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TEXAS A&M UNIVERSITY - CORPUS CHRISTI
College of Nursing and Health Sciences

NURS 4564 NURSE AS PROVIDER OF CARE TO PSYCHIATRIC/CHEMICAL DEPENDENCY PATIENTS

Spring 2014

Faculty: Eva M Bell, DNP, RN, FNP-BC, PMHNP-BC
Office Hours: By appointment
Office Phone: 361-825-5939
Office: Island Hall 350C
Email: eva.bell@tamucc.edu
Credits: 5 credit hours

Faculty: Carmen Hernandez MSN, RN
Office Hours: Monday 9-11 and 1-3; Tue: 9-10 Other times by appointment
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Office: Island Hall 333
Email: carmen.hernandez@tamucc.edu
Credits: 5 credit hours

Faculty: Kathy Deis MSN, RN
Office Phone: 361-825-3087
Office: Island Hall 331

Faculty: Nancy Schierding, MSN, RN
Office Phone: 361-902-6809
Office: 6th floor (Geriatric Unit) Christus Spohn Memorial
Course Description: Emphasis is on the nurse as provider of care to individuals, families and groups experiencing psychiatric/mental health problems. Theoretical foundations for the practice of psychiatric/mental health nursing and theoretical frameworks for understanding human behavior are studied.

Course Objectives with examples of outcome criteria:

1. Examine theoretical frameworks of human behavior and development that explain normal and abnormal behavior.
   1.1 Compare and contrast the concepts of mental health and mental illness.
   1.2 Interpret the assumptions and key concepts of the neuron-chemical-biologic, psychoanalytic, behavioral and social-interpersonal frameworks.
   1.3 Describe the implications each framework has for psychiatric nursing practice.
   1.4 Recognize that the knowledge of growth and development is an integral component of nursing assessment and nursing diagnosis.
   1.5 Summarize theories that purport to explain stress.

2. Analyze nursing theory as a basis for psychiatric nursing.
   2.1 Evaluate the usefulness of selected contemporary nursing theories for organizing data and guiding the practice of psychiatric nursing.
   2.2 Comprehend key concepts in selected contemporary nursing theories.
   2.3 Apply theories to clinical practice and integrate into clinical journal.

3. Relate the usefulness of research in psychiatric nursing.
   3.1 Identify critical issues associated with the application of nursing research to psychiatric nursing practice.
   3.2 Predict directions for future psychiatric nursing research.
   3.3 Utilize psychiatric nursing research in nursing practice.
   3.4 Participate in the examination and application of current psychiatric research in classroom exercises.
   3.5 Evaluate the clinical care of patients in light of current psychiatric research.

4. Recall clinical modalities and psychiatric terminology as it relates to psychiatric/addictions nursing practice.
   4.1 Explain the psychopathology and neurochemistry of specific mental and addictive disorders.
   4.2 Describe the behavioral manifestations of specific mental and addictive disorders.
   4.3 Describe classes, properties, use and side effects of the major psychotropic medications.
   4.4 Relate the movement disorders caused by psychotropic drugs.
   4.5 Identify specific interventions for psychiatric and addictive disorders.
   4.6 Correlate DSM IV with the nursing process in providing care for patients with mental and addictive disorders.
   4.7 Identify factors affecting families of mentally ill and chemically dependent individuals.

5. Relate the legal, ethical, political, historical and cultural factors critical to the practice of psychiatric and addictions nursing.
5.1 Relate the importance of psychiatric/addictions nursing assessment to legal, ethical and practice issues.
5.2 Identify ethical dilemmas in psychiatric nursing.
5.3 Recall critical historical elements associated with the development of psychiatric/addictions nursing.
5.4 Discuss the relevance of cultural factors in psychiatric/addictions nursing practice.
5.5 Describe the relationship between the legal and civil rights of mental health patients.
5.6 Relate the Texas Mental Health Code and its relevance to the practice of psychiatric nursing in Texas.
5.7 Evaluate the importance of State Mental Health Codes and the protection of the mentally ill.

6. Analyze the component of the caring-empathic relationship.
6.1 State the nature and goals of the caring-empathic relationship.
6.2 Identify common characteristics of the caring-empathic relationship.
6.3 Explain the nurse’s role and potential issues that may arise in each phase of the nurse-patient relationship.
6.4 Compare and contrast major theories of communication with psychiatric and chemical dependency patients.
6.5 Explain such strategies as boundaries, distance, self-disclosure, acceptance of gifts, limit setting, confrontation and use of touch with mentally ill and chemically dependent patients.
6.6 Relate a personal philosophy and values framework salient to the care of psychiatric and chemically dependent patients.

7. Accept responsibility for own learning.
7.1 Attend class regularly and in a timely manner.
7.2 Participate in classroom exercises, activities and discussions.
7.3 Select independent learning experiences related to own interests and needs.
7.4 Practice appropriate communication techniques in the classroom.
7.5 Evaluate progress in relation to objectives.
7.6 Apply critical thinking exercises to classroom discussion.
7.7 Complete assignments within designated time period and submit neatly prepared written work.

Required Textbooks:

Learning Experiences and Teaching Methods:
Course objectives may be met through individual study using suggested resources, active involvement in classroom activities, formal and informal exchange of ideas with classmates and colleagues regarding specific topics as well as utilizing critical thinking skills. **Consistent classroom attendance and participation is a requirement of this course.** Teaching methods include lecture, seminar, discussion, small group work, independent study of texts and library resources, computer-assisted instruction, audio-visual aids and the assignments listed below. While the professor will provide guidance and consultation, the student is responsible for identification of learning needs, self-direction, seeking consultation and providing measurable demonstration of course objectives.

Student Class Rights and Responsibilities:
Students are:

1. Expected to respect the learning rights of others in the classroom, individual conversations, arriving to class late and studying for another class during classroom time is unacceptable behavior, disruptive and considered non-contributive to a positive learning environment. **See College of Nursing policy on Academic Integrity and Professional Conduct**
2. Expected to complete all required reading prior to each class period.
3. Written homework may be assigned at the discretion of the faculty. As a 5 semester credit course, faculty expect 10-12 hours of independent preparation and study each week, in addition to class time. Preparation for all classes includes assigned readings for the scheduled topics and completion of class assignments.
4. Permission to tape record must be obtained from each lecturer prior to class. Clinical examples or examples from clinical experiences are not to be recorded.
5. Children are NOT permitted in the classroom at any time. (See University Student Manual.)
6. Attendance will be taken when all Famous Person Presentations are scheduled. A contract will be signed with specific details.

CLASS POLICIES
Grading Policy
**Successful completion of NURS 4564 requires the following:**

1. Completion of the theoretical component: The test average (including the HESI final) must average a minimum of 75%. After the grade average on the four (4) exams meets an average of 75%, the Famous Person Presentation grade will be averaged in to achieve the final course grade. You must successfully complete clinical practicum to pass this course.

2. Clinical practice is the application of the theoretical component into the practice area. Preparation for clinical practice is required. Clinical performance is graded **pass/fail** and is evaluated on the basis of written clinical objectives. **If the student fails clinical, he/she will receive an “F” in the course, regardless of the theory grade. If the student fails theory, he/she will receive an “F” in the course, regardless of the clinical grade.** Theory is given a letter grade and if the student passes clinical, the course grade will be the grade achieved in theory. To pass the theory component the student must achieve a minimum average of 75%.
3. A HESI specialty exam will be given for this Course (see Course Schedule) and is mandatory. If HESI, the specialty exam is not taken, due to the student’s failure to attend the scheduled date and time, a grade for the Course will not be issued.

4. College of Nursing and Health Sciences Grading Scale

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<td>F</td>
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5. Evaluation Methods:

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<td>Exam II</td>
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<td>Exam III</td>
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<td>Famous Persons Presentation</td>
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<td>HESI Exam</td>
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100%

6. Examination blue prints and Test Challenge forms are in Appendix C.

7. Class Participation:

Class participation is defined in the following manner:

a. Regular and timely attendance at all scheduled classes – coming in late is considered disruptive to the learning environment; the issue will be addressed individually with the student and, if necessary, the Policy on Academic Integrity and Professional Conduct will be instituted.

b. Participation in discussion of assigned classroom activities and classroom objectives.

c. Discussion and presentation of assigned objectives during classroom group work.

d. Implementation of assigned classroom activities.

e. Analysis of classroom lecture content, assigned scenarios and video presentations during class time.

f. Cell phones are to be turned off during the class and examinations. During exams cell phones must be put away and not accessed during the examination period.

g. Any in class assignments must be completed on the day they are assigned. No exception.
Missed Examinations:
The student is permitted to miss only **ONE** examination of the **THREE** faculty generated examinations. Missing an examination **MAY** be due to a personal or professional emergency **ONLY**. If a student misses either Exam I, II or III a mean of the **TWO** exams taken is calculated to tabulate the score of the **ONE** missed exam. There are NO make-up examinations. Please notify faculty in advance if you must miss an exam. The student must have an **average of 75% on all four exams** to pass the theory portion of the course.

1) **The HESI exam is an exit exam and must be taken on the assigned day and time. There is NO make-up time allowed for the HESI exam.**

Examination Guidelines:

1) A blueprint for each exam is included in this syllabus – this blueprint was created by the baccalaureate faculty and approved for classroom use.

2) The final examination will be comprehensive.

3) Testable material is based on course, class and clinical objectives. Included are all required readings, lecture and discussion content, related material in the course syllabus, content covered by media presented in or required for class/clinical, power-point, and material given as handouts.

4) **A student self-paced, independent review Study Guide** has been provided as a **review of the lecture and text material** for each week as a way of assisting the student in studying for EXAMS I, II, & III and preparing for the HESI. **Students are expected to attend the class lectures and ask questions about the review material following the weekly lectures.** The purpose of this independent, student directed review is to assist the student in taking the exams and studying for the HESI specialty exam.

5) Exam dates, times and locations are subject to change by the professor or the University.

6) To reinforce learning and to promote understanding of content, the following policies apply:
   a. Exam reviews will occur immediately following completion of the exam. The course faculty will review the test statistics and questions that were problematic and review these the following week.
   b. **A TEST CHALLENGE FORM** is provided in this syllabus to use in identifying questions that require clarification from the professor. **ALL TEST CHALLENGE FORMS** are to be signed by the student and turned in to the professor after the review of the examination.
   c. After review of the **TEST CHALLENGE FORM**, the professor will determine the appropriate action. Students will be informed in the next class if there has been a point reallocation for specific questions.
   d. Students are expected to review their exams during the classroom time allocated for review.
   e. Students may further review Exams I, II & III during the professor's office hours or at a previously arranged appointment time.
   f. Any bonus points assigned to an exam will be added onto the grade if the grade is 75% or above. No bonus point will move the exam grade from below 75% to above 75%. That minimum number must be achieved on exam questions before bonus points are added to the final grade.
Class Cancellation:
In the event that a class is canceled, the student is expected to do the readings and complete the objectives for that day. The content will still be included on course examinations.

Course Changes:
Elements of this syllabus may be changed at any time and the Course Calendar is subject to change.

University Policies:

**Academic Advising:** The College of Nursing and Health Sciences require that students meet with an Academic Advisor as soon as they are ready to declare a major. The Academic Advisor will set up a degree plan, which must be signed by the student, a faculty mentor, and the department chair. The College’s Academic Advising Center is located in Faculty Center rooms 163 & 165, and advisors are Rachel Taylor 825.3748 and Angelica Santillan 825.2461.

**The Veterans Office – Student Services Center:**
The Office of Veterans Affairs at Texas A&M University - Corpus Christi provides assistance for active duty and reserve service members, Veterans, and their dependents in applying for Veterans Education Benefits under the GI Bill and/or Texas Hazlewood and Hazlewood Legacy Act. If you are new to Texas A&M Corpus Christi, you can use this online checklist to help you get started on your application for admission and your application for Veterans Education Benefits. If you have any questions during this process, contact the Veterans Office at TAMUCC at (361) 825-2331 or e-mail us at: veterans.affairs@tamucc.edu.

**Students with Disabilities:** The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you believe you have a disability requiring an accommodation, please contact the Disability Services Office at 361.825.5816 or visit the office in CCH 116. Exam Services: 825.2259.

**Academic Honesty:** University students are expected to conduct themselves in accordance with the highest standards of academic honesty. Academic misconduct for which a student is subject to a penalty includes all forms of cheating, such as illicit possession of examinations or examination materials, forgery, or plagiarism. Plagiarism is the presentation of the work of another as one’s own work.

http://conhs.tamucc.edu/shb/docs/AcademicHonesty.pdf

**Grade Appeal Process:** As stated in the College of Nursing and Health Sciences (CONHS) Handbook under section VII Policies and Procedures, a student that believes they have an academic grade appeal is encouraged to go through the University Grade Appeal. See the handbook for the process.

As stated in University Rule 13.02.99.C2, Student Grade Appeals, a student who believes that he or she has not been held to appropriate academic standards as outlined in the class syllabus, equitable evaluation procedures, or appropriate grading, may appeal the final grade given in the course. The burden of proof is upon the student to demonstrate the appropriateness of the appeal. A student with a complaint about a grade is encouraged to first discuss the matter with the instructor. For complete details, including the responsibilities of the parties involved in the process and the number of days allowed for completing the
steps in the process, see University Procedure 13.02.99.C2.01, Student Grade Appeal Procedure. These documents are accessible through the University Rules Web site.

http://registrar.tamucc.edu/change_grade.html

For assistance and/or guidance in the grade appeal process, students may contact the Office of Student Affairs.

Dropping a Class: I hope that you never find it necessary to drop this or any other class. However, events can sometimes occur that make dropping a course necessary or wise. Please consult with me before you decide to drop to be sure it is the best thing to do. Should dropping the course be the best course of action, you must initiate the process to drop the course by going to the Student Services Center and filling out a course drop form. Just stopping attendance and participation WILL NOT automatically result in your being dropped from the class. April 11, 2014 is the last day to drop a class.

Method of scholarly citations: APA
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<tbody>
<tr>
<td>Jan 22</td>
<td>Introductions</td>
<td>Readings due for class: Text: Ch. 1, 25, 28</td>
<td>Complete Text Readings for class and the case studies in Appendix A;</td>
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<td></td>
<td>Course Overview</td>
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<td>Review the ethical principles in Appendix B</td>
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<td>Week # 1</td>
<td>Lecture: Mental Health Trends and the Historic Role of the Psychiatric Mental HX Nurse; Psychiatric Mental HX Nursing Across the Continuum; Ethical and Legal Principles</td>
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<td>January 29</td>
<td>Lecture – Psychotherapeutic Management</td>
<td>Readings due for class: Text: Pg (Addictive behavior) 314; 495; (Adol) 223-230; (Affective D/O) 334-346; (Personality D/O) 287-289; Ch. 2, 4</td>
<td>Complete Text readings Videos in class: Psychotropic Medications; Medication Issues - Movement Disorders: If time permits</td>
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<td>Week # 2</td>
<td>Psycho-pharmacology; Interpersonal Relationships- Cornerstone of Psych Nursing; Boundary Management</td>
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<td>Therapeutic Use of Self and TC: From Self-Discovery to Interpersonal Skill Integration; Anxiety D/O Nursing Theories</td>
<td>Text Ch. 9, 13, Defense Mechanisms Ch. 10</td>
<td>Videos: Anxiety and Medications: If time permits; The Emotional Life; Stress and Your Body</td>
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<td>Week # 3</td>
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<td>Pag. 38</td>
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<td>February 12</td>
<td>EXAM I – 0800-0930 Lecture:1000-1050</td>
<td>Readings due for class: Text: Ch. 5</td>
<td>Review Power Point Outlines</td>
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<td>Critical Thinking, Clinical Decision Making and The Interpersonal Relationship</td>
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<td>Week # 4</td>
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<td>February 19</td>
<td>Lecture Exam I Statistical Review</td>
<td>Readings due for class: Text: Ch. 6, 8, &amp; 20</td>
<td>Complete Text readings Review Power Point Outlines</td>
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<td>Psychotherapeutic Management</td>
<td>Crisis Intervention; Risk Factors for Mental Illness and Nursing Interventions for Prevention; Psychological Problems of Physically Ill Persons</td>
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<td>Week # 5</td>
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<td>February 26</td>
<td>Lecture Psychotherapeutic Management:</td>
<td>Readings due for class:</td>
<td>Complete Text readings Review Power Point Outlines Video: Depression and medications: If time permits; John Nash; 20/20 Documentary on Childhood/Adolescent Schizophrenia</td>
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<td>*Week # 6</td>
<td>Psychopathology</td>
<td>Text: Ch. 11, 26, Managing Anger/Violence (Word document is listed under Wk 6 pg. 70-73)</td>
<td>J ohn Nash; 20/20 Documentary on Childhood/Adolescent Schizophrenia</td>
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<td>*Pg. 63</td>
<td>Psychoses &amp; Schizophrenia (Thought D/O); Vulnerable Population and the Role of the Forensic Nurse</td>
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<td>Managing Anger &amp; Violence</td>
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<td>March 5</td>
<td>Lecture Psychotherapeutic Management:</td>
<td>Readings due for class:</td>
<td>Complete Text readings Review Power Point Outlines Video: Depression and medications: If time permits</td>
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<td>*Week # 7</td>
<td>Mood (Affective) D/O; Suicide Cognitive-Behavioral Interventions</td>
<td>Text Ch. 12 and Pg. 194-195</td>
<td>J ohn Nash; 20/20 Documentary on Childhood/Adolescent Schizophrenia</td>
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<td>*Pg. 74</td>
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<td>Review and study for Exam II</td>
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<td>Suicide (Word document is listed under Wk 7 Pg. 78)</td>
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<td>March 19</td>
<td>EXAM II – 0800-0930</td>
<td>Readings due for class: Text Ch. 14, 17</td>
<td>Complete Text readings Review Power Point Outlines</td>
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<td>Week # 8</td>
<td>Lecture 1000-1050</td>
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<td>Pg. 80</td>
<td>Personality Disorders</td>
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<td>Dissociative Disorders</td>
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<td>March 26</td>
<td>Exams II: Statistical Review</td>
<td>Readings due for class: Text Ch. 15, 19, 20</td>
<td>Complete Text readings Review Power Point Outlines</td>
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<td>Lecture</td>
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<td>Psychotherapeutic Management:</td>
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<td>Substance Abuse</td>
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<td>Brain Chemistry of Addiction</td>
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<td>Eating Disorders; Psychological Problems of Physically Ill Persons</td>
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<td>April 2</td>
<td>Lecture</td>
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<td>Week # 10</td>
<td>Psychotherapeutic Management:</td>
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<td>Pg. 87</td>
<td>Domestic Violence; Working with Children; Mental Health Concerns</td>
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<td>Regarding Adolescents</td>
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<td>April 9</td>
<td>EXAM III 0800-0930</td>
<td>Readings due for class:</td>
<td>Complete Text readings</td>
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<tr>
<td>Week # 11</td>
<td>LECTURE: 1000-1050</td>
<td>Text Ch. 23 &amp; 27</td>
<td>Review Power Point</td>
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<tr>
<td>Pg. 97</td>
<td>Issues Specific to Elders, Cultural,</td>
<td></td>
<td>Outlines</td>
</tr>
<tr>
<td></td>
<td>ethnic and spiritual issues</td>
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<tr>
<td>April 16</td>
<td>Exam III – Statistical Review</td>
<td>Statistical Review</td>
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<td>Famous Persons Presentations</td>
<td>Student Presentations</td>
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<tr>
<td>April 23</td>
<td>Famous Persons Presentations</td>
<td>Student Presentations</td>
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<td>Week # 13</td>
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<td>Week # 14</td>
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<td>TBA</td>
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APPENDIX A

LEGAL/ETHICAL

CLINICAL CASE # 1

On a Wednesday morning in 2010 in Lewisville, Ohio, a man walked into Samuels Hardware Store, grabbed a pick-ax, and began swinging at the customers and shouting about the devil. When he left, one person was dead and two others were critically injured. Ten days later, police received a call from Mr. T., who was a patient in the 49-bed psychiatric unit at St. John's Hospital. Mr. T told the police that his roommate at the hospital confessed to the crime in Lewisville. However, he didn't know his roommate's name but they could get it from the nurses. The police contacted Nurse S.R. and asked her to identify the patient but she refused to do so. She told them that she believed his name was shielded by state mental health law guaranteeing the confidentiality of mental patients. Hospital administrators supported her decision and obtained legal counsel for her.

QUESTIONS:

1. Why did the nurse require legal counsel?

2. Was the nurse legally correct in her refusal to divulge information? Why?

3. Was the nurse ethically correct in her refusal to divulge information? Why?

4. If she had divulged the identity of the patient, what legal action could be taken against her, if any?

5. Under what circumstances could the nurse be required to divulge information about this case?

Be prepared to discuss this case in class.
LEGAL/ETHICAL
CLINICAL CASE: #2

Thomas W., age 30, was brought to the hospital by city police. He was found outside the city library ranting and raving about Satan. He was admitted to the unit with a diagnosis of schizophrenia, paranoid type. He told the nurse that he has electricity in his blood and that he possessed super powers given to him by God. Although he was not displaying weapons at the time of the arrest, the police found and confiscated a gun from Mr. W. During a conversation with the nurse on the third day after admission, he tells her that his ex-girlfriend works at the city library and that he was going there to kill her because she is filled with Satan. He becomes very secretive and suspicious when the nurse asks him if he still wants to kill his girlfriend. At one point he looks at the nurse with a murderous look in his eyes and says: "You are just like her! The Holy Ghost told me you are filled with Satan, too!"

QUESTIONS:

1. What is the best action for the nurse to take at this moment?

2. Does the nurse report the patient's intent to kill his girlfriend? If so, why?

3. To whom does the nurse report the intent?

4. What will happen to the nurse if she:
   
   Does report the intent?

   Does not report the intent?

5. What is likely to happen to Mr. W?

Be prepared to discuss in class.
Carrie Williams has been admitted to the Psychiatric Unit at Bay Shore Treatment Facility. She is eight-and-one-half months pregnant and in a manic state. She has not slept for three days, is hyperactive and hyper-verbal. When you come on duty, she is running all over the Day Room, jumping from chairs and standing on tables saying to everyone: "I am Lindsay Lohan and I will perform for you. My agent wants you to listen to me and come to see my movies. I'm going to Hollywood and if you treat me right I will take you along."

