PSYCHIATRIC-MENTAL HEALTH NURSING

An Interpersonal Approach

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STUDENT GUIDE

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CONTENTS

I. THE PRACTICE OF PSYCHIATRIC-MENTAL HEALTH NURSING

1. Mental Health Trends and the Historical Role of the Psychiatric-Mental Health Nurse 4
2. Interpersonal Relationships: The Cornerstone of Psychiatric Nursing 6
3. Therapeutic Use of Self and Therapeutic Communication: From Self-Discovery to Interpersonal Skill Integration 9
4. Boundary Management 11

II. HEALTH PROMOTION AND ILLNESS PREVENTION

5. Critical Thinking, Clinical Decision Making, and the Interpersonal Relationship 13
6. Crisis and Crisis Intervention 15
7. Psychiatric Case Management 17
8. Known Risk Factors for Prevalent Mental Illness and Nursing Interventions for Prevention 19
9. Systems Concepts and Working in Groups 21
10. Theories of Mental Health and Illness: Psychodynamic, Social, Cognitive, Behavioral, Humanistic, and Biological Influences 23

III. ACUTE AND CHRONIC ILLNESS

11. Thought Disorders 26
12. Affective Disorders 29
13. Anxiety Disorders 31
14. Personality Disorders 34
15. Addictive Disorders 37
16. Cognitive Disorders 39
17. Impulse Control Disorders 42
18. Sexual Disorders and Dysfunctions 44
19. Eating Disorders 46
20. Psychological Problems of Physically Ill Persons 48

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

21. Working With Children 50
22. Mental Health Concerns Regarding Adolescents 53
23. Issues Specific to the Elderly 55
24. Victims and Victimizers 57

V. MENTAL HEALTH CARE SETTINGS

25. Psychiatric-Mental Health Nursing Across the Continuum of Care 59
26. Vulnerable Populations and the Role of the Forensic Nurse 61

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

27. Cultural, Ethnic, and Spiritual Concepts 63
28. Ethical and Legal Principles 65
29. Policy, Policy Making, and Politics for Professional Psychiatric Nurses 67

INTRODUCTION

This Student Guide is designed to further develop your understanding and application of psychiatric-mental health nursing concepts. Key Terms, Expected Learning Outcomes,a nd Need to Know points are reviewed. Further cases are presented to gain more practice of care planning skills. Additionally, there are exciting and enlightening hyperlinks to films that illustrate the main point or theme of each chapter. Overall this material will supplement what you are learning in class, challenge and stimulate your thinking, and hopefully prompt lively discussion among you and your peers around this important area of nursing practice.

CHAPTER 1

MENTAL HEALTH TRENDS AND THE HISTORICAL ROLE OF THE PSYCHIATRIC-MENTAL HEALTH NURSE

KEY TERMS

Deinstitutionalization: movement of patients in mental health institutions back into the community

Interpersonal models: models that focus on the interaction of the person with others

Milieu management: the provision and assurance of a therapeutic environment that promotes a healing experience for the patient

Process groups: traditional form of psychotherapy where deep feelings, reactions, and thoughts are explored and processed in a structured way

Psychopharmacology: use of drugs to treat mental illness and its symptoms

Psycho-educational groups: groups designed at imparting specific information about a select topic such as medication

Somatic: referring to the body

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Dorothea Dix was instrumental in advocating for the mentally ill. She is credited with the development of state mental hospitals in the United States.
2. In the late 1960s, care of the mentally ill began to shift to community clinics.

3. Psychiatric nursing is practiced at two educational levels: generalist practice (ADN, Diploma, BSN) and advanced practice (MSN, DNP, PhD). Advanced practice nurses are clinical nurse specialists (CNS) and nurse practitioners (NP).

HYPERLINKS

Restoration of Sanity, a 1957 Russian film depicting then "state of the art" treatment of mental illness. The role of the nurse is profiled as that of custodial care taker.

1. http://www.youtube.com/watch?v=BZ1Ll--yQl4
2. http://www.youtube.com/watch?v=BWEUDLKqudM

CHAPTER 2

INTERPERSONAL RELATIONS: THE CORNERSTONE OF PSYCHIATRIC NURSING

KEY TERMS

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

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

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

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

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

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

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

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

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

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

Rapport: nursing actions that alleviate an ill person's distress; a concern for others and an active interest in them, a belief in the worth, dignity, uniqueness, and irreplaceability of each individual human being, and an accepting, nonjudgmental approach

Resolution phase: last phase of Peplau's nurse-patient relationship occurring when the patient's needs have been met through the collaborative work of nurse and patient.

