply of mental health services and providers; ensuring delivery of state-of-the-art treatments; tailoring treatment to age, gender, race and culture; facilitating entry into treatment; and reducing financial barriers to treatment (Satcher, 1999). Subsequently, mental health care was brought to the forefront.

Current Perspectives

Following publication of the Surgeon General’s Report in 1999, another key report focusing on children’s mental health was published. The Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda called for:

• Improved recognition/assessment of children’s mental health needs and promotion of public awareness of children’s mental health issues.
CHAPTER 1: MENTAL HEALTH TRENDS AND THE PSYCHIATRIC-MENTAL HEALTH NURSE

Achieving the Promise: Transforming Mental Health Care in America, was issued in 2003 with several recommendations for service delivery. It identified the need for changing the current system to one that is more consumer- and family-driven and that underscored the need for mental illnesses to receive the same attention as other medical illnesses. Many of these changes are in the process of being implemented on the national and state levels (President’s New Freedom Commission on Mental Health, 2003).

Mental health, which first appeared as a major priority area in the Healthy People 2000 objectives, continued to be a priority for Health People 2020. In December of 2010, the Healthy People 2020 objectives were released. As in 2010, mental health and mental disorders are a priority concern. The Healthy People 2020 objectives for mental health and mental disorders are highlighted in Box 1-1.

Continued development, dissemination, and implementation of scientifically proven prevention and treatment services.

Reduction and/or elimination of disparities in access to mental health services and increased access and coordination of quality mental health services (U.S. Public Health Service, 2000).

This report further emphasized the need for improved mental health care.

Continued problems in the mental health system prompted the launch of the President’s New Freedom Commission on Mental Health in 2001. Its goal was to promote increased access to educational and employment opportunities for people with mental health problems. This Commission was specifically targeted with reducing the stigma associated with mental illness, lifting the financial and access barriers to treatment, and addressing the system fragmentation. The report,BOX 1.1: HEALTHY PEOPLE 2020 OBJECTIVES

MENTAL HEALTH AND MENTAL DISORDERS

1. Reduce the suicide rate.
2. Reduce the rate of suicide attempts by adolescents.
3. Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.
4. Reduce the proportion of persons who experience major depressive episode.
   4.1. Adolescents aged 12 to 17 years.
   4.2. Adults aged 18 years and older.
5. Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.
7. Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.
8. Increase the proportion of persons with serious mental illness who are employed.
9. Increase the proportion of adults with mental health disorders who receive treatment.
   9.1. Adults aged 18 years and older with serious mental illness.
   9.2. Adults aged 18 years and older with major depressive episode.
10. Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
11. Increase depression screening by primary care providers.
   11.1. Increase the proportion of primary care physician office visits that screen adults aged 19 years and older for depression.
   11.2. Increase the proportion of primary care physician office visits that screen youth aged 12 to 18 years for depression.
12. Increase the proportion of homeless adults with mental health problems who receive mental health services.

The early beginnings of psychiatric-mental health nursing can be traced back to Florence Nightingale, who first identified the need to view the patient holistically. Her focus was not mental illness; she was an advocate for patient self-care, believing that when a patient developed independence, he or she would be better able to face illness with lessened anxiety.

Specialization for psychiatric-mental health nursing arose along the same time that humane treatment for mental illness was coming to the forefront. Linda Richards, the first nurse trained in the United States, opened a training school for psychiatric-mental health nurses (PMHNs) in 1882. Although the training primarily consisted of meeting the patient’s physical needs, Richards strongly emphasized the need to assess a patient’s physical and emotional needs both. Thus, she is credited as being the first American psychiatric nurse.

Approximately 40 years later, the first nursing program for psychiatric-mental health nursing was established by

---

**Figure 1–1** Evolution of mental health care and psychiatric-mental health nursing. Events listed at the right identify key developments associated with mental health care. Events listed at the left identify key developments associated with psychiatric-mental health nursing. Note how significant events in mental health care parallel those in psychiatric-mental health nursing.
Effie Taylor at Johns Hopkins Phipps Clinic. Taylor, like Nightingale, emphasized the need to view the patient as an integrated whole. She also believed that general nursing and mental health nursing were interdependent. This was the first time that a course for psychiatric-mental health nursing was included in a curriculum.