Along with several other nurses, you decide the patient must be placed in seclusion for her protection and the safety of the fetus. She is also disrupting the Unit and upsetting the other patients. Tension in the Day Room is very high as Mrs. Williams climbs over the back of a sofa and almost falls over a table.

After being placed in seclusion, the patient rolls on the floor and bounces herself off the walls with her protruding stomach. The psychiatrist is notified and orders that liquid Haldol (an appropriate dosage for the patient) be injected into the patient's sealed juice containers and that she be encouraged to drink the juice. As the nurse working with this patient you would:

**QUESTIONS:**

1. Call the Patient's Rights Advocate since this patient's mental health rights are being violated.

2. Inject the Haldol into the patient's juice and encourage her to drink it.

3. Refuse to administer the medication to the patient.

4. Tell the physician if he wants the medication injected into the patient's juice without her knowledge - he can do it.

Be prepared to discuss in class.
APPENDIX B

ETHICAL CONCEPTS

1. AUTONOMY - The right of self-determination, independence and freedom.

2. JUSTICE - The obligation to be fair to all people.

3. FIDELITY - The person’s obligation to be faithful to commitments made to the self and others.

4. BENEFICENCE - The commitment to do only that which is good for the patient.

5. NONMALEFICENCE - The requirement that health care providers do no harm to patients.

6. VERACITY - The requirement that the health provider tell the truth and not intentionally deceive.

7. STANDARD OF BEST INTEREST - A decision that is made about the person’s health care when they are unable to make an informed decision.

8. UTILITARIANISM - The ethical system of utility; greatest good for the greatest number and the end justifies the means.

9. Kantianism – Establishing, maintaining, and improving quality health care consistent with the values of the profession through individual and group action.
APPENDIX C

Examination Blue Prints

I, II, III

TEST CHALLENGE FORMS

Examination: I, II, III
### Exam I Blueprint

<table>
<thead>
<tr>
<th>Textbook Chapters</th>
<th>Topic/s</th>
<th>Number of Questions</th>
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<tbody>
<tr>
<td>1, 28, 25, 3, 4</td>
<td>Legal Ethical</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Interventions (Communication)</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Conceptual Models</td>
<td>4</td>
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<tr>
<td><strong>Medication handout (BB)</strong> pg 314-317, 495, 223-230, 474-476, 345-347, 254-258; Ch 2, pg 9,</td>
<td>Psychopharmacology</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing Process</td>
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<tr>
<td></td>
<td></td>
<td>Therapeutic Milieu</td>
</tr>
<tr>
<td>Ch 13, pg 44-46 (syllabus); pg 167 text, Ch 10</td>
<td>Anxiety</td>
<td>15</td>
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<tr>
<td></td>
<td></td>
<td>Defense Mechanisms/Mental HX Theories</td>
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<td>Total</td>
<td>60</td>
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### Exam II Blueprint

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<th>Textbook Chapters</th>
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<tr>
<td>(Insert: Anger and Aggression); 5, 6, 8, 20</td>
<td>Anger/Aggression- Seclusion &amp; Restraint</td>
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</tr>
<tr>
<td></td>
<td>Nursing Process/Critical Thinking</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Psychological Probs of Phy. Ill Clients</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Crisis Intervention</td>
<td>10</td>
</tr>
<tr>
<td>11, 26, (Insert: Violence)</td>
<td>Psychopathology – Psychoses and Schizophrenia- Vulnerable population</td>
<td>26</td>
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<tr>
<td></td>
<td>Violence in a Psychiatric Setting</td>
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<td>Total</td>
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## Exam III Blueprint

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<th>Topic/s</th>
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<td>15, 20</td>
<td>Substance Abuse/addiction</td>
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<td>Psych Prob of Phy Ill Person</td>
<td>2</td>
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<td>12, 17, 14, (Insert: Suicide)</td>
<td>Mood (Affective) Disorder-CBT</td>
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<tr>
<td></td>
<td>Suicide</td>
<td>10</td>
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<td></td>
<td>Personality Disorders</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Impulse Control Disorder</td>
<td>5</td>
</tr>
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<td>19, 24, 21, 22, 23</td>
<td>Eating Disorders</td>
<td>7</td>
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<td></td>
<td>Domestic Violence/Victim/Victimizers</td>
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<tr>
<td></td>
<td>Children, Adol. Ederly</td>
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<td></td>
<td><strong>Total</strong></td>
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# NURS 4564.001 – TEST CHALLENGE

**Exam I, II, III (Circle one)**

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Student Signature          Date
**APPENDIX D**

**CRITERIA – GROUP POWER POINT PRESENTATION**

MENTAL ILLNESS AND FAMOUS PERSONS

**Group Assignment** (Approximate time 30 minutes)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Points</th>
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<tbody>
<tr>
<td>1. Select a famous person – living or dead to assess for mental illness –</td>
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<tr>
<td>describe demographics and behaviors</td>
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</tr>
<tr>
<td>2. Using a mental status exam* or brief psychiatric scale* – evaluate</td>
<td>10</td>
</tr>
<tr>
<td>that persons mental status with available pertinent information from</td>
<td></td>
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<tr>
<td>the literature (use only areas that apply).</td>
<td></td>
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<tr>
<td>3. Determine a DSM-IV diagnosis for that person (Text Appendix A).</td>
<td>10</td>
</tr>
<tr>
<td>4. Determine two nursing diagnoses pertinent for this person’s mental</td>
<td>10</td>
</tr>
<tr>
<td>status and nursing care needs</td>
<td></td>
</tr>
<tr>
<td>5. Identify five nursing interventions and rationale for each one</td>
<td>15</td>
</tr>
<tr>
<td>6. Prepare a Power Point presentation addressing these criteria and</td>
<td>10</td>
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<tr>
<td>present this information during the assigned class period. Time: 30</td>
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</tr>
<tr>
<td>minutes</td>
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<tr>
<td>7. APA (possible 8 pts) and grammar (possible 7 pts)</td>
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<tr>
<td>8. Peer evaluation</td>
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* See your syllabus

**Group members**

__________________________  __________________________  __________________________

__________________________  __________________________  __________________________

__________________________  __________________________  __________________________
BRIEF PSYCHIATRIC ASSESSMENT

ANXIETY
Demonstrates excessive worry, fear, over-concern for the present or future.

PHYSICAL CONCERNS
Preoccupation with physical health, fear of physical illness, talks incessantly about ailments.

EMOTIONAL WITHDRAWAL
Lack of spontaneous interaction, isolation, deficiency in relating to others.

DISRUPTIONS IN THOUGHT
Thought processes are confused, disconnected, disorganized, grandiose or obsessive.

GUILT FEELINGS
Extreme self-blame, shame and remorse over the past or behavior. Inability to shift focus of topic from shame and blame.

TENSION
Physical and motor evidence of nervousness, over-activation.

MANNERISMS AND POSTURING
Peculiar physical movements, bizarre and unnatural motor behavior.

GRADIOSITY
Exaggerated self-opinion, arrogance, conviction of super-human or unnatural powers of abilities.

DEPRESSIVE MOOD
Extreme sadness, despondency, pessimism and sorrow. Unable to energize; moves in slow-motion, sits or sleeps a lot.

HOSTILITY
Animosity, contempt, belligerence and disdain for others. Assumes aggressive stances and using threatening body movements.

SUSPICIOUSNESS
Mistrust, belief that others harbor malicious or discriminatory intent. Guarded and watchful.
**HALLUCINATIONS**
Grinning, laughing, moving lips without making any sounds, slowed verbal responses as if preoccupied. Silent, sits by self. Suspicious of questions. Reports threatening and accusatory voices. Voices may instruct to hurt self or others.

**MOTOR RETARDATION**
Slowed, weakened body movements or speech. Sluggish in walking. Frequent sighs and preference for sitting or lying down.

**UNCOOPERATIVENESS**
Resistance, guardedness, rejection or suspicion of authority.

**UNUSUAL THOUGHTS**
Reports unusual, odd, strange, bizarre thought content.

**BLUNTED EXPRESSIONS**
Reduced emotional tone, agitation, increased reactivity.

**DIORIENTATION**
Confusion or lack of proper association to time, person or place.

**EXCITEMENT**
Heightened emotional tone, agitation, increased reactivity.

**SUICIDAL IDEATIONS**
Expresses thoughts of self-harm; identifies a plan, method and means.

Mental Status Exam (MSE)

This provides a "snap shot" of the patient, a picture of them as they exist at one point in time. MSE is a brief bedside test that is an excellent means of quantifying cognitive function and decline. Frequently, several interactions are required along with information about the patient's usual level of function before you can come to any meaningful conclusions about their current condition. The components of the MSE are as follows:

1. Appearance: How does the patient look? Neatly dressed with clear attention to detail? Well groomed?
2. Level of alertness: Is the patient conscious? If not, can they be aroused? Can they remain focused on your questions and conversation? What is their attention span?
3. Speech: Is it normal in tone, volume and quantity?
5. Awareness of environment, also referred to as orientation: Do they know where they are and what they are doing here? Do they know who you are? Can they tell you the day, date and year?
6. Mood: How do they feel? You may ask this directly (e.g. "Are you happy, sad, depressed, angry?"). Is it appropriate for their current situation?
7. Affect: How do they appear to you? This interpretation is based on your observation of their interactions during the interview. Do they make eye contact? Are they excitable? Does the tone of their voice change? Common assessments include: flat (unchanging throughout), excitable, appropriate.
8. Thought Process: This is a description of the way in which they think. Are their comments logical and presented in an organized fashion? If not, how off base are they? Do they tend to stray quickly to related topics? Are their thoughts appropriately linked or simply all over the map?
9. Thought Content: A description of what the patient is thinking about. Are they paranoid? Delusional (i.e. hold beliefs that are untrue)? If so, about what? Phobic? Hallucinating (you need to ask if they see or hear things that others do not)? Fixated on a single idea? If so, about what. Is the thought content consistent with their affect? If there is any concern regarding possible interest in committing suicide or homicide, the patient should be asked this directly, including a search for details (e.g. specific plan, time etc.). Note: These questions have never been shown to plant the seeds for an otherwise unplanned event and may provide critical information, so they should be asked!
10. Memory: Short term memory is assessed by listing three objects, asking the patient to repeat them to you to insure that they were heard correctly, and then checking recall at 5 minutes. Long term memory can be evaluated by asking about the patients job history, where they were born and raised, family history, etc.
11. Ability to perform calculations: Can they perform simple addition, multiplication? Are the responses appropriate for their level of education? Have they noticed any problems balancing their check books or calculating correct change when making purchases? This is also a test of the patient's attention span/ability to focus on a task.
12. Judgment: Provide a common scenario and ask what they would do (e.g. "If you found a letter on the ground in front of a mailbox, what would you do with it?").
13. Higher cortical functioning and reasoning: Involves interpretation of complex ideas. For example, you may ask them the meaning of the phrase, "People in glass houses should not throw stones." A few common interpretations include: concrete (e.g. "Don't throw stones because it will break the glass"); abstract (e.g. "Don't judge others"); or bizarre.

Chapter 1  Mental Health Trends and the Historical Role of the Psychiatric-Mental Health Nurse

Introduction
Florence Nightingale identified a need to organize the nursing profession into a respectable discipline with its own body of knowledge and practice skill sets.

Current Perspectives
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; promotion of public awareness of children's mental health issues
- Continued development, dissemination, and implementation of scientifically proven prevention and treatment services
- Reduction and/or elimination of disparities in access to mental health services; increased access and coordination of quality mental health services

(U.S. Public Health Service, 2000)

The President's New Freedom Commission on Mental Health, in 2001
1. _________ was to promote increased access to educational and employment opportunities for people with _________
2. Achieving the promise: Transforming Mental Health Care in America, was issued in 2003.
3. ______________________ continues to be a priority for Healthy People 2020.

Evolution of Psychiatric-Mental Health Nursing
Figure 1-1 depicts a timeline of events, highlighting significant events in the evolution of mental health care in conjunction with significant events in the evolution of psychiatric-mental health nursing.

From the 1890s to after World War II, nurses did things to and for patients, rather than with patients. Nursing activities were focused on the carrying out of medical regimes.

Hildegard Peplau (1952)
Defined ____________ 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."

Therapeutic Communication
_______________ - focused interactive process involving verbal and nonverbal behaviors

Milieu Management
Refers to the provision and assurance of a therapeutic environment that promotes a healing experience for the patient.
Nurses became the ______________ of the milieu, responsible for recognizing that they are part of the milieu, and thus had to conduct themselves in a manner conducive to supporting a therapeutic environment.

**Psycho-Educational Groups**
Nurse-led groups such as medication education

**Process Groups**
Nurses frequently co-facilitate these groups, which are more traditional forms of psychotherapy where deep feelings, reactions, and thoughts are explored and processed in a structured way

**Medication Management**
Medication administration and monitoring were added to the nurse-patient experience

The one-to-one nurse-patient relationship still remained ______________ in nursing

**Division of Psychiatric and Mental Health Nursing Practice of the American Nurses Association (ANA)**
1960s released the “Statement on Psychiatric Nursing Practice”
It emphasized involvement in a wide range of activities addressing health promotion and health restoration

The 1990s Known as “____________________________”
Less time, less money and less integrated service lines; the generalist psychiatric nurse’s role shifted to more of case managers of care
Duties were more focused on admission and discharge proceedings, medication administration and monitoring, community linkage, and ________________

**Contemporary Psychiatric-Mental Health Nursing Practice**
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

**Scope and Standards of Practice Standards of Practice address six major areas**
- Assessment
- Diagnosis
- Outcomes identification
- Planning
- Implementation
- Evaluation

**Standards of professional performance address nine areas, including**
- Quality of practice
- Education
- Professional practice evaluation
- Collegiality
- Collaboration
13 Specific Areas or “Phenomena of Concern” (pg. 11).
Health promotion
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,
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
Basic level PMHNs are registered nurses who have graduated from an accredited nursing education program and are licensed to practice in their state
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

Roles and Functions of the PMHN

Chapter 28 Ethical and Legal Principles

Introduction
• Psychiatric-mental health nurses (PMHNs) make critical decisions about patient care every day
• PMHNs need a firm understanding of ethical theories and legal tenets that form the foundation from which to make ethical and legal decisions to protect their patients and themselves
• Ethics is a collection of philosophical principles that _________ the rightness and wrongness of decisions and conduct as human beings
• Personal moral convictions of PMHNs serve as a foundation to reflect on ethical quandaries that arise in daily work
• Foremost, the nurse has a responsibility to protect the rights, health, and safety of the patient

• Ethical Theories and Principles
• Utilitarianism professes that decisions should be based on producing the best outcome or the greatest happiness for the greatest number of people
Proponents of utilitarianism believe the end justifies the means, whereas opponents might argue that the interests of the _______________ and of the individuals should not be ignored.

- Kantianism is in contrast to utilitarianism. It focuses primarily on **performing one’s duty** rather than the “rightness” or “wrongness” of the outcome
  - This theory explores the concepts of autonomy (capacity to make decisions and act on them), beneficence (doing what is best), non-maleficence (doing no harm), justice (fair and equal treatment), veracity (honesty and truthfulness), and fidelity (acting as promised)

- **Model for Ethical Decision Making** (Box 28-1 pg. 601)

- **Voluntary and Involuntary Admission**
  - **Voluntary admission** is when the patient agrees or consents to admission
    - The majority of mental health patients apply for service voluntarily and stays for as long as the treatment team feel it is necessary
  - **Involuntary commitment**, or involuntary admission, is when the patient is admitted against his or her wishes
    - Usually initiated by family members, friends, health care providers, police, or firefighters who encounter a patient with ineffective community coping

- **Competency**
  - Determined by the legal system; the definition may vary from state to state
  - Most health care providers define competence as the degree to which a patient possesses the cognitive ability to _______________ and _______________ information
  - Consent and the right to self-determination are based on a person’s competency

- **Restrains and Seclusion**
  - Restraints and seclusion are used only when there is an emergency, it is determined that the patient’s behavior is unsafe, and there is imminent danger
  - The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has established restraint and seclusion standards, and revises them on an ongoing basis. As of July 1, 2009 current standards include the following:
    - A restraint order that is being used for violent or self-destructive behavior has a definite time limit associated with it (see Standard PC.03.05.05, EP4)
    - Standard: unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits
      - ___ hours for adults 18 years of age or older
      - ___ hours for children and adolescents, 9 to 17 years of age
      - ___ hour for children under 9 years of age
    - Orders may be renewed according to the time limits for a maximum of 24 consecutive hours
• **Nursing Responsibilities**
  Nurses are legally responsible to protect the private health information of all patients through the federal laws and through the regulations subscribed by the State Board of Examiners for Nursing of the state in which they practice.

• **Confidentiality**
  ____________enacted the Health Insurance Portability and Accountability Act of 1996 (HIPPA)
  Maintaining ____________ is a priority, however, if a patient clearly threatens ____________ to another, a nurse is ____________ responsible to report this.

Legal Liability
PMHN's decrease their risk for legal liability by adhering to standards of nursing practice and by practicing within the appropriate ____________. ____________includes practicing outside the scope and standards of PMHN can result from ____________ behaviors.

• **Psychiatric nursing instituted HIPPA before there was a HIPPA**
• **Tarasoff case**

**Chapter 25 Psychiatric-Mental Health Nursing Across the Continuum of Care**

• **Introduction**
  Psychiatric-mental health nursing is a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of patients presenting with mental health problems and psychiatric disorders along a **continuum of care** (an integrated system of settings, services, health care clinicians, and care levels spanning illness to wellness in a variety of health care settings).

• **Psychiatric-Mental Health Nursing Across the Continuum of Care**
  Psychiatric-mental health nursing employs the purposeful use of self as its art, based on Peplau's theory
  Integrates the interpersonal process incorporating the therapeutic use of _____ and the collaborative partnership between the _______ and ________
  The continuum of care covers the range from illness to wellness and requires coordination of care and services for the patient to achieve optimal health.

• **Goal of the Least Restrictive Environment**
  Continuum of care is designed to ensure that treatment provided to a patient allows the patient the highest level of functioning in the **least restrictive environment**; that is, in the safest environment with the minimum___________ on personal liberty necessary to maintain _________ of the patient and the public, and to allow the patient to achieve independence in daily living as much as possible.
Consultation-Liaison Services

- When a patient requires psychiatric-mental health care in a setting other than a psychiatric service setting, such as a medical hospital unit, nursing home, and rehabilitation facility, a PMHN, typically at the advanced level of practice, may be called upon to provide ______________ liaison services

Levels of Care

- Psychiatric emergency care
  - Psychiatric emergency care, like medical emergency care, often involves life and death situations. Safety of the patient and those around him or her is the priority

- Acute inpatient care
  - Inpatient care for the psychiatric-mental health patient is most often acute and short term. The inpatient unit may be in a general medical hospital or psychiatric hospital

- Intermediate/long-term inpatient care
  - Intermediate or long-term inpatient care is required for patients who cannot be stabilized in an acute setting; for example, patients who are chronically destructive, psychotic, or ____________ to others in the community

- Partial hospitalization/day treatment
  - A partial hospitalization program provides a structured treatment program during the day with the patient returning to his or her living environment at night

- Residential services
- Community-based care
- Psychiatric rehabilitation programs
- Assertive community treatment (ACT)
- Clubhouse model
- Respite care
- Nursing homes
- Outpatient care
- Home care
- Housing services
- Personal care homes
- Supervised apartments
- Therapeutic foster care
- Halfway house/sober house

- The Continuum of Ambulatory Behavioral Health Services
- A model for the movement of patients along the continuum of available services to the most clinically appropriate and cost effective level of care (pg.560)
  - Ambulatory Level 1 services
  - Ambulatory Level 2 services
  - Ambulatory Level 3 services
Specialized PMHN Roles Within the Continuum of Care

- Self-employment
- Tele-health
- Case management
- Disaster response
- Forensic nursing

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<td>• Encouraging ventilation</td>
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**REALITY ORIENTATION**

- "I know that is real to you but it is not real to me."
- "I do not hear any voices."
- "I do not believe the CIA is listening to us."
- "I do not have a microphone on my name tag."
- "You can make a decision to change your behavior - it is within your control."
- "Your life will change when you make a decision to change it."

**REDIRECTING**

- "Let’s go for a walk and talk."
- "I know you are angry right now - let’s talk about what you can do about the anger."
- "If you look at me and talk to me it is likely the voices will go away or diminish."
- "Let’s identify some things you can do with those angry feelings."

**DEFLECTING TO FEELINGS**

The patient is verbally attacking you: 
- "You seem really angry - tell me what this is about."
- "I see you walking very rapidly around the Day Room - what’s going on with you right now?"
- "You seem anxious - tell me what’s going on right now."
- "There’s something else going on - what is it?"

**LIMIT SETTING**

- "I know you are upset however you cannot talk to me that way."
- "That behavior (describe) is not appropriate."
- "If you cannot control your behavior we need to look at some ways to help you control it."
- "Let’s start with one problem/issue at a time."
- "You may not touch me."
- "Let’s try to focus on the issue."
- "Come and tell me when you are feeling very angry and we will: Go for a walk, talk about it, go to the weight room....."
- "Let’s talk about what you can do instead of yelling in the Day Room."
- "I’d rather talk about you than me."

**BEHAVIOR MODIFICATION TECHNIQUES**

- Positive reinforcement (nice job)
- Extinguish the behavior
• Negative reinforcement (reinforcement is to avoid unwanted consequence—spanking, time out, lose license…)
• Modeling
• Contracting

**ENCOURAGING VENTILATION**
• Release phenomenon
• Fosters reality testing
• Eliminates perceptual distortions
• Reduces self-referencing
• Provides opportunity to confront defense mechanisms
• Prevents sand-bagging feelings

**PROBLEM SOLVING**
• Assess the events/issue/situation
• Identify the issue or problem
• Discuss relevant factors
• List and evaluate interventions/solutions
• Attempt one or more interventions
• Re-evaluate

**REFRAMING**
• Taking a seemingly negative situation or characteristic and reconstructing it in a positive manner such as with: Deliberate cognition, visual imagery, affirmations

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**WEEK TWO**

**Chapter 2 Interpersonal Relationships: The Cornerstone of Psychiatric Nursing**

• **Interpersonal Relationship** (IPR) – connection that exists between two or more individuals
• Observation, assessment, communication, and evaluation skills serve as the foundation for IPR
• Development of any interpersonal relationship requires the individual to have a basic understanding of self
• Second-most important skill is communication: nonverbal and verbal
• Interpersonal relationships form the basis of nursing interventions for psychiatric-mental health nursing
• Establishment of a nurse-patient relationship is one of the nurse’s primary __________
• The nurse-patient relationship is reflected and integrated into the plan of care for any patient of any age, culture, or socioeconomic background
• Nursing Theories about IPR
• Two primary nursing theorists

1. Hildegard E. Peplau
• Considered the founder of psychiatric-mental health nursing theory and professional practice
• Developed the first master’s degree clinical nurse specialist psychiatric-mental health nursing program at Rutgers University School of Nursing in New Jersey

2. Peplau’s Theory of Interpersonal Relations
• According to Peplau, nurses integrate an understanding of their own behavior and self-awareness to assist patients in identifying problems and to work toward achieving health and well-being

• Peplau: Four Phases of the Interpersonal Process (pg. 19-21)

Phase 1: Orientation Phase
1. Includes ___________contact between the nurse and client
2. _________________ is the focus of the communication.
3. Nurse observes the patient and makes assessments of the patient’s _____________ and needs during this phase of the relationship.