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

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

HYPERLINKS

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

1. http://www.youtube.com/watch?v=3ZvwNVVWyZ4
2. http://www.youtube.com/watch?v=Nmq6CxF9paA
3. http://www.youtube.com/watch?v=EuW25fEj-ao
4. http://www.youtube.com/watch?v=ydSHZzzhjOc&playnext=1&list=PL427F7EC89D65EE7D
5. http://www.youtube.com/watch?v=_72omxkmgCI
6. http://slsu-coam.blogspot.com/2008/08/life-of-hildegard-peplau.html

CHAPTER 3

THERAPEUTIC USE OF SELF AND THERAPEUTIC COMMUNICATION: FROM SELF-DISCOVERY TO INTERPERSONAL SKILL INTEGRATION

KEY TERMS

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

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

Beliefs: ideas that an individual holds to be true

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

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

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

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

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

1. Describe the term self.

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

NEED TO KNOW

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

HYPERLINKS

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

1. http://www.youtube.com/watch?v=09kPWcCA3dw&feature=related

CHAPTER 4

BOUNDARY MANAGEMENT

KEY TERMS

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Boundaries may be physical or psychological, and can be classified as rigid, flexible, or enmeshed.
2. Boundaries are initially established during the orientation or original encounter phase.
3. Managing transference and counter-transference are essential to boundary management.
4. The nurse dresses appropriately, addresses patients by their proper names, and uses self-disclosure appropriately to maintain intangible boundaries.
5. Patients commonly test boundaries by attempting to change a therapeutic relationship into a social one.
6. Boundary crossings between nurses and patients can be reversible and in some instances therapeutic.
7. Boundary violations are never helpful and can lead to harm for the patient and possible criminal charges for the nurse. Detachment from a patient to the point of neglect is also a boundary violation.

8. Warning signs of boundary problems include:
   - Not monitoring transference and counter-transference
   - Over/inappropriate use of self-disclosure
   - Feeling as though the relationship with a patient is “special”
   - Getting personal needs met (e.g., admiration, physical compliments) through a relationship with patients
   - Becoming distant and secretive from peers

HYPERLINKS

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

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

CHAPTER 5

CRITICAL THINKING, CLINICAL DECISION MAKING, AND THE INTERPERSONAL RELATIONSHIP

KEY TERMS

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

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

Dispositions: the way a person approaches life and living

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

Psychoeducational intervention: interventions that include a significant educational component

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Critical thinking is a purposeful method of reasoning that is systematic, reflective, rational, organized, and outcome-oriented. Effort, practice, and experience are necessary to develop critical thinking.
2. The four domains of critical thinking are: elements of thought, abilities, affective dimensions, and intellectual standards. Critical thinking involves the use of cognitive skills and working through dispositions or the way a person approaches life and living.
3. The psychiatric-mental health nurse uses critical thinking skills to find the answer to the question about what to do or say to meet the patient's needs.

4. Both the nursing process and the interpersonal relationship reflect a problem-solving approach to providing care. Psychiatric-mental health nurses integrate the nursing process and interpersonal relationship for sound clinical decision making in psychiatric-mental health nursing.
5. During the planning and implementation stages of the nursing process and the exploitation phase of the interpersonal relationship, the nurse works with the patient and uses critical thinking skills to determine the most plausible strategies, analyze these strategies, and ultimately arrive at the best courses of action for the patient.
6. Psychoeducaton is an excellent intervention that can consist of verbal one-on-one interaction, printed handouts, or other audio-visual materials.
7. Interventions need to be appropriately timed and paced to be successful.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=ZQwe4Mwi1po
2. http://www.youtube.com/watch?v=bUVEvi8SqQM

CHAPTER 6

CRISIS AND CRISIS INTERVENTION

KEY TERMS

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

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

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

HYPERLINKS

Steps of Crisis Intervention, De escalation techniques to help avert a crisis in clients that may be escalating due to anxiety and a student made film of role playing crisis intervention.

1. http://www.youtube.com/watch?v=pBe4A32fpyI
2. http://www.youtube.com/watch?v=IUSHKNKSBl0

CHAPTER 7

PSYCHIATRIC CASE MANAGEMENT

KEY TERMS

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

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Case management refers to an outcome-oriented process that coordinates care and advocates for patients and patient populations across the health care continuum. Although not exclusive to psychiatric-mental health nursing, it is an important component of psychiatric-mental health nursing.