**Continued Evolution**

During the first half of the twentieth century, the mental health field continued to evolve through the discovery of new therapies and theories. With the introduction of these new therapies, PMHNs were required to adapt the principles of medical-surgical nursing care to the care of psychiatric patients. In 1920, the first textbook of psychiatric-mental health nursing was written by Harriet Bailey. This book primarily focused on procedure-related care by nurses.

Continued involvement with the use of therapies resulted in a struggle for PMHNs to define their role. However, the social climate of the time promoted a view of women as subservient to men. This view also carried over into the realm of nursing.

Near the middle of the twentieth century, **INTERPERSONAL MODELS** (those that focus on the interaction of the person with others) by leaders such as Harry Stack Sullivan and others began to emerge. Sullivan believed that personality was an observable reflection of an individual’s interaction with other individuals. Thus, a person’s personality, be it healthy or ill, was a direct result of the relationship between that person and others. Sullivan also identified two key needs: the need for satisfactions (biologic needs) and the need for security (state of well-being and belonging). Any block to satisfactions or security results in anxiety (Sullivan, 1953).

Again, the emergence of interpersonal models paralleled a shift in nursing practice as interpersonal models of nursing practice were being developed. Interpersonal systems became prominent in mental health around 1945 and then in nursing practice in 1952. Both the field of mental health and the field of nursing flourished during this time period with an abundance of theorists contributing to their respective disciplines.

Nursing as a profession began to refine itself with the emergence of theorists such as Hildegard Peplau (1952) who defined nursing as “a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals and communities. Nursing is an educative instrument, a maturing force that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living” (p. 16). Nurse educators thus began to emphasize the importance of interpersonal relations and integrated relevant content in the curricula. Peplau further clarified the PMHN’s role as that of counselor, differentiating PMHNs working as general staff nurses from those who were expert practitioners with advanced degrees. According to Peplau, “psychiatric nursing emphasizes the role of counselor or psychotherapist...From my viewpoint, a psychiatric nurse is a specialist and at this time specialist status can be achieved by two routes—experience and education” (Peplau, 1962, p. 51). (For a more in-depth discussion of Peplau, see Chapter 2.)

As a result, nurses were being educated in modes of **THERAPEUTIC COMMUNICATION** (patient focused interactive process involving verbal and nonverbal behaviors), which were seen as integral parts of the patient’s recovery. It was not uncommon for nurses to carry a case load of patients and to spend significant portions of their shift having one-to-one, planned, structured conversations. These conversations were then recorded in the nursing record and their content was processed by the psychiatrist and other health professionals in their evaluation of progress in treatment. (For a more in-depth discussion of therapeutic communication, see Chapter 3.)

**MILIEU MANAGEMENT**, which developed after 1950, was adopted by psychiatric care facilities. Milieu management refers to the provision and assurance of a therapeutic environment that promotes a healing experience for the patient. This treatment approach is reflected in everything from the physical attributes of the mental health unit such as wall color and choice and arrangement of furniture, to source and levels of lighting. Nurses became the managers of the milieu, responsible for recognizing that they themselves were part of the milieu and thus had to conduct themselves in a manner conducive to supporting a therapeutic environment. This required an ever-conscious focus on dress, body language, tone, and style of verbal interaction, as well as vigilant awareness of surroundings and environment. For example, it would not be unusual for a nurse who was mindful of milieu management therapy to sense that the unit was tense and volatile and to respond by slowly and subtly adjusting the level of light or noise to produce a more relaxed environment. As much thought was spent about how to manage the unit as on how to manage any individual patient.

Nurses also conducted groups. Sometimes these were with a psychiatrist or other psychiatric staff member. Nurses led **PSYCHO-EDUCATIONAL GROUPS** (groups designed at imparting specific information about a select topic such as medication) and co-facilitated **PROCESS GROUPS** (more traditional form of psychotherapy where
Psychiatric-mental health nursing is “a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders” (ANA, 2007, p. 14). A major component of this specialized practice is the therapeutic use of self in conjunction with theoretical and research-based foundations from the various scientific disciplines. Psychiatric-mental health nursing occurs across a continuum of care encompassing a wide variety of settings (Box 1-2).