Phase 2: Identification Phase
Patient _____________his or her needs for health care, for which the nurse can provide assistance.
1. Nurse senses that the patient has identified the needs and has cast him or her in the role of provider of care.
2. Nurse _________________ personal knowledge, attributes, and skills that he or she can bring to the relationship to provide nursing care.
3. Patient and nurse develop __________________________ and begin working together to address the patient’s need.
4. Expression and exploration of the patient’s feelings are __________

Phase 3: Exploitation Phase
Bulk of the work in the nurse patient relationship is accomplished with the patient taking full _____________ of the nursing services offered.
1. Phase encompasses all of the therapeutic activities that are initiated to reach the identified _____________
2. Open _________________ is essential during this time and requires a _________________ relationship.
3. Shift in _____________ from the nurse to the patient occurs during this phase.

Phase 4: Resolution
Occurs when the patient’s needs have been met through the collaborative work of nurse and patient.
1. Nurses evaluation of the patient’s readiness to move through ____________________ of the relationship is crucial to resolution.
2. 
Peplau
In 1988, 1997 Peplau condensed these phases into three phases:
• Orientation Phase
• Working Phase
• Termination Phase

Nursing Roles
Peplau defined six primary nursing roles during the nurse-patient relationship
— Stranger
— Resource person
— Teacher
— Leadership
— Surrogate
— Counselor

Joyce Travelbee
Human to Human Relationship Theory focuses on caring and the therapeutic use of self

Joyce Travelbee’s Human to Human Relationship Theory

Phase 1: Original Encounter –characterized by ______________ impression by the nurse of the ill person and by the ill person of the nurse.

Phase 2: Emerging Identities –the nurse and the ill person perceive each other as __________________________ individuals and the bond of a ______________ begins to form.

Phase 3: Empathy Phase – “an intellectual process and, to a lesser extent, emotion comprehension of ___________ person…” (Travelbee, 1964, p. 68)

Phase 4: Sympathy Phase – occurs when the nurse desires to alleviate the __________ of the patient’s illness or suffering
— Requires a combination of the disciplined ______________ approach combined with the ______________ use of self

Phase 5: Rapport Phase – rapport includes a “concern for others and an active interest in them, a belief in the__________________________, and irreplaceability of each individual human being, and an____________________, nonjudgmental approach” (Travelbee, 1963, p. 71)
— The ill person exhibits both ________and ______________________________ in the nurse

Peplau and Travelbee’s Theories
Both of these theories correlate with the Nursing Process

Take each theory and relate it to the Nursing Process-
refer to your text
Chapter 4  Boundary Management

- **Therapeutic Boundaries**
  - Professional spaces between the nurse’s _____________ and the patient’s _____________ (NCSBN, 1996s)
  - Must be careful not to be ____________ or ____________-involved in a nurse-patient therapeutic relationship
  - Nurses gain the trust and respect of the patient by presenting him- or herself as _____________ and empathic

- **Boundaries**
  - Provide a separation for that person from another’s physical and psychological personal space
  - Are unique to that person and reflect his or her own self
  - May be **physical** (privacy, physical proximity, touching, and sexual behavior) or **psychological** (feelings, choices, interests, and spirituality)
  - Are individualized

  - Classified as
    - Rigid – _____________ to consider alternative views or ways of doing things
    - Flexible –able to _____________ his or her boundaries when necessary.
    - Enmeshed –experiences a _____________ or overlapping with another’s boundaries

- **Establishment of Professional Boundaries**
  How does the nurse establish professional boundaries?????
  - Remember that there is an imbalance of _____________ in the nurse-patient relationship
  - Recognize that patients are in a position of _____________ due to their illnesses
  - Nurses are in a position of power based on their knowledge, experience, and status
  - Nurses must abstain from obtaining _____________ at the patient’s expense
  - Nurses must also refrain from inappropriate involvement in the patient’s personal relationships

- **American Nurses Association (ANA) Code of Ethics for Nurses**

  *When acting in one’s role as a professional, the nurse recognizes and maintains boundaries that establish appropriate limits to the relationship. In all encounters nurses are responsible for maintaining professional boundaries (ANA, 2001).*
• National Council of State Boards of Nursing (NCSBN)

Professional boundaries are the spaces between the nurse’s power and the patients’ vulnerability. The power of the nurse comes from the professional position and the access to private knowledge about the patient. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the patients’ needs (National Council of State Boards of Nursing, 1996, p. 3)

Failure to adhere can result in disciplinary action by the board of nursing in the practicing state

• Applying Peplau’s or Travelbee’s Theories

• Boundaries are initially established during the ________________ or original encounter phase and then maintained throughout the other phases
  – This is the ideal time to begin establishing _____________ boundaries within the relationship

• Professional _________________ is essential to maintaining boundaries

• Transference

Psychodynamic term used to describe the ________________ emotional response to the health care provider
  – Example: patient may feel and/or think that the nurse reminds him or her of a relative or a past romantic interest because there is some emotional or physical similarity to someone else in the patient’s life…….This can be positive or negative

• Counter-Transference

Occurs when the ________________ develops a positive or negative emotional response to the patient’s transference…….can lead to interfering with the establishment of a therapeutic relationship between the nurse and patient if not managed by the nurse

• Boundary Testing

Examples of boundary-testing behaviors by the patient may include
  – Attempting to initiate a _____________ relationship
  – Attempting role reversal where the patient offers care to the n______________
    Soliciting personal information about the nurse violating the ______________ space of the nurse.

• Challenges to Boundaries

Occurs when patients attempt to ________________ therapeutic relationships into social ones, thereby testing the boundaries of therapeutic encounters

Playing pool (while a social activity) can be a therapeutic strategy to develop trust and rapport, thereby assisting in the progression through the identification phase of the relationship

• Boundary Crossing versus Boundary Violation

Boundary Crossing: refers to a transient ______________ excursion across a professional boundary
  – Example: (pg. 59)
—Example: a patient who shares with a nurse that he just received news that his mother has passed away, and begins sobbing profusely. In the nurse’s effort to comfort and console the patient, the nurse embraces the patient and offers a hug.
—What was the violation?
—What are some ways this action can be misunderstood?

• **Boundary Crossing versus Boundary Violation (cont.)**
  • Boundary violation: allows the nurse to meet his or her own needs rather than the patient’s needs
  • Boundary violations are never helpful and can lead to harm for the patient and possible criminal charges for the nurse
    — Examples: Excessive personal disclosure by the nurse to the patient, keeping secrets with the patient, or possibly role reversal between the nurse and the patient, sexual misconduct.

• Risk Factors for Unhealthy Nurse-Patient Boundaries
  • Feeling frustrated with your job
  • Not connecting with peers
  • Finding one’s self focusing on one patient disproportionately

• **Ways to Avoid Boundary Issues**
  • Self-awareness
  • Establishing clear boundaries at the beginning stages of the nurse-patient relationship
  • Ask for clinical supervision and feedback from peers
  • Always ask, “Whose needs are being met by this action?”

### WEEK THREE

• **Chapter 3 (Process recording handouts)**
  • Therapeutic Use of Self and Therapeutic Communication: From Self-Discovery to Interpersonal Skill Integration

  • “No man can come to know himself except as an outcome of disclosing himself to another person” (Jourard, 1971)

• **The Therapeutic Use of Self**
  • A specialized skill set used by nurses, especially in psychiatric-mental health nursing practice
  • Therapeutic use of self is complex and involves a process of ______________ through one’s own growth and development as well as one’s interactions with others

• **The Concept of Self**
  • Awareness of a sense of the self is core to a human being’s personal identity
  • Experience of the self represents a lifelong journey of discovery of personal ______________

Important part of the psychiatric-mental health nurse is the “person"
• **Carl Rogers** – known as the founder of person-centered counselling
  — Congruence (mind and body being one)
  — Empathy (put yourself in the other ________________ shoes emotionally)
  — Unconditional positive regard (not judging anyone and having a positive and supportive attitude toward them—(Rogers, 1951)

• **Other Theorists**
  • The term “therapeutic use of self” primarily came from the work of three theorists writing about the one-to-one nurse-patient relationship, namely Hildegard Peplau, June Mellow, and Ida Jean Orlando

• **Lego**
  • Lego synthesized the work of these early theorists to provide a ____________definition of the concept *therapeutic use of self* as: 
  “…the relationship between a psychiatric nurse and his/her patient, formed for the purpose of brief counselling, crisis intervention, and/or individual psychotherapy. The emphasis is on the interpersonal relationship between the nurse and the patient, with all its vicissitudes, as opposed to physical care of the patient” (1999, p. 4).

• **President’s New Freedom Commission, 2003 (United States)**
  • Cited a need for transforming mental health service delivery with *recovery* as the goal of this transformation.
  • The Substance Abuse and Mental Health Services Administration (SAMHSA)
  • Described “mental health ____________ as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential” (SAMHSA, 2006).

• **SAMHSA – Ten Fundamental Components of Recovery**
  Self-directed
  • Individualized and person-centered (based on unique strengths and resiliencies, needs, preferences, experiences, and cultural background)
  • Empowerment (authority to choose from a range of options and participate in all decisions)
  • Holistic (mind, body, spirit, and community; all aspects of life)
  • Non-linear (continual growth, occasional setbacks, and learning from experience)
  • Strengths-based
  • Peer-supported
  • Respect
  • Responsibility
  • Hope (SAMHSA, 2006)

• **Phil Barker’s Tidal Model**
  • First mental health recovery model developed conjointly by psychiatric-mental health ____________ and people who have used mental health services
  • First recovery-focused model of psychiatric-mental health nursing recognized internationally as a significant ________________ theory of nursing (theory that is more concrete and less abstract in scope)
• **Development of the Therapeutic Use of Self**
  • **Therapeutic** – means for or relating to the treatment of disease or disorders by remedial agents or methods
  • **Therapeutic Use of Self** – integrates theory, experiential knowledge and self-awareness to assist patients in exploring their impact with others to promote behavioral changes in the patient
  • Therapeutic use of self is a key element of the therapeutic nurse-patient relationship
  • Psychiatric-mental health nurses develop it through self-awareness and self-reflection

• **Self-Awareness**
  • Process of ______________________ of one’s own values, beliefs, thoughts, feelings, reactions, motivations, biases, strengths, and limitations and recognizing their effect on others

• **Values**
  • Abstract ______________________ concepts that represent ideal conduct and goals
  • Sense of what is right and wrong, providing a “____________________”
  • Developed from one’s experiences with family, friends, culture, and the environment

• **Beliefs**
  • Ideas that an individual holds to be true
  • Can be rational (based on objective evidence), irrational (idea held despite contradictory evidence), blind (idea held without any objective evidence, such as faith), and stereotypical (idea describing an oversimplified or undifferentiated concept that is socially shared)

• **Attitudes**
  • Generally reflect a person’s values and provide a person with a **means for organizing how to**

• **Self-Reflection**
  • Process of becoming _______________ of largely tacit or intuitive knowledge, motives, and attitudes that underlie a professional interpersonal interaction

• **Self-Evaluation**
  • Ask
    – What in my past or current life circumstances helps or hinders my ability to respond therapeutically to this patient?
    – Of whom does this patient remind me?
    – What am I thinking about while the patient talks?
    – How does this patient make me feel?
    – Why did I react to the patient in this particular manner?
    – Who talked the most in this patient interaction?
    – Why am I seeking out or avoiding this patient?
    – How did my reactions to this patient help or hinder meeting his/her needs?

• **Therapeutic Relationship**
  • Psychiatric-mental health nurse must develop empathy, the ability to see the world through the patient’s eyes
• **Therapeutic Communication**
  - Interaction between a nurse and patient that is focused on the patient
  - Based on the patient's needs
  - Geared to promoting the patient's health and well-being and positive outcomes
  - Therapeutic communication is the basis for the nurse-patient relationship
  - Communication
  - Verbal and nonverbal communication
  - Verbal communication, as the term implies, refers to information that is spoken – it also includes the written word
  - Nonverbal communication refers to information that is sent without words

• **Therapeutic Communication Techniques (pg. 43)**

• **Active Listening**
  - ________________ effort on the part of the nurse to pay close attention to what the patient is saying
  - Nurse focuses on the words being spoken and the ________________ being sent both verbally and nonverbally

• **Egan (2003) Developed a Model for Positioning Oneself**
  - S = Sit squarely with the nurse ________________ the patient
  - O = Open posture with legs and arms ________________
  - L = Lean slightly forward to convey ____________ and ____________ in the interaction
  - E = Eye contact to ________________ interest and willingness to listen
  - R = Relax

• **Process Recording**
  - Interaction between the patient and nurse is recorded verbatim to the extent possible; includes both verbal and nonverbal communication of both parties
  - Content of the interaction is analyzed for its meaning and pattern of interaction

• **Process Recording activity (View video—complete hand outs)**

• **Self-Disclosure**
  - Psychiatric-mental health nurse uses self-disclosure only if it will help
    - Educate the patient about him- or herself to better deal with the issues at hand
    - Build rapport, so that the patient feels free to share information more freely
    - Encourage reality testing, thereby helping to support the patient’s feelings in response to the current situation
Barriers to Effective Therapeutic Communication
- Physical barriers can negate meaningful engagement and dialogue
- Noise, furniture, temperature, lighting extremes, or equipment can interfere
- Clichés, false reassurance, advice, closed-ended questions and stereotyped, judgmental, belittling, challenging, or defending comments or statements can be detrimental to the therapeutic interaction

Chapter 13 Anxiety Disorders

Anxiety is a common human emotion that is often difficult to define
- Words used to describe anxiety reflect one's inner experience
- Can be quite ________________
- Anxiety can be a normal emotional response to a stressor
- Becomes a symptom of a disorder or pathological condition when it interferes with ability to function

Epidemiology
- Anxiety disorders are ______________________________ psychiatric diagnoses
- Most costly psychiatric illnesses in the United States
- Estimated that three out of ten people will suffer from an anxiety disorder in their life time
- Anxiety disorders frequently co-occur with depressive disorders or substance abuse disorders

Incidence
- Approximately 6 million adults 18 and older, or about 2.7% of this age group, have panic disorder in a given year
- Median age of onset is 24 years
- Approximately 2.2 million American adults age 18 or older, or about 1.0% of people in this age group, have ____________________________ (OCD) in a given year
- Symptoms of OCD often begin during childhood or adolescence
- Approximately 7.7 million American adults age 18 and older, or about 3.5% of this age group, have a diagnosis of ____________________________ (PTSD) in a given year
- Median age of onset is 23 years
- Approximately 6.8 million American adults, or about 3.1% of people age 18 and over, have a diagnosis of ____________________________ (GAD) in a given year
- Median age of onset of 31 years
- Approximately 15 million American adults age 18 and over, or about 6.8% of this age group, have social phobia in a given year
- Onset is usually around 13 years of age
- Approximately 1.8 million American adults age 18 and over, or about 0.8% of this age group, have agoraphobia without a history of panic disorder in a given year
- Median age of onset of 20 years
- Approximately 19.2 million American adults age 18 and over, or about 8.7% of this age group, have some type of specific phobia
- Median age of onset of seven years
- Morbidity and Mortality
Anxiety disorders, through effects of the neurologic, endocrine, and immune mechanisms, or direct neural stimulation resulting in conditions such as hypertension or cardiac arrhythmia, can contribute to morbidity and mortality.

Anxiety disorders have high rates of comorbidity with major depression and alcohol and drug abuse.

Female-to-male ratio for any lifetime anxiety disorder is 3:2.

### Diagnostic Criteria (pg. 248-251)

- Panic Disorder
- Obsessive-compulsive Disorder
- Posttraumatic Stress Disorder
- Generalized Anxiety Disorder
- Specific Phobia
- Social Phobia
- Acute Stress Disorder

### Etiology

- Psychosocial theories
  - Reality anxiety—most basic form
  - Neurotic anxiety—unconscious fear
  - Moral anxiety—fear of violating societal moral codes

- Psychodynamic influences
  - Repression—most powerful according to ____________. Pushes unacceptable id impulses out of awareness back into ______________ mind. Foundation for other ______________

- Behavioral influences (learned behavior)
- Pavlov and classical conditioning

- Biological theories
- Genetic predisposition

- Neurobiological influences
  - Malfunctioning of amygdala (fear, worry, misery, apprehension, ______________ thinking)
  - Cortico-striatal-thalamic-cortical loop circuitry

- Genetic vulnerability
- Family history

### Psychodynamic Influences (pg. 252)

- Peplau wrote extensively about unexplained discomfort and described four types of anxiety
  - Mild anxiety: motivates individuals every day; considered “normal anxiety;” ____________ motivator for personal growth and success
  - Moderate anxiety: individuals hear, see, and grasp less due to ______________ of perceptual field; decreased awareness of the environment and decreased focus, noticing only things brought to their attention
• Severe anxiety: individual’s thoughts become ____________, focusing on small details; ____________ to problem-solve or use the learning process to make decisions

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

• Treatment Options (pg. 254-264)
  • Pharmacological therapy
    – Selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs) are the drugs of choice for treating both depressive disorders and anxiety disorders
    – Benzodiazepines also may be used in conjunction with these agents
    – Herbal preparations

  – Individual psychotherapy
  – Biofeedback
  – Functional neurosurgery
  – Cognitive behavior therapy
  – Informational interventions
  – Music
  – Dietary changes

• Self-monitoring and symptom diary

• Cognitive restructuring

• Exposure therapies – systematic desensitization or flooding

• Abdominal breathing

• Progressive muscle relaxation

• Exercise

• Guided imagery

• Applying the Nursing Process from an Interpersonal Perspective

• Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for patients with anxiety disorders

• Strategies for Optimal Assessment

• Therapeutic use of self
  – Nursing process is therapeutic when Nursing process is therapeutic when the nurse and the patient can come to know and to respect what is the same and what is different in one another, thereby coming together to share in the solution of a problem

  – Planning Appropriate Interventions

• Meeting the patient’s focused needs
  – A patient seeking assistance on the basis of a need is often the first step in a dynamic learning experience from which a constructive next step in ___________________________ can occur
• **Implementing Effective Interventions**
  
  • Timing and pacing
  
  – Nursing interventions must be protective and supportive
  
  – For those experiencing panic and severe levels of anxiety, patient safety is paramount
  
  – Timing and pacing are critical when administering medications in this situation

• **Evaluating**
  
  • **Objective critique of interventions and self-reflection**
  
  – Evaluation occurs as a continuous, cyclical, and ongoing process throughout the nursing process
  
  – Self-reflection is an invaluable tool
  
  – Evaluation phase is also part of the termination of the nurse-patient relationship

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<tr>
<th>Defense Mechanism</th>
<th>Definition</th>
<th>Example</th>
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<tr>
<td>Circumstantiality</td>
<td>Bringing up details that are irrelevant to the discussion at hand.</td>
<td>A woman is talking about her husband and brings in detailed information about his sister.</td>
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<td>Compensation</td>
<td>Attempting to compensate for ego deficit</td>
<td>A man brags about his high IQ though he has numerous problematic relationships.</td>
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<td>Confabulation</td>
<td>Filling in memory gaps with untrue/unsubstantiated events.</td>
<td>An elderly woman talks about the visit of her daughter from out-of-town who has not visited in weeks.</td>
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<td>Conversion</td>
<td>Converting anxiety into a physiological event</td>
<td>Clients request headache and anti-acid medications after group.</td>
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<td>Denial</td>
<td>Refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others (psychotic denial used when there is gross impairment in reality testing)</td>
<td>A teenager’s best friend moves away, but the adolescent says he does not feel sad.</td>
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<td>Devaluation</td>
<td>Attributing exaggerated negative qualities to self or others.</td>
<td>A boy has been rejected by his long time girlfriend. He tells his friends that he realizes that she is stupid and ugly.</td>
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<tr>
<td>Displacement</td>
<td>Transferring a feeling about, or a response to, one object onto another (usually less threatening), substitute object.</td>
<td>A child is mad at her mother for leaving for the day, but says she is really mad at the sitter for serving her food she does not like.</td>
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<tr>
<td>Dissociation</td>
<td>Experiencing a breakdown in the usually integrated functions of consciousness, memory, perception of self or the environment, or sensory and motor behavior.</td>
<td>An adult relates severe sexual abuse experienced as a child, but does it without feeling. She says that the experience was as if she were outside her body watching the abuse.</td>
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<td>Humor</td>
<td>Emphasizing the amusing or ironic aspects of the conflict or stressor.</td>
<td>A person makes a joke right after experiencing an embarrassing situation.</td>
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<tr>
<td>Intellectualization</td>
<td>Excessive use of abstract thinking or the making of generalizations to control or minimize disturbing feelings.</td>
<td>After rejection in a love relationship, the rejected explains about the relationship dynamics to a friend.</td>
</tr>
<tr>
<td>Passive aggression</td>
<td>Indirectly and unassertively expressing aggression toward others. There is a</td>
<td>Passive aggression often occurs in response to demands for independent action or performance or</td>
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<tr>
<td>Defense Mechanism</td>
<td>Description</td>
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<tr>
<td>Façade of overt compliance masking covert resistance, resentment, or hostility</td>
<td>the lack of gratification of dependent wishes but may be adaptive for individuals in subordinate positions who have no other way to express assertiveness more overtly.</td>
<td>A child is very angry at a parent, but accuses the parent of being angry.</td>
</tr>
<tr>
<td>Projection</td>
<td>Falsely attributing to another one’s own unacceptable feelings, impulses, or thoughts.</td>
<td>A child is very angry at a parent, but accuses the parent of being angry.</td>
</tr>
<tr>
<td>Rationalization</td>
<td>Concealing the true motivations for one’s own thoughts, actions or feelings through the elaboration of reassuring or self-serving but incorrect explanations.</td>
<td>A man is rejected by his girlfriend, but explains to his friends that her leaving was best because she was beneath him socially and would not be liked by his family.</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>Substituting behavior, thoughts, or feelings that are diametrically opposed to one’s own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression)</td>
<td>A wife finds out about her husband’s extramarital affairs and tells her friends that she thinks his affairs are perfectly appropriate. She truly does not feel, on a conscious level, any anger or hurt.</td>
</tr>
<tr>
<td>Repression</td>
<td>Expelling disturbing wishes, thoughts, or experiences from conscious awareness (the feeling component may remain conscious, detached from its associated ideas).</td>
<td>A woman does not remember the experience of being raped in the basement, but does feel anxious when going into that house.</td>
</tr>
<tr>
<td>Splitting</td>
<td>Compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images.</td>
<td>Self and object images tend to alternate between polar opposites: exclusively bad, hateful, angry, destructive, rejecting, or worthless. Once friend is wonderful and another former friend, who was at one time viewed as being perfect, is now believed to be an evil person.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Channeling potentially maladaptive feelings or impulses into socially acceptable behavior.</td>
<td>An adolescent boy is very angry with his parents. On the football field, he tackles someone very forcefully.</td>
</tr>
<tr>
<td>Suppression</td>
<td>Intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences.</td>
<td>A student is anxiously waiting tests results, but goes to a movie to stop thinking about it.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Words or behavior designed to negate or to make amends symbolically for unacceptable thoughts, feelings, or actions.</td>
<td>A man has sexual fantasies about his wife’s sister. He takes his wife away for a romantic weekend.</td>
</tr>
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Chapter 10 Theories of Mental Health and Illness: Psychodynamic, Social, Cognitive, Behavioral, Humanistic and Biological Influences