2. Returning World War II veterans experiencing psychiatric conditions and the deinstitutionalization of chronic mentally ill patients are two key events that prompted the evolution of psychiatric-mental health case management.
3. Multiple case management models exist with the PMHN assuming the role of primary case manager or functioning as part of a case management team in collaboration with other health professionals. Services provided by the PMHN case manager can range from initiating the service to providing clinical case management.
4. Four models of psychiatric-mental health case management include: in-patient psychiatric case management model; continuum of care psychiatric case management model; the broker model; and clinical case management model.
5. The case management process requires an interactive relationship that views the patient holistically and fosters empowerment through advocacy and education.
6. A PMHN case manager must be skilled in critical thinking, communication, negotiation, and collaboration.
7. The case management process involves the functions of assessment, planning, implementation, coordination, monitoring, and evaluation.
8. The case management process closely resembles the steps of the nursing process and the stages of the therapeutic relationship.
9. When engaged in the case management process, the PMHN case manager can assume seven different roles: advocate, consultant, educator, liaison, facilitator, mentor, and researcher.
10. Case management services range in intensity from the most extensive support for individuals with the greatest need (Level One) to the least extensive support providing a basic link to crisis management services (Level Three).
11. At any level of service, case management must include the critical elements of coordination, consumer choice, determination of strengths and preferences, comprehensive, outcome-oriented service planning, collaboration with psychiatrists and other service providers, continuity of care, and family and kindred support.
12. The underlying premise of all case management is that everyone benefits when the patient reaches his or her optimum level of wellness and capability.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=5fYR_2IyUUU&feature=related

CHAPTER 8

KNOWN RISK FACTORS FOR PREVALENT MENTAL ILLNESS AND NURSING INTERVENTIONS FOR PREVENTION

KEY TERMS

Primary prevention: interventions that delay or avoid the onset of illness

Protective factor: characteristic, variable, or trait that guards against or buffers the effect of risk factors.

Psychomimetic disorders: medical disorders that mimic psychiatric disorders

Resilience: the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress

Risk factor: issues that increase an individual's chance for developing an illness

Secondary prevention: interventions focusing on treatment including identifying persons with disorders and standardizing treatment for disorders

Stress-vulnerability-coping model: one way of understanding how risk factors are involved with the development of psychiatric-mental health disorders; identification of risk factors according to three categories: biological; personal; and environmental.

Temperament: innate aspects of personality that determine how a child tends to respond to the world; distinctive behavior involved with activity and adaptation.

Tertiary prevention: interventions focusing on maintenance including decreasing relapse or recurrence, and providing rehabilitation

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Risk factors are characteristics, variables, or hazards that increase the probability that an individual will develop a disorder.
2. Risk factors may be classified in different ways. Possible categories include: individual, family, and community; biological and psychosocial; intrapersonal and environmental; or genetic, biological, psychological, social, and environmental. Many psychiatric disorders share risk factors that can be differentiated as biological and/or genetic or personal/social/environmental.
3. Individuals possess characteristics, variables, or traits that guard against or buffer the effect of risk factors. These are known as protective factors.
4. Resilience is a protective function that is learned over time.
5. Genetics/biology and temperament are two important intrapersonal risk factors for the development of psychiatric-mental health disorders occurring from infancy to adolescence.
6. Risk factors for schizophrenia include the interaction between genetics and environment. In addition, gestational and birth complications are associated biological risk factors.
7. Genetics is a risk factor for both depression and bipolar disorders. Gender, life stressors, substance abuse, and inadequate social supports are additional risk factors.
8. Substance use disorders are strongly linked to familial patterns. Genetics, biology, and learning from the environment are also thought to be intrinsically connected.
9. An optimistic outlook, social support, and resilience are protective factors for anxiety disorders.
10. In general, risk factors for personality disorders include a family history of personality disorders or other mental illness; verbal, physical, or sexual abuse, neglect, or trauma during childhood; a chaotic family life during childhood; diagnosis of a childhood conduct disorder; and death or divorce of parents during childhood.
11. Any medical disorder could be a risk factor for a psychiatric-mental health disorder. Any psychiatric-mental health disorder might place a patient at greater risk for a medical disorder.
12. Integrating the interpersonal process at the primary, secondary, and tertiary levels of prevention can help to minimize risk factors and enhance protective factors. Establishing a therapeutic nurse-patient relationship also acts as a protective factor.
13. Primary prevention interventions address and neutralize the influence of risk factors to avoid or delay the onset of illness.
14. Secondary prevention activities focus on early detection and intervention in an effort to reduce the possible duration of the disorder and its associated complications.
15. Tertiary prevention activities focus on minimizing complications and promoting the patient's return to his or her maximum level of functioning.