Scope and Standards of Practice

Initially developed in 1973, and most recently revised in 2007, the Scope and Standards of Practice delineate the specific responsibilities for psychiatric-mental health nursing. The Standards are divided into two areas: Standards of Practice and Standards of Professional Performance. The Standards of Practice address six major areas: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The Standards of Professional Performance address nine areas including quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and deep feelings, reactions, and thoughts are explored and processed in a structured way). Regardless of the treatment modality, the energy expended by the nurse in the delivery of psychiatric care revolved around the development and maintenance of a therapeutic relationship and the promotion of a therapeutic environment.

From 1954 onward, the discovery and use of antipsychotic medications such as chlorpromazine (Thorazine) revolutionized the understanding of and care for the severely mentally ill. It signaled a change of course for both nursing and mental health care. Medication administration and monitoring were added to the nurse-patient experience. Because of the effectiveness of newer longer acting medications (such as haloperidol [Haldol] and fluphenazine [Prolixin]), the 1960s were a time of care transition from hospital setting to community setting. However, the one-to-one nurse-patient relationship still remained important in nursing (Doona, 1979).

During the 1960s, the Division of Psychiatric and Mental Health Nursing Practice of the American Nurses Association (ANA) published the Statement on Psychiatric Nursing Practice. This was the first document to address the PMHN’s holistic view of the patient. It emphasized involvement in a wide range of activities addressing health promotion and health restoration. Since its initial publication, the document has been updated three times, expanding and clarifying the roles and functions of the PMHN to reflect the status of the current society.

By the 1990s, research and understanding of brain chemistry exploded so rapidly that it became known as the “decade of the brain.” Again, this signaled a shift in both mental health care and nursing practice because medical SOMATIC (referring to the body) interventions became the primary focus of treatment.

Inpatient stays became shorter and funding for mental health treatment began to diminish both at the inpatient and community levels. The role of the psychiatrist changed from the provider of therapy and medication to that of diagnostic and pharmacological expert as schools of medicine no longer offered therapy as part of physician training. Therapy was also now seen as the domain of the PhD-prepared psychologist and other independent providers such as social workers and advanced practice psychiatric nurses. With less time, less money, and less integrated service lines, the generalist psychiatric nurse’s role shifted to more of case manager of care. Duties were now more focused on admission and discharge proceedings, medication administration and monitoring, community linkage, and crisis management. These changes are still evident today.

**BOX 1.2: SETTINGS FOR PSYCHIATRIC-MENTAL HEALTH NURSING PRACTICE**

- Crisis intervention services
- Emergency psychiatric services
- Acute inpatient care
- Intermediate and long-term care
- Partial hospitalization programs
- Intensive outpatient treatment programs
- Residential services
- Community-based care: home, work sites, clinics, health maintenance organizations, shelters, schools, and colleges
- Assertive community treatment (ACT) programs
- Primary care
- Integrative programs
- Telehealth
- Self-employment
- Forensic mental health: correctional facilities
- Disaster response
leadership. Each area includes specific criteria for use in measuring achievement of the standard.

**Phenomena of Concern**

The psychiatric-mental health practice division of the ANA has developed a list of 13 specific areas or “phenomena of concern.” The phenomena provide the focus of patient care for PMHNs. These areas reflect the holistic view of the patient including the needs of the patient, family, group, and community. Therefore, when providing care to patients, PMHNs focus on the following:

- Health promotion (optimal mental and physical health and well-being) and prevention of mental illness
- Impaired ability to function
- Alterations in thought, perception and communication
- Potentially dangerous behaviors and mental states
- Emotional stress
- Management of symptoms, side effects or toxicities related to treatment
- Treatment barriers
- Changes in self-concept, body image, and life process; issues related to development and end-of-life
- Physical symptoms associated with changes in psychological status
- Psychological symptoms associated with changes in physiologic status
- Effects of interpersonal, organizational, sociocultural, spiritual, or environmental aspects
- Issues related to recovery
- Societal factors (ANA, 2007)

**Levels of Psychiatric-Mental Health Nursing Practice**

Two levels of psychiatric-mental health nursing currently are recognized: basic and advanced. The levels are distinguished by the educational preparation, complexity of practice, and specific nursing functions (ANA, 2007). The American Nurses Credentialing Center (ANCC) certifies both basic and advanced practice psychiatric nurses through an examination and credential review process.