- Introduction
- What is mental illness?
- What does mental illness mean to you?
- Evolution of Thinking About
Mental Illness
Attempts to understand the human mind, body, and behavior can be traced as far back as Aristotle

• The Current State of Mental Illness

• Mental illness is considered to be epidemic, based on recent studies and statistics
• What are some variables that research has implicated affect mental illness?
• Despite much research, at this time, there is no full disciplinary, interdisciplinary, or subspecialty consensus on the value, validity, or reliability of the understandings of mental illness

• Theories
• There are three main theories
  – Grand: most ______ and broad in scope
  – Middle-range: less abstract (more concrete) than grand theories
  – Micro-level: __________ abstract and narrow in scope

Theories and Concepts Related to Mental Illness
• Different schools of thought are prevalent in mental health and psychology but all share the same commonality – the study of the mind, body, and/or behavior

Psychodynamic Theories
• Focus on the unconscious and assert that underlying unconscious or repressed conflicts are responsible for conflicts, disruptions, and disturbances in behavior and personality

• Some theorists
  – Sigmund Freud, Alfred Adler, Viktor Frankl, Eric Erickson, Karen Horney, and Carl Jung

Behavioral Theories
• Assume that only observable, measurable, objective criteria are important to understand human behavior and effect behavioral change
• Some theorists

Cognitive Theories
• Cognitive theories arose out of the need to explain more complex behavior that could not be explained by observable actions alone
• These theories focus on how a person’s __________ about a situation or event affects the stimulus and response
• Some theorists
  – Aaron Beck and Albert Ellis

Social Theories
• Social mental health and psychology theorists agree that understanding________, __________, and other environmental factors is important to understand human behavior
• Some theorists
  – Albert Bandura, Kurt Lewin, Leon Festinger (Lewin’s student), Neal Miller, John Dollard, Robert Merton, and Alfred Allport
Humanistic Theories
• Humanistic theories reflected the theoretical shift toward a more ________ interpersonal, positive perspective
  – Nurse theorists include: Hildegard Peplau (see Chapter 2 for a detailed discussion), Joyce Fitzpatrick, Rosemarie Parse, Patricia Starck, Joyce Travelbee (see Chapter 2 for a detailed discussion), and Jean Watson
  – Psychological theorists include Carl Rogers, Abraham Maslow, and Everett Shostrom
  – Physician theorists included Viktor Frankl (who had moved away from psychoanalytical theory), and Fritz Perls

Biological Theories
• Includes brain physiology, genetics and evolution as means for understanding behavior
• Although numerous frameworks have evolved, they all address the effect of the mind on ____________ processes (or vice versa) in relation to disease states and behaviors
• Theorists
  – Robert Ader was the first and numerous have followed

WEEK FOUR

Chapter 5 Critical Thinking, Clinical Decision Making, and the Interpersonal Relationship
Introduction
• Patients of all ages in need of psychiatric-mental health nursing care can be found in hospitals, community agencies, and residential settings
• Critical thinking and clinical decision making are crucial elements to ensure that the patient’s needs are assessed, relevant problems are identified, and therapeutic nursing interventions are planned, implemented, and evaluated

  • Critical Thinking
  • Refers to a purposeful method of reasoning that is systematic, reflective, rational, and outcome-oriented
  • Critical thinking is dynamic, not static, and ever-evolving based on the circumstances of the individualized situation
  • Critical thinking is a positive skill set used by nurses to plan patient care

  • Domains of Critical Thinking
  • Elements of thought—the basic building blocks of thinking—such as purpose (what one hopes to accomplish), question or problem at issue, points of view or frame of reference, empirical dimension (evidence, data or information), concepts and ideas, assumptions, and implications and consequences (Paul, 1993)

  Abilities—the skills essential to higher-order thinking—such as evaluating credibility, analyzing arguments, clarifying meanings, generating possible solutions, and developing criteria for evaluation (Paul, 1993)
• **Affective dimensions**—the attitudes, dispositions, passions, and traits of mind essential to higher-order thinking in real settings—such as thinking independently, being fair-minded, developing insight, intellectual humility, intellectual courage, perseverance, and developing confidence in reasoning and intellectual curiosity (Paul, 1993)

• **Intellectual standards**—the standards used to critique higher-order thinking—such as clarity, specificity, consistency, preciseness, significance, accuracy, and fairness (Paul, 1993)

• Elements Necessary for Critical Thinking
  • The use of cognitive skills and working through dispositions

• **Critical Thinking Indicators™ (CTIs™)**
  • Knowledge indicators involve
    – Clarifying nursing versus medical information; normal and abnormal function, including factors that affect normal function; rationales for interventions, policies and procedures, standards; laws and practice acts that are applicable to the situation; ethical and legal principles; and available information resources
    – Demonstrating focused nursing assessment skills and related technical skills; clarifying personal values, beliefs, and needs, including how one’s self may differ from others’ preferences and organizational mission and values

• **Intellectual skills and competencies involve**
  – Application of standards, principles, laws, and ethics
  – Systematic and comprehensive assessment
  – Detection of bias and determination of information credibility
  – Identification of assumptions and inconsistencies
  – Development of reasonable conclusions based on evidence
  – Determination of individual outcomes with a focus on results
  – Risk management; priority setting
  – Effective communication
  – Individualization of interventions

• **Framework for Critical Thinking and Clinical Decision Making**
  • “How is critical thinking related to clinical decision making in psychiatric-mental health nursing?”
    – A framework that structures psychiatric-mental health nurse’s clinical decision making for psychiatric-mental health patients and their needs throughout the interpersonal relationship

• **The Nursing Process**
  • Systematic method of problem solving that provides the nurse with a logical, organized framework from which to deliver nursing care
  • The nursing process integrates critical thinking skills and clinical decision making
  • Nurses use the nursing process to deliver safe, effective therapeutic nursing care regardless of the setting
• **The Nursing Process and the Interpersonal Relationship (pg 71-74)**
  • Peplau’s four (4) phases of the interpersonal relationship closely parallel the stages of the nursing process
  • Both the nursing process and the interpersonal relationship reflect a ________________ approach to providing care

• **Assessment**
  • Involves the collection of patient data through a patient ____________and physical assessment
    (head to toe---think of Prof. Millers Health Assessment class! 😊)
  • A __________ examination and psychosocial assessment are essential components
  • The data collection process is ongoing, with the nurse __________ updating and ______________ the information
  • Peplau’s orientation and identification phases correspond to the assessment phase of the nursing process

• **Planning and Implementation**
  • Correspond to the Peplau’s third phase of the interpersonal relationship, the ________________ phase
  • The nurse works with the patient and uses critical thinking skills to determine the most plausible strategies, analyzes these strategies, and ultimately arrives at the best course of action for the patient

• **Psychoeducational Interventions**
  • Interventions that include a significant ________________ component
  • Psychoeducation is an excellent intervention that can consist of verbal 1:1 interaction, printed handouts, or other audio-visual materials

• **Evaluation**
  • Correlates to Peplau’s final phase of interpersonal relationship, resolution
  • Evaluation and resolution can be a time to celebrate successes and gains made by the patient because the outcomes and goals have been achieved. It can also be a time of loss and sadness
  • Evaluation stage and resolution phase provide the nurse an opportunity to determine what went well in the nurse-patient relationship and what might be an opportunity for improvement in the nurse’s clinical decision making skills

• **Implications for Psychiatric-Mental Health Nursing**
  • An ebb and flow exists between stages and phases
  • Patients may revisit issues in any stage or phase that the nurse thought were resolved previously
    – Revisiting of needs and issues, however, does not mean that a patient is not making progress
Chapter 6 Crisis and Crisis Intervention

- Crisis in mental health may range from violent, out of control behavior to withdrawal and suicidal ideation, affecting individuals, families, communities and the world
- Understanding the nature of crisis and how to best intervene is crucial to nurses’ skill set

- Stress Response
  Stress is an increase in an individual's level of arousal created by a stimulus. Initially, as stress levels increase, a person's performance and ability to focus may actually improve
  - Classic _________________________ reaction can ensure one's safety
  - Once a stress threshold is crossed, these benefits are lost and performance and health deteriorate
  - Sustained stress response can cause damage to the cardiovascular, immune, and nervous systems, causing chronic illness and maladaptation

- General Adaptation Syndrome
  - _________________________first identified the body’s reaction to physiologic stress
  - There are _______________ stages of a person's reaction to stress and the accompanying responses experienced
  - Can happen when subjected to

- Three Stages of Stress Adaptation (pg 84)
  - Alarm stage
    - Stimulated by a stressor
    - Hypothalamus stimulates the sympathetic nervous system, which leads to innervation of the glands, such as the pituitary and adrenal glands, and various body systems to prepare the body to defend itself against the stressor
  - Resistance and recovery stage
    - Body maintains its preparedness against the stressor and adapts to the situation
    - Stressor abates and the body recovers, returning to its normal state
      - Exhaustion stage
        - Occurs when the person is no longer able to adapt to the continued stress
        - Defense mechanisms and reserves of the body are depleted
        - If intervention does not occur, exhaustion continues, which can lead to death

Crisis
- A time-limited event, usually lasting no more than 4 to 6 weeks
- Results from extended periods of stress unrelieved by adaptive coping mechanisms
- Different types of stress can lead to crisis
– Global natural disasters (tsunami in Phuket, Thailand and Hurricane Katrina in New Orleans)
– Man-made disasters (9/11 in NYC and U.S. Pentagon, 2004 train bombing in Madrid)

• Characteristics of a Crisis
  • Occurs when there is a real or perceived threat to a person’s physical, social, or psychological self
  • Witnessing a trauma of another individual or an __________________________ can also lead to crisis
  • Crisis can have positive or negative results for a person
  • Crisis is not an established psychiatric diagnosis

• Factors Impacting an Individual's Response to Crisis
  • Highly individualized (what may be a crisis for one person may not be viewed that way from a different individual)
  • Not every person experiencing stress will go on to experience crisis

• Balancing factors include:
  • 1. The individual's perception of the event
  • 2. Availability of situational supports
  • 3. Availability of adequate coping strategies

• Development of Crisis (pg. 87-89).
  • Phase 1
    – Begins with ____________ to a significant precipitating stressor
    – Stressor can be large or small in scale (affecting a single individual or many persons), a natural- or human-initiated disaster, or an accident or an intentional affront
    – Individual experiences __________and begins to use ________ problem-solving strategies used for coping
    – Becomes problematic when it cannot be resolved by the individual and the crisis begins to interrupt daily functioning

• Development of Crisis (cont.)
  • Phase 2
    – Individual moves into the second phase of crisis when anxiety exacerbates to a level where problem-solving ability is __________ or becomes unsuccessful
    – Stress __________with daily activities and the person becomes increasingly uncomfortable
    – If not resolved can lead to a sense of restlessness, confusion, and helplessness

• Development of Crisis (cont.)
  • Phase 3
    – Individual draws upon all available resources, internal and external, in an attempt to relieve the stress and discomfort
    – May seek the assistance of professionals such as a nurse, psychologist, crisis worker, or some other external source for possible answers and resolution
    – If the new methods are_________________, the crisis will resolve, allowing the individual to return to a functional level, which may be the same, higher, or lower than the person’s previous level of functioning
• **Development of Crisis (cont.)**
  
  • **Phase 4**
    
    — Level of anxiety can approach ________ or despair
    
    — Emotions are __________ and labile, thought processes are___________, possibly even with psychotic thinking, and external supports are necessary

• **Classification of Crises**
  
  • Maturational crisis
  
  • Includes leaving home for college (for either the child who is leaving or the parent who is left behind), getting married, having children, or retirement

  • Situational crisis
    
    □ Unanticipated life event that threatens one’s sense of self or security
    
    □ Examples: family illness, unexpected death of a loved one, foreclosure on a home, death of a pet, and being fired from a job

• Social crisis (AKA: Adventitious crisis)
  
  1. Also called an adventitious crisis, results from an unexpected and unusual social or environmental catastrophe that can either be a natural or man-made disaster

**Crisis Intervention**

  Defined as being self-limiting; requires ________ intervention to achieve a positive outcome

  • With effective professional intervention, psychosocial homeostasis can be restored and the individual can resume or even exceed the pre-crisis level of functioning

  • A negative outcome, in which the individual stabilizes at a lower level of functioning, is also possible

  • Prior history of psychiatric instability or illness increases risk for a negative outcome

**Three Goals of Crisis Intervention**

  • __________ of the acute distress
  
  • Restoration of independent functioning
  
  • Prevention or resolution of psychological trauma

**Nurses and Crisis Intervention: Historical Perspectives**

  • Since the middle 1800s, nurses have assumed an active role in managing crises

  • Florence Nightingale during the Crimean War, administering nursing practice to the wounded on the battle fields

  • Hildegard Peplau, a pioneer in psychiatric-mental health nursing, published studies examining anxiety and its role in crisis management
Nurses and Crisis Intervention: Current Perspectives

- The psychiatric-mental health nurse recognizes that each individual’s response to stress is ______________; this variation in response is due to personality traits, environment, life experience, and coping skills
- Psychiatric-mental health nurses can assist through the development of an interpersonal relationship during times of stress

Nursing Process (pg. 91)

- Psychiatric-mental health nurses use the nursing process, integrating critical thinking and clinical decision making, to provide the highest quality of nursing care

Assessment
- The nurse typically asks the person to describe the ______________ and when it occurred
- Provides the nurse with clues as to how the person perceives and interprets the incident
- Gathers information about the person’s history of ___________ stressors and how and what the person used to cope with them while developing the interpersonal relationship
- The nurse analyzes the information gained from the assessment to identify the person’s priority needs, which form the basis for the nursing diagnoses

Planning
- The nurse integrates critical _______ and clinical _______ _______ in developing the plan, taking into consideration the type of crisis the person is experiencing and the individual’s strengths, weaknesses, and support systems
- The nurse determines the appropriate outcomes based on the priority nursing diagnoses and plans appropriate interventions

Implementation
- The nurse must immediately address any life-threatening injuries or conditions first
- The nurse can then begin to using therapeutic communication and therapeutic use of self to continue establishing the interpersonal relationship
- Identify positive and negative coping strategies, working with the client to form healthy alternatives to the negative ones

Evaluation
- Focuses on whether the crisis has been resolved
- Nurse reassesses the situation, looking for the following:
  - _______________behavioral changes
  - Use of effective _______________ coping methods
  - Individual’s growth with insight into the crisis and precipitating events
Belief in ability to respond to future stressors to avoid crisis development
Anticipatory plan of action for future responses to similar stressors

Nurse’s Role During and After Community and Global Disasters
To intervene effectively during any crisis, nurses must develop expertise to identify persons in crisis and prioritize their needs
Television, the Internet, Facebook, and Twitter allow us to interface in real time with people enmeshed in disasters of a local, national, and global scale
Unlike previous generations, we are all touched and impacted by the trauma and we may grieve with the victims

Impact of Dealing With Crisis on Psychiatric-Mental Health Nurses
Dealing with the stress of crisis on a day-to-day basis can affect a nurse’s or care provider’s mental health.

Crisis Prevention Intervention (CPI) or equivalent programs are taught to registered nurses during orientation before a nurse can engage in crisis intervention on a unit
There is increased interest in conducting research on health care providers who have been involved in disasters, such as post 9/11 and Hurricanes Katrina, and Sandy and the burn out they can experience

Supplemental Information—Crisis PP

<table>
<thead>
<tr>
<th>Crisis Management</th>
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<tbody>
<tr>
<td>Attributes of Crises</td>
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<tr>
<td>Viewed as both a critical situation and an opportunity</td>
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<tr>
<td>Is acute, time-limited condition causing disequilibrium</td>
</tr>
<tr>
<td>Person is temporarily unable to cope with or adapt to the stressor</td>
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<tr>
<td>Often are turning points in people’s lives</td>
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Attributes of Crises
Unsuccessful resolution of a crisis leaves the person feeling anxious, threatened and unable to handle daily stressors

All crises are sudden occurrences
The crisis is perceived as life-threatening

Attributes of Crises
There may be a sense of real or perceived displacement from normal reality, familiar surroundings or significant others

All crises are accompanied with a sense of loss - perceived or real
Impact of the crisis can be altered by the behavior of the health care provider
Progression to mental and emotional illnesses that accompany physical illnesses can be prevented by the CARING and ATTENTIVE management of the crisis

Sequence of Crisis

Pre-Crisis Stage
The stage of maintaining or attempting to maintain equilibrium. When successful the person avoids a crisis and reverts to a state of dynamic equilibrium

Crisis Stage
A reaction to a stimulus such as an event, situation or trauma. It is not the stimulus itself. The nature of the reaction is
highly individualized but always involves a sense of disequilibrium for the individual

Post-crisis stage
During this stage the person arrives at or develops a new steady state. This state may resemble the pre-crisis condition or may be more positive or negative

Balancing Factors
Perception of the event
Situational support
Coping mechanisms
How the person perceives the crisis is crucial to its resolution. Whether the crisis is viewed realistically or distorted is a critical element

Situational support
Adequate support derived through interpersonal relationships is crucial to the effective resolution of the crisis

Coping mechanisms
The effectiveness of past coping mechanisms to relieve anxiety and tension alter the impact of the crisis and give the person time to meet the challenge

Role of the care-giver
Assess the patient’s status - how does the patient look?
Assess the patient’s perception of the event/trauma - “Tell me what’s going on with you right now? What are you thinking about this news? What are you feeling?
Utilize the patient’s social support system when trauma is expected - “We have some information to discuss and some decisions to make. Who would you want to bring with you?
Become a balancing factor for the patient by providing empathy, offering to contact a supportive other, stay with patient until someone arrives, do follow-ups to see how the patient is doing
Refer to support groups or other treatment

Chapter 20 Psychological Problems of Physically Ill Persons

- Mental and physical health are deeply intertwined
- Stress leads to physical changes in the body that ultimately affect the mental health of the person
- A person’s mental health can result in changes to that individual’s physical health
- Suffering and the Therapeutic Use of Self

- Suffering is often defined as the experience of distress or pain which can be emotional or physical
- Several theorists have addressed this concept as it relates to mental health

- Theoretical Views of Suffering
- According to Travelbee, suffering must be explored as part of the ____________________
- Making one’s own self a therapeutic tool is often the only defense in a world that too often depends on technology alone to save individuals from the human condition of suffering
• **Suffering and the Impact on Nurses**
  • The therapeutic use of self places nurses at risk for ____________ because they are directly involved in the patient’s experience of suffering

• **Compassion fatigue**, or the emotional and physical burnout that may interfere with ____________, is an occupational hazard and does not constitute a character defect

• *Critical incident debriefing* is a *formally recognized program* with trained staff that allows staff to vent and process feelings in a structured way after particularly ________________

• **Special Issues Related to Mental Health and Physical Illness**
  • Assessing a physically ill patient’s mental health is important because stress, loss, changes in body image, or pain can impact the patient’s physical status as well as place the patient at risk for developing depression, anxiety, or delirium, the most common mental health comorbidities of physical illness

• **Impact of Stress**
  • *Compassion Fatigue* (pg. 436)

  **Nurse’s Role**
  Within the context of the therapeutic relationship, the nurse uses ________________ skills to assist the patient and family to identify their feelings and put them into words to foster communication

• **Loss and Grief**
  • Nurses need to assess for signs and symptoms of the grief response in all patients facing illness
  • Nurses who understand the nature of deep emotions as ________________, and intense ________________ are better able to develop plans of care that incorporate attention to these emotions in addition to providing disease-related treatments
  • Grief and loss affect not only the patient but the __________ as well

• **Body Image Changes and Stigma**
  • Changes in body image and the stigma attached to the change can elicit a grief response (WHY??)
  • Nurses need to help the patient *reframe* his or her relationship to the change

• **Pain and Other Physical Symptoms**
  • Nurses need to assess a patient’s pain and understand that pain is highly subjective

• **Anxiety and Depression**
  • Physical illness is acute or chronic
  • While acute illness is often accompanied by high levels of anxiety, and chronic illness may be attended by depression, anxiety and depression are frequently comorbid conditions
• Studies have shown that patients with anxiety and depression have demonstrated increased serum cholesterol, triglycerides and low density lipoprotein cholesterol (LDL-C), and reduced high density lipoprotein cholesterol (HDL-C) levels, increasing the patients’ risk for coronary artery diseases occurring during physical illnesses.  

  _Continued anxiety and/or depression without relief can be life-threatening_  

• Assisted suicide has emerged as a potential option for patients whose physical illness has pushed them beyond their ability to cope.