HYPERLINKS

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

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

CHAPTER 9

SYSTEMS CONCEPTS AND WORKING IN GROUPS

KEY TERMS

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

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

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

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

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

Group process: interaction among group members

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. A system is a group of components that interact, such that a change in one component affects the other components and the system overall. Using systems theory or systems thinking provides an opportunity to look at the "bigger picture" and promotes treatment planning that ultimately can lead to higher levels of functioning.
2. Systems thinking is not new to nursing. The environment has been a major component of many nursing theories.
3. Two or more people together functioning interdependently form a group. Family is a specialized type of group.
4. Groups may be classified by membership as open or closed, by purpose as insight-oriented or supportive, and by setting as in-patient or out-patient.
5. Yalom identified eleven curative factors that are interdependent within a group. They are the central core necessary for group survival.
6. Cohesiveness in a group reflects the solidarity of the group. It is a curative factor essential for ensuring the effectiveness of group therapy.
7. A group progresses through three phases of development: orientation, working, and termination.
8. The group leader or facilitator assumes different roles depending on the phase of the group's development and in response to the members' participation.
9. Group members can assume roles that keep the group on task and focused, that maintain the group, and that threaten curative factors and group functioning.
10. A psychoeducational group is one example of a group led by psychiatric-mental health nurses prepared at the basic (generalist) level.
11. Family therapy is a specialized form of group therapy that focuses on the family as an open system to alter the interactions between or among members.
12. Key concepts associated with the Bowen Family Systems include: differentiation of self, emotional triangles, and multigenerational transmission of anxiety.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=C7FpVJs3Rbg
2. http://www.youtube.com/watch?v=rXrFTxv4IiU

CHAPTER 10

THEORIES OF MENTAL HEALTH AND ILLNESS: PSYCHODYNAMIC, SOCIAL, COGNITIVE, BEHAVIORAL, HUMANISTIC AND BIOLOGICAL INFLUENCES

KEY TERMS

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

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

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

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

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

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

Gestalt: human experience of being whole

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

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

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

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

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

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

Psychodynamic theories: theories that focus on the unconscious and assert that underlying unconscious or repressed conflicts are responsible for conflicts, disruptions, and disturbances in behavior and personality.

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

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

10. Biological psychology theory includes brain physiology, genetics, and evolution as means for understanding behavior. Although numerous frameworks have evolved, they all address the effect of the mind on biological processes (or vice versa) on disease states and behaviors.

HYPERLINKS

Is Depression A Chemical Imbalance In The Brain? Mind Control Report. A critical analysis of the prevailing biological theory of depression.

1. http://www.youtube.com/watch?v=4KDP2v3Jp08

CHAPTER 11

THOUGHT DISORDERS

KEY TERMS

Affective flattening: restricted range and intensity of emotion

Alogia: decreased production of speech

Anhedonia: inability to feel pleasure or joy from life

Anosognosia: poor insight

Avolition: diminished goal directed activity

Delusion: erroneous false, fixed beliefs; a misinterpretation of the an experience

Echolalia: parrot-like repetition of another's words

Echopraxia: involuntary imitation of another's movements and gestures

Erotomanic: delusions that another person, usually of higher status, is in love with the individual

Grandiose: delusions of inflated worth, power or knowledge; possibly involving special relationships with deity or famous person

Hallucination: most commonly auditory or visual, erroneous or false sensory perceptions

Neuroleptic malignant syndrome: a rare, but life-threatening, idiosyncratic reaction to a neuroleptic medication.

Psychosis: condition involving hallucinations, delusions, or disorganized thoughts, behavior or speech

Schizophrenia: diagnostic category within the group of schizophrenia spectrum disorders

Thought disorder: broad term applying to illnesses involving disordered thinking and disturbances in reality orientation and social involvement

EXPECTED LEARNING OUTCOMES

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

1. Define thought disorder.
2. Identify the disorders associated with Schizophrenia Spectrum Disorders (SSD).
3. Describe the history and epidemiology of thought disorders.
4. Discuss current scientific theories related to the etiology of thought disorders including relevant biological and psychosocial theories.
5. Distinguish among the diagnostic criteria for thought disorders as identified by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM- IV-TR)*.
6. Describe common assessment strategies for individuals with thought disorders.

7. Explain treatment options for persons demonstrating thought disorders, emphasizing those that reflect evidence-based practices.
8. Apply the nursing process from an interpersonal perspective to the care of patients with thought disorders.