Basic level PMHNs are registered nurses who have graduated from an accredited nursing education program and are licensed to practice in their state. In addition, basic level PMHNs possess specialized knowledge and skills to care for patients with mental health issues and psychiatric problems. They apply the nursing process through the use of the therapeutic nurse-patient relationship, therapeutic interventions, and professional attributes such as self-awareness, empathy, and the therapeutic use of self (ANA, 2007). The ANCC recognizes the baccalaureate degree in nursing as the preferred level of educational preparation.

Advanced practice PMHNs are educated at the master’s or doctorate level of education in the specialty and have achieved certification in this specialty by the ANCC. Advanced practice focuses on the “application of competences, knowledge, and experience to individuals, families, or groups with complex psychiatric-mental health problems” (ANA, 2007, p. 19). Mental health promotion, collaboration, and referral are key components of the advanced practice PMHN.

When graduate programs in psychiatric-mental health nursing were first introduced, the focus was on preparing educators to teach in basic nursing programs. Faculty members also were prepared to integrate psychiatric-mental health concepts throughout the undergraduate nursing curricula. Components such as communication skills, process recordings, and understanding of the emotional dimensions of physical illness were integrated into all nursing courses. The first psychiatric advanced practice role was the psychiatric clinical nurse specialist implemented by Hildegard Peplau. During the mid-1960s, more clinical nurse specialist (CNS) programs were introduced, emphasizing the preparation of specialists for both psychiatric-mental health nursing direct care roles, and for teaching, consultation, and liaison with other nurses in clinical practice. The core focus of CNS practice today emphasizes three spheres of influence: organizational and systems; nursing practice; and client (patient). The CNS seeks to improve patient outcomes by influencing nursing practice via research and mentorship, influencing organizational systems via consultation, or through direct care to individuals or communities (Fulton, Lyon, & Goudreau, 2010). Most psychiatric CNSs have training in individual psychotherapy, group psychotherapy, organizational consultation and liaison work, and research. More recently, some psychiatric CNSs have opted to add prescriptive authority to their set of services.

In the early 1960s the Nurse Practitioner (NP) role was introduced in rural areas of the United States. By the late 1990s, the psychiatric-mental health NP role was introduced. Traditionally, this role has been seen as a provider of common physician services such as direct patient care for complex diagnosis and management of medical illnesses with medication prescription. More recently, the development is the blending of the CNS and NP roles for preparation of advanced practice nurses (APNs) in psychiatric-mental health nursing. The challenge to educators, however, is how to combine the two roles while
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).

Preserving the uniqueness of each (Jones, 2010). The American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric Nurses (ISPN), two professional psychiatric-mental health nursing organizations, are in the process of reviewing the standards for credentialing for future psychiatric-mental health nursing practice at both basic and advanced levels.

Roles and Functions of the PMHN

Both basic and advanced practice PMHNs are guided by the Scope and Standards of Practice developed by the ANA. However, specific standards and criteria used for measurement are expanded for the advanced practice PMHN. Table 1-1 highlights the key functions for each level of practice.

### Table 1-1: Functions of PMHNs

<table>
<thead>
<tr>
<th>Basic Level</th>
<th>Advanced Practice Level (CNS / NP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of the therapeutic nurse-patient relationship</td>
<td>In addition to basic level functions:</td>
</tr>
<tr>
<td>Use of the nursing process</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Participation as a key member of the interdisciplinary team</td>
<td>Referral</td>
</tr>
<tr>
<td>Health promotion and health maintenance activities</td>
<td>Primary psychiatric-mental health care delivery</td>
</tr>
<tr>
<td>Intake screening, evaluation, and triage</td>
<td>Comprehensive psychiatric and mental health evaluation (assessment and medical diagnosis)</td>
</tr>
<tr>
<td>Case management</td>
<td>Prescription of psychopharmacological agents (if allowed by state)</td>
</tr>
<tr>
<td>Milieu management</td>
<td>Integrative therapy interventions</td>
</tr>
<tr>
<td>Administration of psychobiological treatments and monitoring and evaluation of response and effects</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Crisis intervention and stabilization</td>
<td>Complex case management (individual- or population-based)</td>
</tr>
<tr>
<td>Psychiatric rehabilitation</td>
<td>Consultation/liaison</td>
</tr>
<tr>
<td></td>
<td>Clinical supervision</td>
</tr>
<tr>
<td></td>
<td>Program development and management</td>
</tr>
</tbody>
</table>

**Summary Points**

- Early views of mental illness in the West focused on demonic possession with treatment consisting of charms, spells, witch hunts, and exorcisms. As the late eighteenth century approached, medical interventions such as bloodletting, immobilization, and specialized devices were used to treat mental illness. These practices were eventually stopped as the focus changed to supportive, sympathetic care in a quiet, clean environment.