• The Nurse’s Role in Breaking Bad News (Box 20-5 pg. 444)  
  • Bad news is defined as any new information that the patient interprets as representing significant loss  
  • Nurses can use the SPIKES protocol to deliver bad news therapeutically.  
  • The SPIKES protocol addresses setting, perception, invitation, knowledge, emotions and empathy, and summary and strategy.

• End-of-Life Care  
  • The first step in becoming proficient in providing care for those facing end-of-life and their families is to become familiar and comfortable with one’s own mortality  
  • Death/Dying Activity

• Conversations About Death and Dying  
  • The therapeutic goal of such conversations should be to keep the line of communication open.

• Conversations About Code Status  
  • This is a process of exploration. It can also include the completion of advance directives (_____________ and durable power of attorney for ________________) to fully document the patient’s preferences.

• Conversations Involving a Shift from Cure-Driven Care to Palliative Care  
  • The health care provider is working to develop a ______________ because the cure-driven plan is no longer achieving desired outcomes

• Conversations About Hospice Care  
  • Hospice care is considered the gold standard of end-of-life care, allowing patients to remain at home in their own community  
  • Nurses involved in end-of-life care need to be prepared to have ______________ conversations about death and dying, code status, palliative care, and hospice care

• The Role of the Mental Health Liaison/Consultation Nurse  
  • In numerous facilities nationwide, recognition that medical-surgical patients present with psychosocial distress due to their illnesses, treatments, and hospitalizations has led to the
creation of the mental health liaison/consultation nurse role and similar interdisciplinary mental health teams

• Such nurses often function in an advance practice capacity

• Applying the Nursing Process from an Interpersonal Perspective
  • The nurse will use the interpersonal process throughout to not only develop the relationship with the patient but also to _______ through the stages of the nursing process

Strategies for Optimal Assessment

• Therapeutic use of self
  — An important skill used throughout the nursing process when dealing with mental health issues in patients with physical illnesses

• Diagnosing and Planning Appropriate Interventions

• Meeting the patient’s focused needs
  — Prioritizing and meeting patient needs when the presenting problems are medical usually requires emergent physical needs to be met before ___________ or ___________ needs. At end-of-life, this may not hold true, and in fact, doing so can often interfere with a healing outcome for patient and family

• Implementing Effective Interventions

• Timing and pacing
  — In many situations, providing psychosocial care can be accomplished as the nurse provides physical care for the patient. For example, a dressing change may prompt a conversation about how the patient is coming to terms with the loss of a leg from amputation
  What are other examples you can think of?

• Evaluating

• Evaluating includes assessing if the patient, family, or significant other’s goals been met

• Objective critique of interventions and self-reflection
  — Evaluation should encourage self-reflection, including whether or not the nurse capitalized on his or her strengths
  — Look for mentorship in areas that need improvement and continue to seek to refine critical thinking skills

Chapter 8 Known Risk Factors for Prevalent Mental Illness and Nursing Interventions for Prevention

• Why does a patient develop a mental disorder?
• What makes one person more susceptible to developing mental illness than another?

• Risk Factors

• Table 8:1 (pg 123)
  Might predispose an individual to develop a ________________.
  However, risk factors do not ________________ that a mental illness will occur
Knowledge about risk factors is important to psychiatric-mental health nurses as they develop interventions focused on preventing mental illness.

- **The Nature of Risk Factors**
  - Underlying cause(s) of mental illness continue(s) to be elusive
  - Research into biology of mental illness led to belief that there is a ____________ in neurotransmission in the brain
  - Currently, scientists believe that mental illness is due to a ____________ of influences, not just the person’s biologic makeup
  - Existence of multiple risk factors is common to many psychiatric-mental health disorders
  - One factor is _______________ enough to initiate a mental illness.

- **Categories of Risk Factors**
  - One method divides risk factors as: ____________, ____________, or community risk factors
  - Another way of categorizing risk factors is into biological and psychosocial categories, or intrapersonal and environmental categories
  - A third approach delineates risk factors into more specific categories, such as ____________, biological, psychological, social, and environmental factors

- **Protective Factors**
  - Characteristics, variables, or traits that _______________ or buffer the effect of risk factors
  - Classified as internal or external
    - Examples of internal protective factors include: good health, high stress tolerance, positive coping skills, average or better intelligence, flexibility, and a positive outlook on life
    - Examples of external protective factors include: supportive and positive family, social and community relationships, adequate economic resources, and recreational activities

- **Resilience as a Protective Factor**
  - Definition of Resilience=Process of adapting well in the face of ____________, trauma, tragedy, threats, or even significant sources of stress (APA);
  - Adaption is learned over time and involves behaviors, thoughts and actions.

The Stress-Vulnerability-Coping Model
Identifies risk factors according to three categories: biological, personal, and environmental
1. _______________ risk factors include a family history of mental illness, brain abnormalities, neuro-developmental problems, and other diseases of a medical nature
2. _______________ risk factors include poor social skills, poor coping skills, and communication difficulties
3. _______________ risk factors include substance abuse, work or school problems, rejection by other people, stressful relationships, poor social support, and the occurrence of major life events
Vulnerability ______________ as the *number and intensity* of risk factors increase. There is a direct correlation.

- Suggests mental illness arises from the interplay of the three dominant factors
  - Stress
  - Vulnerability
  - Coping

**Risk Factors for Major Psychiatric-Mental Health Disorders**
- Disorders of infancy, childhood, and adolescence
  - Genetics/biology and temperament are two important intrapersonal risk factors for the development of psychiatric-mental health disorders occurring from infancy to adolescence

**Schizophrenia**
- 1. Risk factors for schizophrenia include the interaction between genetics and ______________
  - In addition, *gestational and birth* complications are associated biological risk factors

**Affective disorders**
- 1. ______________ is a risk factor for both depression and bipolar disorders
- 2. Gender, life stressors, substance abuse, and inadequate social supports are additional risk factors

**Substance-related disorders**
- Substance use disorders are strongly linked to familial patterns
- Genetics, biology, and ______________ from the environment are also thought to be intrinsically connected

**Anxiety disorders**
- An______________________, social support, and resilience are protective factors for anxiety disorders

**Personality disorders**
- Risk factors for personality disorders include a family history of personality disorders or other mental illness; verbal, physical, or sexual abuse; ______________ during childhood; ______________ family life during childhood; diagnosis of a childhood conduct disorder; and death or divorce of parents during childhood (Virginia Satir)

**The Interface of Psychiatric-Mental Health Disorders and Medical Conditions**
- Medical conditions can act as risk factors, also playing a role in the development of a psychiatric-mental health disorder
- What is your opinion about the above statement? What are some instances when this might occur?
Factors Influencing Risk
Any medical disorder could be a risk factor for a psychiatric-mental health disorder. Any psychiatric-mental health disorder might place a patient at greater risk for a medical disorder. Why???? How???? Small group discussion…list five ways this is true. Draw on your clinical experiences, observations, media…….

Medical and Psychiatric-Mental Health Disorders as Risk Factors
Multiple medical disorders have been associated with the development of psychiatric-mental health disorders
   — Example: List some examples from discussion.

The Interpersonal Process for Risk Reduction
• Awareness is necessary to identify when a risk factor is part of the patient’s assessment information. It presumes that the nurse knows the risk factors, and recognizes the psychiatric-mental health and medical components and their potential consequences
• Judgment is required to determine the importance of the risk factor, and to prioritize among multiple risk factors present. It helps the nurse identify ________________ and how quickly the responses should begin
• Initiative prompts the nurse to take action and address the risk factor. Some risk factors may be more responsive to intervention than others. Unless an emergency is identified, the nurse will have the greatest and most immediate impact on the patient by first addressing risks more easily and quickly ________________.

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

Primary Prevention (pg. 132-136)
• Refers to interventions that delay or avoid the onset of illness
   — Example:

Secondary Prevention
• Refers to treatment including identifying persons with disorders and standardizing treatment for disorders
   — Example:

Tertiary Prevention
• Refers to maintenance, including decreasing relapse or recurrence, and providing rehabilitation
   — Example:
WEEK SIX

- **Chapter 11 Thought Disorders (Schizophrenia)**

  - Thought disorder is a broad term applying to illnesses involving disordered thinking and disturbances in reality orientation and social involvement.
  - Though symptoms of *psychosis* (condition involving hallucinations; delusions; or disorganized thoughts, behavior or speech) are often intermittently or continuously present, the underlying thought disorder is the most prominent cause of disability associated with this group of psychopathologies.
  - The group of disorders are referred to as Schizophrenia Spectrum Disorders (SSD).

- **Epidemiology**
  - Understanding the epidemiology of a disease is critical to identifying risk factors and possible preventive strategies.
  - Schizophrenia studies are plagued by issues that include an imprecise definition of the illness and changing diagnostic criteria over time.

- **Incidence**
  - Incidence refers to the number of ________ cases in a specific time period.
  - Average incidence of schizophrenia across the world is approximately 15.2 per 100,000.
  - For every ______ men affected with SSD, there are ______ women affected.
  - Statistics also reveal a significantly higher rate of the disorder among ________ than in the native-born populations across societies.
  - Those living in ________ areas show a higher incidence rate than those living in rural or suburban settings.

- **Prevalence**
  - According to statistics, prevalence rates (the number of current cases) of the disorders do not vary by gender or urbanicity. Thus, the different research findings for incidence and prevalence remain unexplained in the research literature and are considered as a direction for further study.

- **Mortality**
  - Death is generally reported as standard mortality rate (SMR), which is calculated by dividing the observed mortality rate in the SSD population by the expected mortality rate in the general population, matched in age and gender.
  - The SMR for persons with SSD is 2.6 with no differences noted by ____________.

- **Remission/Recovery**
  - Studies of the course of schizophrenia have reported significantly varying rates of remission and widely different definitions.
• **Thought Disorders Include:**
  Schizophrenia and its five subtypes
  • Schizophreniform disorder
  • Schizoaffective disorder
  • Delusional disorder
  • Brief psychotic disorder
  • Shared psychotic disorder
    — Each disorder has a specific set of diagnostic criteria that a patient must meet for diagnosis

• **Schizophrenia**
  Schizophrenia is manifested by positive and negative symptoms. Positive symptoms are exaggerations of normal function (such as ________________________); negative symptoms indicate decreased emotional expression, such as ________________
  • For diagnosis, the disease must be present for at least _____ months. During this time frame, the patient must actively demonstrate the symptoms for a period of one month

• **Schizophrenia Subtypes**
  • **1. Paranoid type** is characterized by prominent delusions and hallucinations while affect and cognition are relatively preserved
    • Delusions typically are persecutory, involving the feeling that one is being ___________________________; other common themes are jealousy, religiosity, or somatization. Hallucinatory content is also related to the delusions
    • Prognosis for occupational success and living independently is better than for other subtypes
  
  • **2. Disorganized type** is characterized by silliness and laughter not connected to speech content
    • Often have trouble with ______________________________________
    • Delusions and hallucinations, if present, are ________organized around a central theme
    • Subtype is often associated with poor premorbid function, insidious, early onset, and a course of illness without significant remission

  • **3. Catatonic type** is characterized by psychomotor disturbances, which may include immobility, excessive motor activity, extreme negativism, mutism, peculiar voluntary motor movement, echolalia, or echopraxia
    • Motor immobility may be manifested by catalepsy (_____________________) or stupor
    • Voluntary movement may be peculiar and include assuming uncomfortable postures or grimacing
    • During periods of severe stupor or excitement, the person may require careful supervision to avoid **injury to self or others**
    • Also at risk for ______________________________________

  • **4. Undifferentiated type** is defined as schizophrenia with the characteristic of schizophrenia that does not meet the criteria of paranoid, disorganized, or catatonic type
5. Residual type is the term used when there has been at least one episode of schizophrenia, but the current clinical picture is without prominent positive psychotic symptoms.
- Continuing evidence of negative symptoms or two or more less prominent positive symptoms
- If delusions or hallucinations persist, they are not prominent or disturbing to the person

Schizophreniform Disorder
- Schizophreniform disorder shares essential features with schizophrenia, with two differences
  - Total duration of the illness is at least one month but less than six months
  - Impaired social or occupational functioning during some part of the illness may occur but is not required as a criterion

Schizoaffective Disorder
- Uninterrupted period of illness during which there is a major depressive, manic, or mixed episode concurrent with the characteristic symptoms of schizophrenia
- ___________ or ___________ are present
- Risk for suicide is ________________
- Overall prognosis of schizoaffective disorder is better than that for schizophrenia

Delusional Disorder
- Characterized by the presence of one or more non-bizarre delusions that persist for more than one month in a person who has never had a symptom presentation that met the diagnosis of schizophrenia
- Hallucinations, if present, are not ________________

Brief Psychotic Disorder
- A thought disorder that usually has an abrupt onset with at least one positive symptom associated with the characteristics of schizophrenia
- Commonly lasts between 1 and 30 days and the person has a full remission during the specified time period

Shared Psychotic Disorder
- Known as Folie à Deux, a disorder in which a delusion develops in an individual who is involved in a __________________________ with another person
- The inducer is the _______________ person in the relationship and gradually imparts the delusion to the more passive partner
- Can involve more than ___________ people especially in a family situation where the inducer is the parent and the children adopt the delusional belief

Etiology of __________________________ (SSD)
- Psychiatric syndromes whose prominent features involve disorders of thought are serious illnesses, occurring second only to heart disease in contributing to the existing world disease burden
- Unfortunately, the exact etiology of SSD is unknown
• **Psychosocial Theories**
  Early psychosocial theories identified a problematic ___________ relationship as the cause of schizophrenia. Later, other theories addressed social context and unresolved family issues.

• **Biological Theories**
  Biological theories suggest perinatal events, genetics, neur anatomical abnormalities, and dysfunction of neurotransmitters as key risk factors for the development of schizophrenia.

• **Treatment Options**
  Treatment of SSD requires medical/pharmacological, environmental, psychosocial, and _______________________. None of these categories of treatment alone is sufficient to assist the person with SSD to live their life to fullest potential.

• **Pharmacological Therapy**
  Antipsychotic agents are typically classified as first- or second-generation agents.
  Both are associated with extrapyramidal symptoms: parkinsonism, akathesia, dytonias, and tardive dyskinesia.
  Second-generation antipsychotics are associated with the development of metabolic syndrome.

• **Applying the Nursing Process from an Interpersonal Perspective**
  Many individuals with SSD also have comorbidities, including substance abuse, diabetes, and cardiovascular and respiratory disease.
  Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for patients with SSD.

• **Strategies for Optimal Assessment**
  Therapeutic use of self
  Self-awareness
  Rapport
  Environmental management
  Health history and examination

**Diagnosing and Planning Appropriate Interventions**
  Nursing diagnoses also will vary based on the acuity of the patient’s illness, developmental stage, comorbidities, current treatment regimen, and sources of support.
  Patients with schizophrenia often present with a wide range of symptoms. Therefore, nursing diagnoses appropriate for a patient must reflect this variation.

• **Implementing Effective Interventions**
  *Timing and pacing*
  An important consideration when implementing care for a patient with schizophrenia is to ___________ to the prescribed medications. Patient and family psychoeducation is a key intervention.
• **Evaluating**
  Evaluation is a process that begins ______________ after the initiation of each intervention and continues through each episode of care
  Evaluation process in nursing is dictated by the collaborative goals and outcomes set in the ______________ phase of the nursing process

**Chapter 26 Vulnerable Populations and the Role of the Forensic Nurse**

• **Vulnerable populations** are those groups typically defined by race/ethnicity, socio-economic status, geography (urban or rural), gender, age, disability status, and risk status related to sex and gender
  These populations are highly visible throughout society and include, but are not limited to, children, elderly, minority groups, those with intellectual disabilities, the homeless, and those who are incarcerated

  Vulnerable populations experience disparity, or lack of ______________, when it comes to health and health care
  Vulnerable populations and health disparities were addressed in the plan for transforming the mental health care system by the President’s New Freedom Commission on Mental Health (2003). One of the major goals identified was to eliminate disparities in mental health care
  When working with vulnerable populations, nurses function as advocates for the population and work to ensure the safety of all involved

• **Children and Mental Health and Illness (pg. 569)**
  Children are vulnerable because they often are not old enough to ______________ for themselves
  In some cases, they may grow up in ______________ settings with one or both biological parents unable to care and advocate for them
  They may be born to ______________ or live with parents who become homeless due to illness, loss of jobs, or loss of housing
  Mental health care services may be inadequate and/or inaccessible for lower-income families or those who lack any income

• **Nurse’s Role When Working With Children**
  The nurse works to gather information about the child, the child’s family, and functioning ability in school if the child is old enough for school
  The nurse gathers information about the child’s social relationships
  Information about the child’s growth and ______________ is important
  If abuse is suspected, nurses are ethically and ______________ bound to report suspected child abuse
• Aging Individuals and Mental Health and Illness
  • Another vulnerable population that nurses in all areas of practice will encounter is the elderly
  • People aged _____ and older are at the highest risk for completed suicide
    — Possible risk factors for higher suicide rates in later life include: older age; male
gender; living alone; mental illness; access to firearms; social isolation; loneliness;
depression; recent widowing, divorce, or separation; multiple chronic illnesses;
alcohol or substance abuse; need for multiple medications; feelings of hopelessness
  and worthlessness

• Nurse’s Role When Working With the Elderly
  • The nurse’s role when working with the elderly is diverse
  • It may involve helping to improve the patient’s overall health and mental health well-being
  • If abuse is suspected, laws in most states require health care providers to report suspected
abuse or neglect to appropriate law enforcement agencies and Adult Protective Services

• Minority Groups and Mental Health and Illness
  • Racial and ethnic minority groups are identified based on federal categories
  • Minorities have less access to and experience less availability of mental health services
  • Minorities in treatment often receive a poorer quality of mental health care
  • Minorities are underrepresented in mental health

• Nurse’s Role When Working With Minority Groups
  • When working with members of minority groups, the nurse must be sensitive to the traditions
  and ___________ of people of that group, especially related to general and mental health care
  • Cultural differences between professional nurses and their patients increase the complexity
  of providing care within the health care environment
  • Nurses must first reflect on their ___________ beliefs and values to assist them to
  respect the individuality of their patients and to provide culturally competent care

• Individuals With Intellectual Disabilities and Mental Health and Illness
  • Examples of common causes of intellectual disability include Down syndrome, fetal alcohol
  syndrome, genetic conditions, and infections which happen before ___________

• Nurse’s Role When Working With Individuals With Intellectual Disabilities
  • The nurse advocates for the individual and works to protect the ___________ of the individual

• The Homeless and Mental Health and Illness
  • “Homeless” – one who lacks a fixed, regular, and ___________ nighttime residence that is
  a supervised publicly or privately operated shelter, a temporary residence for individuals
  intended to be institutionalized, or a public or private place not ordinarily used as a regular
  sleeping accommodation for human beings
  • The correlation between homeless and mental health problems is significant
  • ___________ account for a significant number of ___________ individuals. These
  veterans often experience the effects of posttraumatic stress disorder
• **Nurse’s Role When Working With the Homeless Population**
  When working with the homeless population, as with any patient population, *a caring, nonjudgmental approach is necessary.*

• **Individuals Who are Incarcerated and Mental Health and Illness**
  Individuals who are ____________ have been involved with the criminal justice system, which includes jails, prisons, juvenile detention centers, substance abuse treatment facilities, and other facilities.
  Jails, prisons, correctional centers, and juvenile detention facilities house individuals who are among the ____________ populations in society – those who are impoverished, marginalized, and subject to discrimination and stigmatization.

• **Nurse’s Role When Working With Incarcerated Patients**
  PMHNs working in correctional facilities administer psychopharmacology, engage in groups, perform medical functions such as drawing specimens for testing and following up with individuals with chronic illnesses, perform treatment, and provide education.

• **Forensic Nursing**
  The International Association of Forensic Nurses (IAFN) and the American Nurses Association (ANA) define *forensic nursing* as “the application of forensic science combined with the ____________ education of the registered nurse in scientific investigation, evidence collection, preservation, and analysis, and prevention and treatment of trauma and/or death-related medical-legal issues.”

• **Subspecialties of Forensic Nursing**
  - Forensic psychiatric nurses
  - Correctional nurses
  - Legal nurse consultants
  - Forensic sexual assault nursing examiners (SANEs)
  - Nurse attorneys
  - Nurse coroners
  - Forensic nurses trained to work in the area of mass disasters

  - **Forensic nurses working in the area of elder mistreatment**
    - Forensic nurse death investigators
      - Interpersonal violence specialists who may work in trauma, transplant, emergency, critical care nursing, and primary care clinics

  - **Educational Preparation**
    - Forensic nurses typically require a graduate-level education and work as forensic psychiatric nurses, correctional nurses, legal nurse consultants, forensic sexual assault nursing examiners, nurse attorneys, nurse coroners, death investigators, and clinical nurse specialists in trauma, transplant, emergency, and critical care.
Roles of the Forensic Nurse

The practice of forensic nursing is challenging. Forensic nurses working in corrections settings are faced with numerous, often emotionally-charged issues.

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Critical Incident Stress Management (CISM)

- Critical Incident Stress Management (CISM) is an interventive strategy designed to reduce the effects of acute mental and emotional disruptions associated with psychological trauma and to prevent the development and progression of posttraumatic stress disorder (PTSD).

Critical Incident Stress Management (CISM) cont.

- This intervention is important for psychiatric nurses working in and/or administering mental health programs. The likelihood of an aggressive episode in a psychiatric setting is greater than in any other area where nurses are employed except the emergency room.

Critical Incident Stress Management (CISM) cont.

- In anticipation of such events in psychiatric hospitals all clinical hospital staff are trained in the management of aggressive and assaultive behavior.
- These programs are usually commercially prepared and provided by experienced trainers.

Pre-crises preparations for both individuals and organizations

Group briefing procedures for use with large numbers of individuals

Individual crisis intervention strategies

Small group discussions - called defusings
Critical Incident Intervention

Large group discussions focusing on cognitive-emotional-cognitive interventions usually lasting 1-3 hours and occurring within 2-7 days of the event. This strategy involves:

- Evaluate the facts, thoughts and emotions of the event
- Consider possible symptomatology associated with PTSD
- Identify strategies for coping

Large group discussions
- Evaluate the facts, thoughts and emotions of the event
- Consider possible symptomatology associated with PTSD
- Identify strategies for coping
- Family crisis intervention

Follow-up for continued counseling and treatment


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**MANAGING ANGER AND AGGRESSION**

- **Intervening In Anger**
- There are three categories of situations that provoke anger
  - Frustration/frustrating situations
  - Situations where the person’s sense of adequacy/security are threatened

- There are three categories of situations that provoke anger
  - Situations where one person’s behavior does not meet the expectations or approval of another

- **Interventions**
  - Reduce or eliminate the frustrating situation

- Encourage expression of feelings

- Identify and discuss expectations

- Implement the problem-solving process

- **Levels of Aggression**
  - **Level I – Potential**
    - Increase in demands, irritability, complaints, sarcasm
    - Mild to moderate anxiety – sudden mood changes, change in voice tone, rate of speech, restlessness, increased motor activity
    - Is able to perceive, communicate and problem solve
Nursing Goals - Level 1
1. Identify the threat and analyze ways to manage it
2. Increase awareness of underlying feelings – encourage appropriate expression
3. Reduce anxiety
4. Use resources to solve rather than act out feeling

• Nursing Interventions – Level 1
1. Observe, recognize and acknowledge patient's feelings
2. Encourage verbalization of feelings
   – Help patient specify anger
   – Connect to feelings, thoughts and behaviors
   – Separate feelings from action
   – There is a difference between anger and aggression
3. Assist in insight development – identify the threat, frustration, expectation
   – Investigate situation immediately preceding the aggression
4. Help patient explore possible consequences to behavior
5. Determine what can be done to remove threat

• Levels of Aggression
• Level 2 – Impending
  – Provoking arguments with others – threats and accusations
  – Moderate to severe anxiety
    • Change in affect or behavior
    • Increased tension and anxiety
    • Limited focus of attention, reduced ability to perceive and communicate

• Nursing Goals - Level 2
1. Express feelings verbally rather than by aggressive acts
2. Maintain safety for patient and others with external controls
3. Release tension through expenditure of energy
• Nursing Goals - Level 2
4. Regain sense of control by elimination of external stressors, threats when possible
• Nursing Interventions – Level 2
1. Encourage verbalization of feelings
2. Help patient isolate threat/frustration
3. Reduce stress when possible:
   – Offer medication
   – Reduce environmental stimulation
   – Provide environmental control
• Nursing Interventions – Level 2
4. Explore consequences of behavior
5. Separate thought from action
6. Set consistent and fair limits
7. If consequences to an action are set, they must be followed through
8. Respond in clear, simple statements
9. Reality orient
10. State expectation that patient will gain control
• Levels of Aggression – Level 3
• Level 3 – Immediate
• Destructiveness toward animate and inanimate objects
• Severe or panic anxiety
  – Scattered attention, easily distracted, confused
  – Inability to communicate or function
  – Reduced comprehension
  – Marked somatic responses

• Nursing Goals – Level 3
1. Immediate establishment of safety for the patient and others
2. Reduction of agitation, tension and anxiety
3. Regained sense of self-control

• Nursing Interventions – Level 3
1. Provide temporary physical and environmental controls
2. Give medication if ordered
3. Communicate with brief, clear, direct responses
   – Tell patient what is happening – assure patient you will stay with him/her
4. Do not introduce any new material for processing
5. Assure the patient staff will help him/her control the behavior with external means

• Monitoring for Aggression
• Assess the pre-cursive signs
  – Increase in motor agitation
  – Threatening verbalizations/gestures
  – Intensification of affect

• Assess the pre-cursive signs
  – Responding to threatening hallucinations
  – Prior history of aggression
  – Use of alcohol or drugs

• Intervening in Aggression
1. Reduce stimuli by withdrawing from the environment any object/person frustrating the patient
2. Put distance between the patient and the nurse who is intervening
3. Explain who you are
4. Give assurance by exploring what’s happening
5. Give the patient choices
6. Attempt to find the source of the problem and correct it
7. Get help - increase the number of interveners
8. Chemotherapy
9. Physical restraint
Chapter 12 Affective Disorders

Fluctuations in mood (a person’s overall emotional status), especially during times of loss, change, and other social stressors are normal as one’s mood is not static. Fluctuations occurring for a sustained period of time are suggestive of an affective disorder. Effective disorders influence a person’s thoughts, emotions, and behavior.

Affective Disorders
- Major depressive disorder
- Dysthymic disorder
- Bipolar disorder: types I and II
- Cyclothymic disorder
- Seasonal affective disorder (SAD)

Historical Perspectives

Epidemiology
- Major depressive disorder is a leading cause of disability in the United States, affecting greater numbers of women than men.

Major Depressive Disorder
- Must include depressed mood or loss of interest or pleasure for at least two weeks in conjunction with at least four other symptoms:
  - Significant weight loss
  - Hypersomnia or insomnia
  - Psychomotor agitation or slowness
  - Fatigue or energy loss
  - Difficulty ____________________________
  - Recurrent thoughts of __________________________

Dysthymic Disorder
- Involves depressive symptoms that are chronic and must be present for at least two years for adults or one year for children and adolescents.
- Dysthymia is considered a milder _____________ form of depression.

Bipolar I Disorder
- Characterized by the occurrence of one or more _______ episodes or mixed episodes (mania and major depression), and often one or more major depressive episodes.

Bipolar II Disorder
- Characterized by a re-occurring major _____________ episode either currently or in the past, and at least one hypomanic episode.


**Cyclothymic Disorder**
- Defined by chronic fluctuations of mood from numerous periods of both depressive symptoms and hypomania
- Diagnosis is not made unless the patient has been free of major depression, manic, or mixed episodes for at least two years

**Suicide**
- Suicide is considered a behavior and not a disorder. The *DSM-IV-TR* does not identify diagnostic criteria for this behavior
- Ambivalence is frequently the underlying theme involved with suicide

**Psychosocial Theories**
- A number of psychosocial/psychological theories suggest psychodynamic influences play a role in causing affective disorders
  - Learned helplessness theory
  - Learned hopelessness theory (exp.)
  - Cognitive theory
  - Temperament
  - Stress

**Biological Theories**
- Most common theories addressing neurobiological influences involve the neurotransmitters serotonin, dopamine, and norepinephrine
- Genetics
  - Most researchers agree there seems to be a ________________ for developing affective disorders
  - Much research is being conducted around genetics

**Treatment Options**
- Face-to-face or Internet individual therapy
- Family therapy
- Cognitive behavioral therapy-focuses on the ____________
- Face-to-face or Internet-based self-help groups
- Pharmacological therapy
- Patient and family education
- Electroconvulsive therapy

**Strategies for Optimal Assessment**
- Therapeutic use of self

**Diagnosing and Planning Appropriate Interventions**
- Meeting the patient's focused needs
- Nurse and patient collaboratively determine the outcomes to be achieved
Implementing Effective Interventions
- Timing and pacing
- Interventions will vary depending on the actual diagnosis

Evaluating
- Objective critique of interventions and self-reflection
- This phase is also part of the termination of the patient-patient relationship
- Many times a patient will have a setback due to their feeling of loss of this relationship

Chapter 17  Impulse Control Disorders
- Classification of impulse control disorder involves those disorders with defining feature of __________ to control or inhibit acting on impulses that might be harmful to self or others
- Disorders classified by the DSM-IV-TR include
  - Pathological gambling
  - Kleptomania
  - Pyromania
  - Intermittent explosive disorder
  - Trichotillomania

Historical Perspectives

Epidemiology
- Intermittent explosive disorder and pyromania are more common in __________
- Kleptomania and trichotillomania are more common in __________
- Two-thirds of those with pathological gambling are male

Diagnostic Criteria
- The impulse response follows a predictable pattern: an increase in stress followed by an increase in arousal, which leads to the act and subsequent experience of __________, gratification, and release of tension, followed by feelings of regret, self-reproach, or guilt

Etiology
- Impulse control disorders and obsessive-compulsive disorders appear to be closely linked clinically
- No single scientific theory has been proposed to explain the cause of impulse control disorders
  - Psychodynamic influences
    - Known psychodynamic influences associated with impulse control disorders vary based on the specific diagnosis
  - Neurobiological influences
    - A decrease in _________________ has been linked to disorders characterized by poor control or impulse control issues
Treatment Options
Non-pharmacologic therapies found to be helpful in the treatment of impulse control disorders include: cognitive restructuring, relaxation, anger management, family therapy, support groups, and coping skills training (Where else have you seen these interventions?)
Primary pharmacologic treatment for impulse control disorders is selective serotonin reuptake inhibitors (SSRIs) such as sertraline (Zoloft) and fluvoxamine (Luvox)

Applying the Nursing Process from an Interpersonal Perspective
Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for patients with impulse control disorders

Strategies for Optimal Assessment
Therapeutic use of self
therapeutic use of self as described by Joyce Travelbee is “the ability to use one’s personality consciously and in full awareness in an attempt to establish relatedness and to structure nursing intervention”

Self-awareness
Data collection

Diagnosing and Planning Appropriate Interventions
• Meeting the patient’s focused needs
  Meeting patient-focused needs during the planning stage of the nursing process can only happen if the nurse has accurately completed an assessment of the patient and his or her perception of the condition
  Focusing on the patient’s ___________ that were identified in the assessment stage is key when planning interventions
  A common priority nursing diagnosis for a patient with an impulse control disorder is

Implementing Effective Interventions
• Timing and pacing
  Nurse provides both non-pharmacologic and pharmacologic therapy and monitoring where appropriate
  In developing interventions, the nurse should consider the need for ___________ with the patient, as these individuals often test the ___________ and push the limits of rules and regulations

Evaluating
Objective critique of interventions and self-reflection
Nurse evaluates how much progress has been made toward achieving expected outcomes
For any goals not met, the nurse needs to self-reflect on anything he or she may have done differently while providing nursing care
Evaluate how the patient presented initially and where he or she is at this time
During this phase of the nurse-patient relationship, the nurse and the patient should reflect on progress made toward reaching the patient goals
### Supplemental Suicide Info

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<td>It is a myth that talking to someone about their suicidal feelings will cause them to commit suicide</td>
<td></td>
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<tr>
<td></td>
<td>Fact: Asking someone about their suicidal thoughts may make the person feel relieved that someone recognized their emotional pain</td>
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<tr>
<td>It is a myth that all suicidal people want to die and there is nothing that can be done about it.</td>
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<tr>
<td></td>
<td>Fact: Most suicidal people are ambivalent, that is, a part of them wants to die but a part wants to live</td>
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<tr>
<td>It is a myth that people who talk about committing suicide never actually do it.</td>
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<tr>
<td></td>
<td>Fact: When someone talks about suicide he/she may be giving a warning signal that should not be ignored by others.</td>
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<tr>
<td>It is a myth that there is a typical type of person who commits suicide...</td>
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<tr>
<td></td>
<td>Fact: The potential for suicide exists in all of us. There is no typical type of suicidal person.</td>
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<tr>
<td>It is a myth that suicide occurs without warning.</td>
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<tr>
<td></td>
<td>Fact: Many people, including adolescents, give warnings of their suicidal intent.</td>
</tr>
</tbody>
</table>
Suicide Safety Plan

I,__________, agree not to perform any self-destructive acts while a patient on this unit. I promise to
seek out a staff member when I feel sad, lonely, nervous, frightened, and/or self-destructive.

_________Patient  ___________Date

_________Witness  ___________Date

• Instructions for Safety Plan
• Read the contract to the patient.
• Have the patient sign the contract with two staff members as witnesses.
• Place one copy of the contract in the patient’s chart/give one copy to the patient.
• Have the patient re-read and report its importance 4 X in 24 hours.
• Rounds are to be made every fifteen minutes on all patients on the psychiatric unit
• Suicide monitoring
  – Staff watch - q 15’
  – Staff close - within view of staff at all times
  – Staff constant - one-to-one around the clock
• INTERVENING IN SUICIDE
• Individual sessions
  – Expression of anger turned inward
  – Find the ambivalence and press the positive
  – Assess for plan, method, means
  – If inpatient, check mouth for swallowing medications
• INTERVENING IN SUICIDE
  – Assess for plan, method, means
• Plan - “Are you thinking of hurting yourself?” “Have you thought of suicide?”
• Method - “If you could do it how would you do it?”
• Means - “Do you have guns in the home?” Or pills, or a car with access to a bridge, etc.
• Individual sessions
  – Cognitive restructuring - confront distortions
  – Problem-solving process

• SUICIDE HOT LINE
• Establish rapport and caring concern for the patient
• 
• Assess lethality of the plan - does patient have gun, near highway
• Get the patient to tell you where they are or agree to come in for an assessment
  – Call police if you know where patient is
  – If there is someone there with them ask them to call them to the phone

• GESTURES VS ATTEMPTS
• Secondary gain - attention getting, getting even, etc.
• Evaluate the lethality of the gestures
• Always believe that the patient is at risk for accidental success or deliberate success in a gesture or attempt
• Never take a threat lightly

WEEK EIGHT

Chapter 14  Personality Disorders

Personality, essentially, refers to who a person is and how that person behaves. It influences an individual’s thoughts, feelings, attitudes, values, motivations, and behaviors
Personality affects how a person deals with stressors and how he or she forms and maintains relationships
Everyone has a unique collection of personality characteristics or traits
Personality traits are different from personality disorders
Personality disorders are classified into clusters A, B, or C based on the predominant symptoms

Cluster A Personality Disorders (appear odd or eccentric)
  – Paranoid
  – Schizoid
  – Schizotypal
Cluster B Personality Disorders (appear dramatic, emotional, or erratic)
- Antisocial
- Borderline
- Histrionic

Narcissistic personality disorders (appear anxious or fearful)
- Cluster C Personality Disorders
  - Avoidant
  - Dependent

Obsessive-compulsive disorders
- Currently there are 10 specific personality disorders, all of which are classified as a separate axis in the DSM-IV-TR

Epidemiology
- Personality disorders usually begin in early adolescence or early adulthood
- Intensity of personality symptoms tends to decrease with age and may, in fact, go into remission as a person matures
- Approximately 9.1% of adults in the United States have a personality disorder as outlined by the DSM-IV-TR
- An association between personality disorders and co-occurring major mental disorders has been identified by research

According to the DSM-IV-TR (2000), antisocial personality disorder is diagnosed more frequently in men, while borderline, histrionic, and dependent personality disorders are diagnosed more frequently in women
- Personality disorders often occur along with another major mental disorder. They are also associated with alcoholism. Violence or violent acts are linked to the development of antisocial and borderline personality disorders

Diagnostic Criteria
- Cluster A personality disorders include individuals that appear odd or eccentric
- Cluster B personality disorders include individuals that appear dramatic, emotional, or erratic
- Cluster C personality disorders include individuals that appear anxious or fearful

Etiology
- There is no one commonly accepted understanding about the etiology of personality disorders
- Most likely, it is a multifaceted process involving both genetic and environmental factors
- There is no one commonly accepted understanding about the etiology of personality disorders

Psychodynamics theories
- Biological theories
  - Genetics
  - Neurobiological influences
Treatment Options
- Psychotherapy
- Cognitive behavior therapy
- Dialectical behavior therapy
- Psychopharmacology

Applying the Nursing Process from an Interpersonal Perspective
Recognizing the differences between normal difficulties and personality disorders can be crucial to nurses’ decision making process in navigating the interpersonal process.

Strategies for Optimal Assessment
Therapeutic use of self
- When beginning a therapeutic relationship with any patient, the development of the nurse’s ________________ is essential.
- Nurse and patient meet as strangers and begin a relationship that involves getting to know one another to promote the development of ________________.
- Environmental management.

Diagnosing and Planning Appropriate Interventions
Meeting the patient’s focused ________________.
Patient should be encouraged to participate in not only ________________ his or her problems and needs but also be encouraged to engage as an active partner in ________________ his or her care.
Assessment findings and identified needs are highly variable for patients with personality disorders.

Implementing Effective Interventions
Timing and pacing
- Safety is of utmost importance.
- Frequently, patients with personality disorders, most particularly with borderline personality disorders, will be at high risk for suicide.
- Specific interventions often vary depending on the type of personality disorder diagnosed.

Evaluating
Objective critique of interventions and self-reflection
- Nurse evaluates how much progress has been made toward achieving expected outcomes.
- Compares the patient’s current level of functioning with the identified goals and outcomes.
- Both the nurse and the patient reflect on ________________ made toward reaching the patient’s goals.
- Rapid change in behavior is highly unlikely in patients diagnosed with personality disorders.
Chapter 15 Addictive Disorders

Introduction

Addiction refers to a “chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences” (NIDA, 2010)

Addiction involves a spectrum of substance use disorders, including substance abuse and substance dependence, and substance-induced disorders including intoxication and withdrawal

Epidemiology

The Substance Abuse & Mental Health Services Administration (SAMHSA) funds an annual National Survey on Drug Use and Health (NSDUH)

The most recent report (2010) reveals that the number of Americans 12 years or older who engaged in the use of an illicit drug was estimated at 21.8 million or approximately 8.7% of the population in 2009

Diagnostic Criteria

DSM-IV-TR (2000) lists specific criteria as possible signs of a drug or alcohol addiction

To be diagnostic, any combination of four or more of these criteria must be present:
- Preoccupation with the use of the chemical between the times of use
- Using more of the chemical than had been anticipated
- The development of tolerance to the chemical in question
- A characteristic withdrawal syndrome when the person stops using the chemical
- Use of the chemical to avoid or control withdrawal symptoms
- Repeated efforts to cut back or stop the drug use
- Intoxication at inappropriate times (such as at work) or when withdrawal interferes with daily functioning (hangover makes person too sick to go to work)
- A reduction in social, occupational, or recreational activities in favor of further substance use
- Continuation of chemical use in spite of having suffered social, emotional, or physical problems related to drug use

DSM-IV-TR classifies addictive disorders into two major categories
- Substance use disorders
  - Further classified as substance abuse and substance dependence
- Substance-induced disorders
  - Further classified as substance intoxication and substance withdrawal

Etiology

There is currently no one theory that explains the cause of addiction or substance use and abuse

Several factors have been identified that increase a person’s vulnerability to developing a substance abuse problem
Psychological factors, environmental factors, shared experiences, neurobiological influences

**Treatment Options**
- Regardless of the origin of the addiction, substance or process, the gender of the individual, or the presence of comorbid conditions, the treatment options are much the same.
- Treatment usually consists of a mix of therapies, including self-help programs, psychopharmacology, and psychotherapy such as cognitive behavior therapy and insight-oriented psychotherapy.

**Applying the Nursing Process from an Interpersonal Perspective**
- Psychiatric-mental health nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for patients with addiction disorders.

**Strategies for Optimal Assessment**
- Nursing and the addiction treatment field agree that clinicians establish rapport for a therapeutic relationship during their face-to-face session.
- Empathy, respect or positive regard, congruence, and genuineness are necessary relationship factors for the therapeutic relationship to develop.
- Self-awareness
- The nurse uses reliable and validated screening tools to provide early detection of substance disorders.
- Physical examination.

**Diagnosing and Planning Appropriate Interventions**
- During the therapeutic nurse-patient relationship, a treatment plan is developed that is “____________-centered, recovery oriented, and evidence-based”.
- Although nursing diagnoses may vary, a common nursing diagnosis for a patient with addiction is ______________ coping.

**Implementing Effective Interventions**
- Timing and pacing
  - An example of integrating the interpersonal approach when intervening is the use of the 5 As: Assess, Advise, Agree, Assist, and Arrange.
- Detoxification involves evaluation, stabilization, and entry into treatment.