- Dorothea Dix was instrumental in the care of the mentally ill in the United States, advocating for their needs through the establishment of state hospitals.

(cont.)
During the twentieth century, Freud’s psychoanalytic theory and the development of psychopharmacology played key roles in the treatment of mental illness. The passage of the National Mental Health Act in 1946 provided funding for research, mental health professional training, and facility expansion programs, and established the National Advisory Mental Health Council and a National Institute of Mental Health (NIMH). Mental health was beginning to gain focus as an important area of health.

In the 1960s, deinstitutionalization occurred. However, community mental health centers were not equipped to deal with the large numbers of persons who were deinstitutionalized. Care became fragmented and inadequate.

In 1999, the Surgeon General issued the first national report that focused on mental health that called for improving the quality of mental health in the nation. In 2001, the President’s New Freedom Commission on Mental Health was created and led to recommendations for changing the current system to one that is more consumer- and family-driven and emphasizing the need for mental illnesses to receive the same focus of attention as medical illness.

Although not a psychiatric-mental health nurse, Florence Nightingale first identified the need to view the patient holistically, advocating for self-care. Linda Richards, credited as being the first American psychiatric nurse, emphasized the need to assess a patient’s physical and emotional needs. Forty years later, the first psychiatric-mental health nursing program was established.

With the evolution of the mental health field, psychiatric-mental health nurses were required to adapt the principles of medical-surgical nursing care to that of psychiatric patients. The emergence of interpersonal models in the fields of psychiatry and nursing led to a refinement in the nurse’s role. Hildegard Peplau emphasized the importance of interpersonal relations and the need to integrate this relevant content into the curricula.

Publication of the ANA’s Statement on Psychiatric Nursing Practice was the first document to address the psychiatric-mental health nurse’s holistic view of the patient and emphasized involvement in a wide range of activities addressing health promotion and health restoration.

The “decade of the brain” shifted the focus of care to medical somatic interventions.

Two levels of psychiatric-mental health nursing are recognized: basic and advanced. Basic level psychiatric-mental health nurses apply the nursing process through the use of the therapeutic nurse-patient relationship, therapeutic interventions, and professional attributes such as self-awareness, empathy, and the therapeutic use of self. Advanced practice psychiatric-mental health nurses have a master’s or doctoral degree and have received certification by the ANCC. Mental health promotion, collaboration, and referral are key components of advanced practice.
NCLEX-PREP

1. A nursing instructor is preparing a class discussion about the development of mental health care over time. Which of the following would the instructor include as occurring first?
   a. Development of psychoanalytic theory
   b. Establishment of the National Institute of Mental Health
   c. Use of medical treatments such as bloodletting and immobilization
   d. Emphasis on supportive, sympathetic care in a clean, quiet environment

2. A group of nursing students are reviewing information related to the development of psychiatric-mental nursing. The students demonstrate understanding of the information when they identify which person as emphasizing the use of the interpersonal process?
   a. Florence Nightingale
   b. Linda Richards
   c. Dorothea Dix
   d. Hildegard Peplau

3. A psychiatric-mental health nurse (PMHN) is preparing a presentation for a group of student nurses about psychiatric-mental health nursing. Which statement would the nurse include in the presentation about this specialty?
   a. A PMHN needs to obtain a graduate level degree for practice.
   b. Advanced practice PMHNS can engage in psychotherapy.
   c. Basic level PMHNS mainly focus on the patient’s ability to function.
   d. PMHNS primarily work in acute in-patient settings.

4. When describing the results of integrating interpersonal models in psychiatric-mental health nursing, which of the following would be least appropriate to include?
   a. Therapeutic communication
   b. Milieu management
   c. Psychopharmacology
   d. Process groups

5. Deinstitutionalization occurred as a result of which of the following?
   a. Mental Retardation Facilities and Community Mental Health Centers Act
   b. National Mental Health Act
   c. Omnibus Budget Reconciliation Act (OBRA)
   d. The Surgeon General’s Report on Mental Health

REFERENCES