**Evaluating**
- It is expected that once the therapeutic relationship is established, the process of change will move forward, and the goals of the treatment plan will be met.
- Ongoing self-reflection to increase self-awareness, manage ________________, and ensure that the goals and outcomes sought are patient-centered rather than geared to meet the needs of the nurse or the system.
Chapter 19  Eating Disorders

• **Eating disorders** involve a serious disturbance in behaviors associated with eating (American Psychiatric Association, 2000)

• Eating disorders include
  
  • **Anorexia nervosa** (refusal or inability to maintain a minimally normal body weight)
  
  • **Bulimia nervosa** (repeated episodes of ____________ eating followed by compensatory behaviors)
  
  • **Obesity** (a body mass index greater than or equal to ____________)
  
  • **Binge eating disorder** (episodes of binge eating [eating in a discrete period an amount of food larger than most other people would eat in a similar period under comparable circumstances])

• Eating disorders not otherwise specified

• How a person eats differs from one individual to another and is dependent on many factors, such as
  
  – Physical needs (biological)
  
  – Cultural needs (cultural)
  
  – Lifestyle (social)
  
  – Emotional needs (psychological)

• **Historical Perspectives**
  
  • In the past 30 years, eating disorders have become more clearly defined
  
  • Western culture, society, and, in particular, the media, offer contrasting messages about food and eating
  
  • The wide societal influences of the media and popular culture have recently received much scrutiny and criticism for their negative aspects in relation to body size and its importance

• **Epidemiology**
  
  • Eating disorders have long been perceived to occur primarily in women; few disorders in general medicine or psychiatry exhibit such a skew in gender distribution
  
  • In the late 1960s, anorexia nervosa became a much more prevalent disorder in Western societies
  
  • In the 1970s, the emergence of bulimia nervosa, where young women alternated self-starvation with binging usually followed by purging, was prevalent
  
  • The group at highest risk is young women between ages _____ and ______
  
  • Anorexia nervosa appears to strike at a younger age, with bulimia nervosa being more prevalent in the older group
  
  • Anorexia nervosa occurs in about 1% of the world population
  
  • The number of men experiencing eating disorders is increasing
  
  • The World Health Organization (WHO) defines **overweight** as a body mass index (BMI) ≥25 (kg/m²) and **obesity** as a BMI of ≥30.0 (kg/m²)
  
  • Obesity is a global public health problem affecting both developed and developing countries
  
  • Obesity is not classified as an eating disorder in the *DSM-IV-TR*

• **Diagnostic Criteria**
  
  • The *DSM-IV-TR* categorizes eating disorders according to behavioral and cognitive characteristics
• **Anorexia Nervosa**
  Anorexia is characterized by (less than 85% of minimally normal weight for age and height), intense fear of gaining weight or becoming fat, disturbed perception of the body, and amenorrhea for at least three consecutive menstrual cycles

• **Bulimia Nervosa**
  Characterized by in combination with an inappropriate means to compensate for the binge eating, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, fasting, or excessive exercise

• **Binge-Eating Disorder**
  Binge-eating disorder is included under the DSM-IV-TR category of “eating disorder not otherwise specified”
  It is currently being reviewed for inclusion in the next edition
  Associated with overweight and obesity

• **Etiology**
  The exact etiology of eating disorders is not fully known
  Various factors have been identified as contributing to the development of eating disorders
  - Biological factors
  - Sociocultural factors
  - Familial factors
    - Commonly involve the issue of due to enmeshment, overly concerned parenting, abnormal attachment processes, and insecure attachments

• Psychological and individual factors
  - Many factors specific to the individual may contribute to the development of an eating disorder
    - These include personality traits, self-esteem deficits, and environmental factors

• Interpersonal factors that have been most frequently linked to the development of eating disorders include abuse, trauma, and teasing

• **Treatment Options**
  Treatment of eating disorders is complex and requires a multidisciplinary approach, drawing on a number of therapies in relation to the biological, psychological, social, and cultural needs of the individual experiencing an eating disorder

• **Applying the Nursing Process from an Interpersonal Perspective**
  Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for patients with eating disorders
• **Strategies for Optimal Assessment**
  - Therapeutic use of self
    - A comprehensive nursing assessment that includes biological, psychological, social, and cultural needs must be completed
    - The nurse must use the time to begin developing the therapeutic relationship
    - The nurse must be cognizant of his or her own ______________________________ related to eating and eating disorders
  - Assess ___________________
  - Assess psychosociocultural status
  - Assess for _________________ for change

• **Diagnosing and Planning Appropriate Interventions**
  - Meeting the patient’s focused needs during the planning stage of the nursing process can only happen if the nurse has accurately completed an assessment of the patient, his or her perception of the eating disorder, and motivation for change
  - Due to the varying assessment findings noted in and wide-range of problems faced by patients with eating disorders, numerous nursing diagnoses would apply

• **Implementing Effective Interventions**
  - **Timing and pacing**
    - When implementing interventions, a strong trusting interpersonal relationship between the nurse and individual experiencing the eating disorder is necessary to ensure effective outcomes

• **Evaluating**
  - Objective critique of interventions and self-reflection
    - By evaluating and reflecting on the process of care, the psychiatric-mental health nurse can identify areas of effective practice and areas that need to be improved upon, thereby developing and promoting best nursing practice
    - The nurse and the patient should reflect on __________ made toward reaching the patient’s goals
    - This phase is also part of the termination of the nurse-patient relationship

*Chapter 20 Psychological Problems of Physically Ill Persons*

There are questions from this chapter in Exam III

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**WEEK TEN**

**Chapter 21 Working With Children**

- **Introduction**
- Childhood behavior varies significantly with developmental stage, psychosocial environment, and genetic influence
- Due to differences between childhood and adult behavior, emotional problems and mental health disorders in children can be difficult to determine
In children, the signs and symptoms must be considered in the context of developmental level and physical and social environment

**Growth and Development Theories**

- **Piaget’s theory of cognitive development**
  - A child’s cognitive development occurs over four developmental stages from infancy through adolescence: sensorimotor, preoperational, concrete-operative, and formal operations
- **Erikson’s theory of emotional and personality development**
  - The majority of an individual’s emotional and personality development occurs during the first 20 years of that person’s life. This development forms the foundation for continued development in adulthood
- **Freud’s theory of psychological development**
  - If an individual does not resolve issues in an early stage, he or she becomes fixated in that stage. Fixation results in ______________ behavior
- **Sullivan’s theory of interpersonal and personality development**
  - Children develop self-system from infancy through late adolescence based on their interactions with ______________
- **Behavioral theories of Pavlov and Skinner**
  - Form the basis for many of the therapies used for childhood disorders

**Overview of Childhood Disorders**

In the *DSM-IV-TR*, over 40 diagnoses often discovered in infancy, childhood, or adolescence are described and divided into categories. These categories include

- Mental retardation
- Learning disorders
- Motor skills disorder
- Communication disorders
- Pervasive developmental disorders
- Attention-deficit and disruptive behavior disorders
- Feeding and eating disorders
- Tic disorders
- Elimination disorders
- Category for other disorders

**Pervasive Developmental Disorders**

The category of pervasive developmental disorders (PDD) contains five separate, but similar diagnoses

- Autism, Rett’s disorder, childhood disintegrative disorder, Asperger’s disorder, and PDD not otherwise specified
- The term Autistic Spectrum Disorder has been proposed to replace PDD; it is likely that PDD criteria and terminology in the next edition of the DSM will differ from the current version

**Autistic Disorder**

*Autism* literally means “____________________________,” and was first used in 1911 to describe poor social relatedness in schizophrenics
• Autistic disorder is the ___________________ most common serious developmental disorder, after only mental retardation
• Genetics, environment, structural, and functional alterations of the brain, and prenatal and postnatal problems have been linked to autism

• **Asperger’s Disorder**
• Asperger’s disorder is similar to autism but the symptoms are ____________________________
• Early cognitive and language skills are not significantly delayed and preoccupation with objects and rituals are less often noted

• **Attention-Deficit and Disruptive Behavior Disorders**
• Disruptive behavior disorders involve a pattern of behavior in which an individual consistently ________________ rules
• It is normal for children to test authority by breaking the rules and demonstrating oppositional behavior in childhood and adolescence
• However, serious and routine oppositional defiance extends beyond normal

• **Attention-deficit hyperactivity disorder (ADHD)**
  – Characterized by inattention and/or hyperactivity-impulsivity that is more frequent and severe than expected for that developmental state
  – Actual prevalence of ADHD is estimated at 3%-7% in school age children
  – Cause of ADHD is not known
  – Inattention and/or hyperactivity-impulsivity are characteristics of ADHD, which is not diagnosed until after the child starts school

• **Conduct disorder (CD)**
  – Children with CD display a repetitive and persistent pattern of behavior that violates _______________ of other people, age-appropriate societal norms, or rules
  – Cause of CD is not known
  – Typically involves ________________ behavior toward individuals or animals, property destruction, deceitfulness or lying, or serious violations of rule

• **Oppositional defiant disorder**
  – Similar to CD and often precedes a CD diagnosis
  – Major difference between the two disorders is that ODD does not include more serious aspects of CD, in which the rights of others or age-appropriate societal norms and rules are violated
  – ODD involves negative, defiant and ________________ behavior usually noted before the child reaches 8 years of age

• **Mood Disorders**
• Affective and anxiety disorders fall into the general category of mood disorders and affect children in precise ways
• Common mood disorders observed in children include
  – Depression, adjustment disorder, and _____________________________ (PTSD)
• **Depression**
  • Symptoms in children are often more subtle than adults, because children may be unable to express sadness, hopelessness, and despair in __________ terms
  • Instead, behaviors such as irritability, difficulty sleeping, social isolation, non-specific somatic complaints, bad dreams, lack of smiling or laughing, anger, and fighting may be more significant for childhood depression

• **Adjustment Disorder**
  • Defined as a psychological response to a stressor resulting in significant emotional or behavioral symptoms
  • Common stressors leading to development of adjustment disorder in children include single events such as
    • A friend moving away or parental __________; recurrent events such as parental substance abuse, peer rejection or bullying; or continuous events, such as living in a high-crime neighborhood

• **Post-Traumatic Stress Disorder**
  • PTSD differs from adjustment disorder in that PTSD is characterized by an ______________ stressor with a specific constellation of symptoms, as opposed to any severe stressor and a wide range of possible symptoms associated with adjustment disorder

• **Feeding and Eating Disorders**
  • A small group of disorders in childhood are characterized by persistent feeding and eating disturbances
  • These are identified in the *DSM-IV-TR* and include
    — Pica, rumination disorder, and feeding disorder of infancy or early childhood

• **Treatment Options**
  • Play therapy
  • Behavioral therapy
  • Cognitive behavior therapy
  • Family therapy
  • Psychopharmacology

• **Applying the Nursing Process from an Interpersonal Perspective**
  • Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for children with mental health disorders
  • In addition, nurses need a firm knowledge base about childhood development because different developmental age groups/stages represent a different stage of interpersonal relationship formation
• **Strategies for Optimal Assessment**

• **Therapeutic use of self**
  – During the assessment phase, the nurse implements a therapeutic use of self (an ability to understand and interpret one’s _________ behavior), in order to understand the dynamics of others’ behavior
  – Self-awareness

**Diagnosing and Planning Appropriate Interventions**

• Meeting the patient’s focused needs
  – After completing the assessment, the nurse, child, and family proceed to develop a plan of care with *mutual goals and expectations* for outcomes
  – Due to the wide range of assessment findings noted in and multiple problems faced by children with mental health disorders, numerous nursing diagnoses would apply

**Implementing Effective Interventions**

• *Timing and pacing*
  – It is increasingly important during this stage that the timing and pacing of interventions meets expectations and abilities of the child, the family, and the provider

**Evaluating**

• Objective critique of interventions and self-reflection
  – The nurse evaluates how much progress has been made toward achieving expected outcomes
  – For any goals not met, the nurse needs to self-reflect on anything he or she may have done differently while providing nursing care
  – During this phase of the nurse-patient relationship, the nurse, child, and parents should reflect on progress made toward reaching the patient goals
  – Termination of the nurse-patient therapeutic relationship

**CHAPTER 22  Mental Health Concerns Regarding Adolescents**

• Adolescence is characterized by a period of ________________ from childhood through puberty and on into adulthood
• This transition brings with it ________________ challenges and is part of normal growth and development
• During this period, the social world begins to have a greater influence and the importance of ________________ becomes evident
• This transition period is taking longer than it did 50 years ago, with some suggesting that adolescence now extends into the mid- or late-20s

**Adolescent Development**

• The beginning of adolescence is unclear; however, it is generally associated with the onset of puberty
• Adolescence is characterized emotionally as a period of searching for ________________, finding meaning in life, and forming a unique personality separate from those of one’s parents
• It is a time of external conflict with those in authority and internal conflict with the adolescent struggling with life meaning

• Adolescence is a time where confidence and self-esteem can ____________________________

• Conflict with ________________ is common and often centers on authority, autonomy, and responsibility

• This conflict, however, is necessary to prepare adolescents for __________________________ in later life

Puberty and Self-Esteem
• Puberty is characterized by change and development in bodily functions. It usually begins around the age of 10, initially signaled with a growth spurt that continues into the late teenage years

• Levels of __________________________ change during adolescence, with it usually increasing with sexual maturity, but with the multitude of changes that happen during this period, healthy self-esteem may not develop until young adulthood

Peer Relationships
• Peer relationships develop in young children and play a significant role in overall development

• As children become older and transition into adolescence, they spend more and more time with their peers

• These relationships strongly influence an adolescent’s development

Adolescent Assessment
• Assessment of an adolescent requires sensitivity and use of appropriate language to determine the adolescent’s view of the problem from ______________ frame of reference

Common Mental Health Problems in Adolescence
• Adolescents often experience mental health disorder problems that are the same as those in adults

• Depression, mania, self-harm, suicidal ideation, alcohol and drug use, eating disorders, and anxiety disorders such as obsessive-compulsive disorder are common in adolescence

Depression
• Major symptoms of depression in adolescents are similar to those in adults and may include: low mood, lack of energy, loss of pleasure, decreased self-esteem and confidence, guilt, feelings of worthlessness, decreased concentration, sleep difficulties, hopelessness, and tearfulness

• The adolescent may present with behavioral problems, such as poor ____________ performance, running away from home, and ______________

• Depression also may present as physical pains, often as complaints of ______________

Mania
• Mania is often seen as part of ___________________________ disorder

• More commonly develops in ______________ adolescence
• Treatment usually involves a combination of structured therapy, family therapy, and psychopharmacology

**Self-Harm**
• Incidence of self-harm is very high in adolescents, conservatively estimated as affecting 5% to 8% of adolescents
• Further studies have reported rates as high as 17%, with a mean onset age of 15 years
• Self-harm without suicidal intent often manifests itself as superficial _____ to the body, minor burns, head banging, and inserting foreign objects into the body
• Self-harm is believed to be a coping mechanism that an individual may use when experiencing distress

**Suicide**
• Reports show that of the 4 million suicide attempts around the world each year, 90,000 of those are completed by adolescents
• Suicide is among the leading causes of ______________ for adolescents worldwide and is ranked as the ______________ highest cause in the United States
• Four out of five adolescents show warning signs prior to a suicide attempt

**Eating Disorders**
• Anorexia nervosa and bulimia nervosa are frequently seen in adolescents, particularly in _____
• Anorexia nervosa has the _____________ death rate of all psychiatric illnesses, with mortality rates of up to 10% being reported

**Substance Misuse and Abuse**
• The use of substances such as alcohol and illicit drugs by adolescents is growing, with some research suggesting that up to 72.5% of high school students have engaged in drinking alcohol and 36.8% have used marijuana (CDC, 2010)
• The most common mood altering drug used by adolescents is _______________, a central nervous system depressant
• Of special interest and growing concern in developing countries is _______________ by adolescents (21 for 21)

**Attention Deficit/Hyperactivity Disorder**
• Attention deficit/hyperactivity disorder (ADHD) is characterized by hyperactivity, _____________, and inability to focus attention, which is inconsistent to the age of the individual
• Working with an adolescent with ADHD involves a family-centered approach

**Conduct Disorders**
• Adolescent-onset conduct disorder is diagnosed when there have been no conduct problems before the age of ______ years
• _________________parenting is common in adolescents with conduct disorder and the family system requires enormous support when dealing with this type of behavior
• Treatment can involve a combination of parent training, family therapy, problem-solving therapy, cognitive therapy, and/or medication such as those used in the treatment of ADHD
**Obsessive-Compulsive Disorder**
- Obsessive-compulsive disorder (OCD) is an anxiety disorder
- The first symptoms usually appear in adolescence

**Social Phobia**
- Social phobia is common in adolescents
- For many, it will diminish naturally as the adolescent develops confidence and self-esteem
- It is characterized by a fear of social situations that results from a fear of embarrassment or humiliation
- Social phobia can lead to the development of poor social skills and low self-esteem, thus affecting the adolescent’s development

**Treatment Options**
- Cognitive behavior therapy
- Family therapy
- Parent training
- Group work
- In-patient care
- Psychopharmacology

**Applying the Nursing Process from an Interpersonal Perspective**
- Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for adolescents with mental health disorders
- Nurses need to remain cognizant of adolescent development to provide an individualized plan of care

**Strategies for Optimal Assessment**
- Therapeutic use of self
  - Therapeutic communication skills including active listening are essential to the development of the therapeutic relationship with an adolescent
  - The adolescent needs to be treated as an individual whose input is valued

**Diagnosing and Planning Appropriate Interventions**
- Meeting the adolescent’s focused needs
  - After completing the assessment, the nurse and adolescent develop a plan of care with mutual goals and expectations for outcomes

**Implementing Effective Interventions**
- *Timing and pacing*
  - A number of potentially effective interventions can be used with adolescents and their families
  - These include supportive counseling, ________________, group work, and family counseling
  - Additional research is needed to determine the true effectiveness of these therapies with adolescents
• Evaluating
  • Objective critique of interventions and self-reflection
    – The nurse encourages the ____________ to reflect on his or her own progress and identify achievements
    – The nurse can highlight the positives to the adolescent and the family and include a plan for aftercare as appropriate
    – Self-reflection
    – Termination of the nurse-patient relationship

Chapter 24 Victims and Victimizers

Introduction
Although definitions may vary, the Centers for Disease Control (CDC) is making efforts to standardize definitions and currently refers to abuse as acts of commission or omission that result in harm, potential for harm, or threat of harm

Domestic Violence
Defined as
  – Causing or attempting to cause physical or mental harm to a family or household member
  – Placing a family or household member in fear of physical or mental harm
  – Causing or attempting to cause a family or household member to engage in involuntary sexual activity by force, threat of force, or duress
  – Engaging in activity toward a family or household member that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested (Child Welfare Information Gateway, 2008, p.1)

Intimate Partner Violence
Violence among spouses or domestic partners
Included under the umbrella term of domestic violence
Types of Abuse
Physical abuse
Sexual abuse
Emotional or psychological abuse
Economic abuse

Historical Perspectives
American women in the 21st century are no longer legally limited by patriarchal views
However, many personal, religious, and cultural beliefs still influence the roles of women and children and how they are treated in the home
In 1994, increasing public pressure to recognize domestic violence as a crime, rather than a family problem, resulted in the passage of the federal Violence Against Women Act (VAWA)
Men can also be the victims of domestic violence

Epidemiology
Abuse crosses all races, genders, socioeconomic status, religion, marital status, age, and culture
• ________________ can be a victimizer or a victim of abuse
• Abuse is a pervasive problem in society
• The effects of abuse are far reaching and impact the entire family, not just the designated victim
• Abuse leads to increased incidence of health problems, substance abuse, school truancy, and more violence (CDC, 2005)

Child Abuse
• Refers to the physical, emotional, and/or sexual abuse of a person under the age of 18 years
• The most frequently identified abuser of children between the ages of three and five is someone the child __________
• Victimized children are told “not to tell” or bad things will happen if they disclose their “secret”
• Almost 3,500 children under the age of 15 die from maltreatment (physical abuse and neglect) every ______________ in the industrialized world

Intimate Partner Violence
• Domestic violence remains the leading cause of injury to women between the ages of 15 to 44 years, more common than muggings, motor vehicle crashes, and cancer deaths combined
• In 2000, intimate partner homicides accounted for __________% of the murders of women in the United States
• While about three-fourths of the victims of family violence were female, about three-fourths of the persons who committed family violence were male

Elder Abuse
• Abuse is often manifested through neglect, which involves failure to provide for the needs of the person, including basic needs for food and shelter as well as medical needs
• It is estimated that up to 2 million Americans 65 years of age or older have been ______________, or otherwise mistreated by someone on whom they depended for care or protection

Etiology
• Most experts believe that domestic violence is a learned behavior that is more common for individuals who have grown up in ______________________________
• Can also be reinforced by cultural beliefs that sanction the use of violence, such as those that permit so-called honor killings

Nursing Responsibilities from an Interpersonal Perspective
• Nurses typically provide care for both the __________________of abuse and their
• ____________
• Self-awareness of feelings and responses for victims of abuse and victimizers is crucial to ensuring the development of a therapeutic relationship
• Nurses are legally mandated to report suspicions of ___________________________, usually within 24 hours

Nursing Responsibilities from an Interpersonal Perspective
• When assessing a victim of IPV, the nurse interviews the victim separately from the victimizer
• In many jurisdictions, suspected elder abuse requires that the clinician report it to local authorities
Chapter 23  Issues Specific to the Elderly

- Elderly are considered to be individuals over the age of _________ years
- Current life expectancy is the United States is predicted to be 85.3 years for women and 82.4 years for men
- For the first time in history, there will be more individuals over the age of 65 than in any other age group

Overview of the Elderly Population
- 39.0% of the aging population believes they are in very good to excellent health and actively access and participate in their health and health behaviors
- 65% of elderly report “poor health,” with a diagnosis of at least one chronic illness
- 29% of the elderly reported the need for assistance in completing their activities of daily living

Quality of Life
- Quality of life, used as an indicator of health by the World Health Organization (WHO), is defined as “a state of complete physical, mental, and social well-being and ____________ the absence of disease or infirmity”

Medicare
- Providing adequate care to those over the age of 65 years requires identification of funding sources for mental health issues
- The primary health insurance provider for many aging Americans is Medicare
- Medicare was never intended to be a 100% reimbursement insurance plan for the elderly, and it is strongly advised that each individual have a supplementary plan

Factors Influencing Mental Health in the Aging Population
- Physical changes
- Chronic illness
- Pain
- Insomnia
- Disabilities and handicaps
- Stress and change
- Loss
- Family coping
- Loneliness
- Abuse and neglect
- Culture and spirituality
• **Common Mental Health Problems Associated With the Elderly**
  • Depression in the elderly
    – Depression in the elderly is reaching epidemic proportions, with estimates indicating depression as the ____________ underlying cause for the increased cost of health care in this population
  • Generalized anxiety disorder in the elderly
    – Treatment of generalized anxiety disorder in the elderly typically involves psychotherapy combined with psychopharmacology or cognitive behavior therapy, followed by psychopharmacology if not successful
  • Substance use and abuse and the elderly
    – Estimates on the frequency of substance abuse among the elderly have been reported to be as low as 2% or as high as 38% for individuals over the age of 65 years
    – ______________ is defined as the use of multiple medications beyond the clinically identified needs of the individual
  • Palliative and End-of-Life Issues With Mentally Impaired Elders
    – Patient Self-Determination Act of 1991 emphasized the right of patients to participate in treatment and health care decisions and the use of advance directives for end-of-life care decisions
    – Especially with the early diagnosis of dementia and associated depression, the aging patient needs to be educated and encouraged to draw up advanced directives, including a living will and durable power of ____________ attorney
  • Hospice care choices

**Trends in Mental Health Care for the Elderly**
• Acute care
• Out-patient services
• Personal belief and desire for mental health care services
• The ability to meet the costs of services
• Physical access to mental health services
• Programs to meet the needs of the elder population

**Applying the Nursing Process from an Interpersonal Perspective**
• Nurses need a firm understanding of the nursing process that integrates the interpersonal process when caring for elderly patients

**Strategies for Optimal Assessment**
• The therapeutic use of self
  – When assessing the elderly individual, the nurse interacts with the patient on a ____________ level to promote trust and foster an atmosphere of genuine interest, acceptance, and positive regard [one of my favorite phrases:] )

**Diagnosing and Planning Appropriate Interventions**
• Meeting the patient’s focused needs
— Nursing diagnoses will vary based on the acuity of the patient’s illness, comorbidities, current treatment regimen, and sources of support
— Nurse and patient collaboratively determine the outcomes to be achieved

**Implementing Effective Interventions**

- **Timing and pacing**
  — Patient __________ is the priority in maintaining and promoting the patient’s optimal mental and physical health
  — Depending on the cognitive ability and overall health of the elderly patient, interventions are implemented in a manner that allows for maximum effectiveness
  — As interventions are effective, the patient’s role changes to one of greater independence, seeking out the nurse as _______________________________

**Evaluating**

- Objective critique of interventions and self-reflection
  — The nurse reviews all activities of the previous phases and determines whether outcomes identified with and for the patient have been met
  — Self ___________ is an important tool at this point
  — Outcome of evaluation is the resolution phase in which the nurse-patient relationship comes to an end

**Chapter 27 Cultural, Ethnic, and Spiritual Concepts**

- **Introduction**
  — “Globalization is putting the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should...Few would disagree that health systems need to respond better – and faster – to the challenges of a changing (and diverse) world” (WHO, 2009)
  — Psychiatric-mental health nurses must be cognizant of the impact of globalization on health care and be prepared to intervene appropriately with patients who are culturally, ethnically, and spiritually different

- **Core Concepts**
  — Diversity is reflected through examination of difference, identity, community, privilege, and power and responsibility. Diversity may be reflected in a broad spectrum of demographic and philosophical differences

- **Globalization and Health Care Disparities**
  — The world is viewed as a __________________________, and as part of that global community, the U.S. population has become increasingly diverse
  — Ethnic, racial, cultural, and social minorities use mental health services to a lesser degree and, when used, the services tend to be _______________ in quality

- **Race, Ethnicity, and Culture and Mental Health**
  — Race, ethnicity, and culture are a significant part of the context in which each individual exists
• They have influence on perceptions of well-being and illness, health care decision making and help-seeking, and health service utilization

• **Racial, Ethnic, and Cultural Diversity**
  • Diversity in race, ethnicity, and culture affect three areas of functioning that influence mental health and mental health care delivery
  • These three areas are cognitive styles, negotiation strategies, and value systems
  • Despite potential increased risks for emotional distress and mental illness among diverse ethnic, racial, and cultural groups, protective factors such as family, group identity, mutual support, and closely held beliefs can help to reduce these risks

• **Language Variations**
  • Research has shown that in some racial or ethnic groups such as Iranian, Rwandan, and Eastern Indian, mental and physical health or emotional distress are encompassed into one word through descriptions of the “body” being sick
  • Studies have identified that cultural and ethnic or racial groups may avoid the use of the word “____________________” and use other terms such as “nerves,” feeling “down” or “blue,” and “emotional problems”
  • Psychiatric-mental health nurses who become ______________ of what language is and is not used by diverse patient groups are better able to match that language when counseling, educating, or referring individuals in the area of mental health

• **Gender, Roles, and Expectations**
  • Cultural precepts related to gender roles and expectations differ from culture to culture
  • Increasing evidence reveals that many cultures focus on the ______________ as a collective unit, whereby important decisions are made with ___________ relevant family members engaging in the decision-making process

• **Immigration**
  • Experiences related to refugee and immigrant status add stressors to an individual or group
  • These stresses may be related to clashes of culture and the process of acculturation (__________________________) into a different society and its accompanying norms
  • Risk factors for mental illness in immigrant populations: social exclusion due to ____ English proficiency, decreased interaction with the new culture, culture shock, family or social isolation, employment difficulties, prejudice and discrimination, feelings of persecution due to prior trauma

• **Mental Health, Mental Illness, and Mental Health Service Use among Ethnic, Racial, and Cultural Groups**
  • ______________ is often an important barrier affecting whether an individual from another racial or ethnic group seeks mental health services

• **Implications for Psychiatric-Mental Health Nursing**
  Disparities require care strategies that demonstrate compatibility between their perceptions, social context, needs, and mental health care services
• **Spirituality, Religion, and Mental Health**
  • As with other components of one’s culture, spirituality and religion influence mental health
  • Spirituality focuses on the cognitions, values, and beliefs that address ultimate questions about the meaning of life, God, and individual existence
  • Religion encompasses a set of ________________ concerning cause, nature, and purpose of the universe, which includes belief in a supernatural entity or entities from which all life originates
  • Religion usually involves devotional and ritual observances, and often contains a moral code that governs how humans should and should not behave in accordance with their religious beliefs

• **Influence on Coping**
  • Use of spirituality and religion has been integrally associated with ________________ during periods of emotional distress
  • Research on spirituality and religion has identified diverse results related to racial, ethnic, and cultural groups

• **Influence on the Etiology of Mental Illness**
  • Even as religious beliefs can assist in coping with mental illness, it can also be used to explain the origins of mental illness based on culture

• **Influence on Mental Illness Symptomatology**
  • Religion and spirituality can influence an individual’s coping methods, beliefs about the causes of mental illness, and how symptoms are manifested

• **Barriers to Mental Health Services**
  • Barriers to mental health services occur at three levels: individual, environmental, and institutional
  • Overcoming barriers
  • Access and use of services
  • Life of overload
  • Marginal living
  • Turning point

• **Implications for Psychiatric-Mental Health Nursing**
  • Be aware of potential cultural or religious ________________ between one’s self and the patient
  • Recognize signs and symptoms of emotional or mental distress during patient assessments
  • Use evidence-based practice to be informed of conditions that may have a high incidence of mental health comorbidity such as diabetes and cardiovascular disease; use that knowledge for a more thorough assessment and patient and family education

• **Implications for Psychiatric-Mental Health Nursing (cont.)**
  • Be knowledgeable of resources that can be used to address mental health needs
  • Bring in the cultural expertise of others, when needed, to encourage and support the patient’s access to mental health care using culturally sensitive language
• **Culturally Competent and Congruent Care**
  - is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families
  - Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations, and communities served

• Practice is driven in service delivery systems by patient preferred choices, not by culturally blind or culturally free interventions
• Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care (National Center for Cultural Competence, 2009)
TEXAS A&M UNIVERSITY - CORPUS CHRISTI

College of Nursing and Health Sciences
NURS 4564 CLINICAL SYLLABUS

Clinical laboratory: Thursday and Friday or Saturday and Sunday: 0645 AM – 1630 PM

CLINICAL FACULTY:
Carmen Hernandez MSN, RN
Office: Island Hall 333
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Internet: carmen.hernandez@tamucc.edu

Kathy Deis MSN, RN
Office: Island Hall 331
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Faculty: Nancy Schierding MSN, RN
Office Phone: 361-902-6809
Office: 6th floor (Geriatric Unit) Christus Spohn Memorial

Credit Hours: 2 semester credit hours (18 hours per week: 90 hours total)
Co-requisite: NURS 4564 Lecture 3 semester credit hours (5 semester credit hours)

Course Description: Application of the nursing process to promote, maintain or restore emotional health to individuals, families and groups. During the clinical experience, students will demonstrate theory-based practice and collaborate with interdisciplinary team members.

Clinical Course Objectives: At the completion of the clinical course, the student will be able to:
1-0 Integrate the process of self-examination into the psychiatric nursing experience.
1-1 Analyze subjective feeling states and reactions in response to psychiatric nursing experience.
1-2 Verbalize feelings aroused by clinical experiences.
1-3 Explain the relationship between self-diagnosis and the therapeutic nurse-patient relationship.
1-4 Explain how behavior is linked to feelings.
Apply the nursing process to situations involving clients with psychiatric and chemical dependency diagnoses.

Assess subjective and objective data related to the client’s mental/substance abuse disorder.

Formulate psychiatric and substance abuse nursing diagnoses for inpatient and outpatient populations.

Plan and implement nursing interventions for clients with mental and substance abuse disorders.

Evaluate client responses to nursing actions.

Demonstrate safe and effective practice.

Demonstrate the components of the empathic-caring relationship.

Create effective caring behaviors to develop, maintain and terminate the empathic-caring relationship.

Implement psychiatric nursing interventions within the nurse-patient relationship.

Demonstrate increasing competency in using therapeutic communication skills with psychiatric/substance abusing clients.

Incorporate the teaching-learning process into the plan of care.

Formulate learning objectives based upon an assessment of an individual or group’s needs and readiness to learn.

Prepare a teaching plan specific to the needs and readiness of the target learner/s.

Implement the teaching plan following objectives and evaluate.

Collaborate with other health care providers in the care of individuals or groups.

Participate with other team members in the formulations of nursing care plans for individuals.

Participate in group, unit and program activities.

Articulate significant client information to team members.

Utilize the resources of other disciplines to solve problems related to specific clients.

Deliver safe and consistent nursing care to individual clients in a variety of settings.

Analyze clinical therapeutic modalities and their effectiveness with clients.

Continually assess the therapeutic milieu for effectiveness and safety.

Interpret the roles of the multi-interdisciplinary team and describe the teams functioning.
6-0  Accept responsibility for own learning.
6-1  Select independent learning experiences related to clinical assignments.
6-2  Evaluate own progress against clinical objectives and expectations.
6-3  Evaluate progress against observed role models in the clinical settings.
6-4  Attend clinical assignments on time, appropriately dressed and following specific clinical guidelines.
6-5  Demonstrate ethical behavior and maintain patient rights and confidentiality.
6-6  Demonstrate respect for clients from diverse cultures and economic status.

Clinical Activities: Students are required to attend 18 hours of clinical each week. Students will follow the clinical rotation assignment and the specific clinical objectives identified for each area. Required clinical activities include:

1. Timely attendance at all clinical placements. **LATE** arrival to the clinical setting is considered unprofessional behavior.
2. Attendance at **two self-selected community** support groups documented in the Clinical Journal by responding to Support Group Clinical Objectives and **completed during the clinical rotation period**. These support groups must comply with module objectives.
3. Weekly documentation of specific clinical objectives in Clinical Journal with timely submission of log to clinical faculty (see specific objectives for each placement site).
5. Implementation and documentation of a group or individual teaching plan utilizing Teaching/Learning Plan and criteria.
6. Completion of a comprehensive nursing care plan on a selected psychiatric patient.
7. Clinical performance in accordance with clinical objectives and outcome behaviors.
8. Completion of outplacement clinical objectives if community resources are utilized.
10. Completion of two satisfactory ADPIE or BAR charting documents.

Patient Rights and Safety
The nature of clinical nursing courses is such that students are involved in the direct delivery of patient care services. The primary purpose of any course is to provide education for students. However, when direct patient care is involved in the learning experience, the safety and well-being of the patient are of paramount concern and take precedence over all other factors. Clinical courses are structured so that as students’ progress through the program they are expected to demonstrate increasing independence, critical thinking and competence in providing nursing care.
Students are expected to demonstrate achievement of the clinical objectives by the end of the clinical course. If the student is deemed unsafe or unable to provide safe nursing care, in the instructor’s professional judgment, and if the deficit is such that it cannot be remedied within the clinical setting, the student will be removed and will receive an “F” in the course.

Clinical Warning and Failure

Clinical attendance is mandatory and professional behavior is expected. Loss of time in the clinical setting for whatever reason could place a student in jeopardy of not meeting the course objectives. There are several infractions that might lead to a student being given a clinical warning for the day. Some infractions include, but are not limited to:

- Unexcused absences
- Tardiness
- Illness minus documentation
- Violation of dress code (either in hospital or support groups)
- Incomplete health immunization records (according to the sponsoring hospital)
- Expired CPR certification
- Failure to turn in care plan or paperwork on assigned date:
  - Incomplete hospital orientation on BB10
  - Violation of Patient Mental Health rights
  - Chewing gum in the clinical setting
  - Absolutely no phones are to be in sight at Bayview Hospital.

If an absence from the clinical site is absolutely necessary, the student must notify his/her clinical instructor at least one hour before the clinical day begins. Accumulating 2 warnings in a 90 hour clinical course will lead to failure of the clinical rotation and therefore, failure of the entire course.

Other offenses, depending on severity, may lead to immediate failure of the course include but are not limited to:

- No call, no show for clinical day
- Unsafe or unprofessional practices or behaviors
- HIPPA violations
• Inability to pass required clinical assignments

• Falsification of records.


<table>
<thead>
<tr>
<th>Clinical Evaluation Criteria</th>
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<tbody>
<tr>
<td>Clinical Performance Evaluation</td>
<td>Excellent, Good, Fair, Poor</td>
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<tr>
<td>Clinical journals</td>
<td>Excellent, Good, Fair, Poor</td>
</tr>
<tr>
<td>Clinical site objectives</td>
<td>Met Unmet</td>
</tr>
<tr>
<td>Clinical outcome objectives</td>
<td>Met Unmet</td>
</tr>
<tr>
<td>Clinical self/professor evaluation</td>
<td>Excellent, Good, Fair, Poor</td>
</tr>
<tr>
<td>Specific clinical site objectives</td>
<td>Met Unmet</td>
</tr>
<tr>
<td>Teaching/Learning plan</td>
<td>Effective Ineffective</td>
</tr>
<tr>
<td>Nursing Care Plan</td>
<td>Excellent, Good, Fair, Poor</td>
</tr>
</tbody>
</table>

| Overall Performance | Pass/Fail |
PSYCHIATRIC NURSING ACUTE INPATIENT
CLINICAL OBJECTIVES

The student will select a patient with the assistance and direction of the staff. For the specific patient, the student will:

1. Establish a one to one relationship.

2. Implement the initial, working and closing phase of the nurse-patient relationship.

3. Utilize appropriate therapeutic communication techniques.

4. Assess current health/illness status of the patient based on identified psychosocial and physical parameters utilizing the A&M Model of Nursing.

5. Appraise the patient’s/family’s subjective and objective data manifested in identified health problems.

6. Analyze the major stressors/stimuli and other influences that result in maladaptive behavior.

7. Provide nursing care to the patient utilizing psychiatric nursing interventions.

8. Deliver necessary teaching to the patient in order to meet documented health problems.

9. Assist with therapeutic interventions and identify patient outcomes.

10. Complete all clinical teaching/learning activities.
LEARNING ACTIVITIES

1. Meet with the faculty for regularly scheduled consultation conferences related to the patient.
2. Complete one (1) Comprehensive Care Plan as outlined in the syllabus.
3. Accompany the patient to program activities as permitted.
4. Co-teach or teach one (1) group/individual utilizing A&M teaching plan and based on an assessment of the patient's needs. This project **MUST** first be approved by the faculty and charge nurse of the unit or facility. Complete a bulleted outline of the project - refer to pg.116.
5. Record three (3) process recording interactions with a patient in the clinical journal using the prototype included in this syllabus (see Process Recording pg.117 of syllabus). Select an interaction that you found challenging to manage.
6. Document two (2) patient incidents in the clinical journal using the APIE (Assessment, Problem, Intervention and Evaluation format) or BIRP (Behavior (pt), Intervention (stud), Response (pt) Plan (of action). In the intervention identify the specific psychiatric nursing intervention utilized.
7. Identify two (2) ethical concepts from Appendix B that apply to two (2) patient care situations observed in the clinical setting. Describe how these ethical concepts relate and the significance to nursing care.
8. Attend two (2) **different** community support groups (AA, NA, ALON, over eaters, anger management.....) and complete the paperwork.
INPATIENT GERO-PSYCHIATRIC PROGRAM

CLINICAL OBJECTIVES

1. Collaborate with the nursing staff in providing psychosocial care to the geriatric psychiatric patient.

2. In collaboration with the Nurse Manager, develop and deliver a mini-group for a pre-selected group of patients.

3. Identify the psychosocial issues crucial to the functioning of these patients.

4. Discuss the physical and psychosocial interventions utilized to provide comprehensive care of the elderly psychiatric patient.

5. Evaluate the impact of the activities therapy on the elderly psychiatric patient.

6. Relate the importance of family (or absence of family) and other aspects of psychosocial support in the care of the elderly psychiatric patient.

7. Report five (5) communication strategies important in relating to the unique needs of these patients.

8. Discuss your personal values/philosophy in the care of these patients.

9. Analyze the role of the nurse in the care of the gero-psychiatric patient.

10. Discuss one of the most common DSM IV-TR diagnostic categories identified in these patient.

11. Analyze the effect of Reminiscence Therapy with this group of patients.
    How does this form of therapy relate to reality orientation?

12. Select three medications prescribed for these patients and identify at least two nursing care concerns for each category of medication.
AAdi Home Health

Psychiatric Home Health Program

At the end of the clinical experience the student will be able to:

1. Discuss the role of the psychiatric home health nurse and relate to the counseling role of the nurse.

2. Delineate the elements of the nursing process implemented in the care of the psychiatric patient by the home health nurse:

   - assessment of the patient in the home.
   - care planning for the patient in the home.
   - involvement of the care giver and/or family members in the plan of care developed by the psychiatric home health nurse.

3. Discuss the psychotropic medications utilized by the patient and the role of the psychiatric home health nurse in the education and monitoring of the patient's medications.

4. Identify the various roles of other team members and the significance of these roles to patient treatment in the home.

5. Describe the case management role of the psychiatric home health nurse in the care of the psychiatric patient.

6. Discuss the process of continuing care of the psychiatric patient in the home.
SOUTH TEXAS SUBSTANCE ABUSE AND RECOVERY SERVICES (STSARS)

Clinical Objectives

At the end of the clinical experience the student will be able to:

1. Discuss the role of substance counselors/therapists and relate to the counseling role of the nurse.

2. Delineate the structure of an outpatient treatment program for substance abusers.
   - What are significant components of the program?
   - How does the program relate to the theories of addictions/substance abuse?
   - What is the relationship between program elements and the 12-Step Program of AA/NA?

3. Describe the functions, protocols and significance of methadone treatment for opiate addiction.

4. Identify the various roles of team members and the significance of these roles to client treatment.

5. Select two program activities that you observed and delineate three important elements about substance abuse treatment that you learned from these two activities.

6. Discuss the stressors that substance abusers face in the process of recovery.

7. Identify two principles of addiction/addictive behaviors that you would use in teaching clients about substance abuse based on this clinical experience.

8. List three attitudes or beliefs you held about substance abusers that have been changed or modified by this clinical experience.

9. In collaboration with the program director, develop and deliver an educational presentation for the clients in the program.
Charlie’s Place
Substance Abuse Recovery Program

At the end of the clinical experience the student will be able to:

1. Discuss the role of substance counselors/therapists and relate to the counseling role of the nurse.

2. Delineate the structure of the inpatient rehabilitation program for substance abusers.
   - What are significant components of the program?
   - How does the program relate to the theories of addictions/substance abuse?
   - What is the relationship between program elements and the 12-Step Program of AA/NA?

3. Describe the functions, protocols and significance of the substance abuse detoxification program and relate to treatment and recovery.

4. Identify the various roles of team members and the significance of these roles to client treatment.

5. Select two program activities that you observed and delineate three important elements about substance abuse treatment that you learned from these two activities.

6. Discuss the stressors that substance abusers face in the process of recovery.

7. Identify two principles of addiction/addictive behaviors that you would use in teaching clients about substance abuse based on this clinical experience.

8. List three attitudes or beliefs you held about substance abusers that have been changed or modified by this clinical experience.
SUPPORT GROUP OBJECTIVES
(MUST ATTEND TWO DIFFERENT SUPPORT GROUPS)

1. In your Clinical Journal, name the group, date attended, time, and length of the group meeting. (Use this format for each group you attend.)

2. Relate the curative factors of support groups utilizing three concepts from– *Psychiatric Mental Health Nursing: An Interpersonal Approach* Chapter 9 – Self-help Groups (pg. 144-154). Use three different categories of curative factors utilized for each group you attend.

3. Analyze the group functions:
   - Did it meet the general criteria of a group? How? (Box 9-1; pg. 148)
   - Did it provide support for the members? How?
   - Were all members involved? Expand on your answer.
   - What was the NATURE and PURPOSE of the support offered?
   - Was there a designated leader? If so describe the role of the leader in this setting.

4. How did the support group differ from the group processes or group therapies you have observed in the hospital setting?

5. What did you learn about support groups in general? This group in particular?

6. What particular problems would prompt you to refer your patient(s) to this support group?
CLINICAL JOURNAL CRITERIA

***Name of student & name of preceptor
***Location and date(s) of client contact
***Approximate length of time spent with the client
***Unit census and brief description of the milieu while on the unit

Journal notes:
Rationale: Objectives and information are required for each entry

Rationale: Record notes on therapeutic communication:
• Therapeutic communication is a complex skill learned with practice and by analyzing communication errors.
• Self-awareness and analysis improves communication techniques.

Objectives for recording journal notes in clinical experiences:
• Generate an account of interaction(s) with clients along with the care-giver’s thoughts and feelings.
• Distinguish between therapeutic and non-therapeutic communication patterns.
• Use reflection and critical thinking to develop more effective and caring communication.
• Record experiences during the clinical for learning purposes.

Information to be included in weekly journal documenting nurse-client interactions:
1. Demographic information, listed at the top of this page (***).
2. Document highlights of the current session with the client. Include the emotions, and feelings expressed by client and you.
   a. What went well during the interaction(s)? What did not go well during the interaction(s)? How did you come to this/these conclusion(s)?
   b. What could you have done to make the interaction go better?
3. Indicate positive and negative, verbal, non-verbal and meta-communication therapeutic communication styles used during the intervention by BOTH you and the client.
4. Describe the depth of assessment and evaluation. Choose some prompts from the brief psychiatric assessment (Syllabus pg. 23-24).
5. Analyze increased awareness and insight into your own feelings, behavior and knowledge of psychiatric clients.
6. List your client’s current medications, their uses and three possible side effects.
7. Approach one new nursing graduate (< 2 years work experience) OR seasoned nurse (> 5 years work experience) and ask him/her to share a memorable encounter with a psychiatric client in the hospital setting. Provide details, outcome and personal growth that occurred as a result of this experience.
TEACHING/LEARNING PLAN CRITERIA

The student will assess the learning need/s, experiential and emotional readiness of a patient or group of patients in the psychiatric setting. Based on that assessment a teaching plan will be developed and implemented within the clinical setting and a copy of the plan included in the Clinical Log.

The teaching/learning plan will be evaluated according to the following criteria:

0 = Unsatisfactory    2 = Acceptable
1 = Questionable      3 = Excellent

0123 Plan contains necessary identifying information - agency, title of teaching, learner/s involved
0123 Learner/s need/s is/are evident in description
0123 Experiential readiness of patient/s is summarized
0123 Emotional readiness of patient/s is described.
0123 Learning objectives are stated as outcomes
0123 Learning objectives are congruent with teaching
0123 Teaching methods and materials are identified
0123 Content is described with adequate detail
0123 Management of the learning environment is described
0123 Teaching actions are specific to content and teaching actions are distinguishable from one another
0123 Method used to evaluate learning is evident
0123 Visual aids are appropriate to the patient/s and setting
0123 Evaluation of teaching and patient learning are evident in the plan
0123 References used to complete the plan are listed
0123 References are in APA format
0123 Teaching plan is prepared in proper from, correct spelling and free of errors.

Total Points
<table>
<thead>
<tr>
<th>Student:</th>
<th>Patient Initials:</th>
<th>Patient Diagnosis:</th>
<th>Date of Interaction:</th>
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<tbody>
<tr>
<td>Patient (verbal/non-verbal communication)</td>
<td>Student Nurse (verbal/non-verbal communication)</td>
<td>Feelings (Feelings of student nurse during interaction)</td>
<td>Meta-Communication (verbal/non-verbal implied)</td>
</tr>
</tbody>
</table>
Nursing Care Plan and all paper work will be provided to you by your clinical instructor.

Good luck!!!!!!