NEED TO KNOW

1. Schizophrenia was initially believed to be a type of early dementia. It was not until 1959 when it was defined with a specific list of symptoms by Kurt Schneider.
2. Initially, patients with schizophrenia were treated cruelly with banishment from society. The discovery of the antipsychotic agent, chlorpromazine, in the early 1950s marked the first time effective treatment was available for schizophrenia.
3. Schizophrenia occurs more commonly in men than in women, more often in immigrants than in the native-born population, and more often in those living in urban areas.
4. Schizophrenia is manifested by positive and negative symptoms. Positive symptoms are exaggerations of normal function; negative symptoms indicate decreased emotional expression.
5. The five subtypes of schizophrenia are: paranoid, disorganized, catatonic, undifferentiated, and residual. Each is associated with characteristic symptoms.
6. Other thought disorders include: schizophreniform disorder, schizoaffective disorders, delusional disorder, brief psychotic disorder, and shared psychotic disorder.
7. Early psychosocial theories identified a problematic maternal relationship as the cause of schizophrenia. Later, other theories addressed social context and unresolved family issues.
8. Biological theories suggest perinatal events, genetics, neuroanatomical abnormalities, and dysfunction of neurotransmitters as key risk factors for the development of schizophrenia.
9. Antipsychotic agents are typically classified as first- or second-generation agents. Both are associated with extrapyramidal symptoms: parkinsonism, akathesia, dytonias, and tardive dyskinesia. Second-generation antipsychotics are associated with the development of metabolic syndrome.
10. Cognitive behavioral therapy (CBT) is an effective treatment modality for schizophrenia because it focuses on the present, involves sessions requiring homework and exercises, and spans a limited time period.
11. Family psychoeducation involves teaching the patient and family about the disorder as well as showing concern and empathy for the family, helping to improve the relationships among family members, promoting adherence to the regimen, and instilling hope.
12. Patients with schizophrenia often have a substance abuse disorder that requires treatment.
13. Patients with schizophrenia may require social skills training, supported employment, illness self-management training, and supported housing.
14. When assessing a patient with schizophrenia, nurses need to be self-aware and to establish rapport with the patient to prevent the stigma associated with this disorder from interfering with the assessment and development of the therapeutic relationship.
15. The psychiatric-mental health nurse needs to use a broad opening statement to obtain information from the patient about his or her current status. Throughout the assessment, the nurse is vigilant in observing positive and negative symptoms of schizophrenia.
16. Patients with schizophrenia often present with a wide range of symptoms. Therefore, nursing diagnoses appropriate for a patient must reflect this variation.

17. An important consideration when implementing care for a patient with schizophrenia is to ensure adherence to the prescribed medications. Patient and family psychoeducation is a key intervention.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=qWiTqDeTY7E

CARE PLANNING PRACTICE

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

CHAPTER 12

AFFECTIVE DISORDERS

KEY TERMS

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

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

Hypomania: a less severe form of mania

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

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

Mood: a person's overall emotional status

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

Suicidal Ideation: intruding thoughts of harming one's self

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

EXPECTED LEARNING OUTCOMES

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

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

10. Apply the nursing process from an interpersonal perspective to the care of patients with affective disorders or who are experiencing suicidal thoughts.

NEED TO KNOW

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

HYPERLINKS

Bi-polar disorder, How to recognize the symptoms of bipolar disorder; a short film on common, basic criteria that may lead to diagnosis of this illness

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

CARE PLANNING PRACTICE

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

CHAPTER 13

ANXIETY DISORDERS

KEY TERMS

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

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

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

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

Fear: feelings consistent with panic and phobias

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

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

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

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

Phobia: intense fear about certain objects or situations

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

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

EXPECTED LEARNING OUTCOMES

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

1. Define anxiety.
2. Identify the disorders classified as anxiety disorders.
3. Describe the historical perspectives and epidemiology associated with anxiety disorders.

4. Discuss current scientific theories related to the etiology of anxiety disorders, including relevant psychodynamic and neurobiological influences.
5. Distinguish among the diagnostic criteria for anxiety disorders as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text revision* (*DSM-IV-TR*).
6. Explain the various treatment options available for anxiety disorders.
7. Apply the nursing process from an Interpersonal Perspective to the care of patients with anxiety disorders.

NEED TO KNOW

1. Anxiety is a vague feeling of discomfort. It can be a healthy response leading an individual to become more focused and able to cope with threatening situations, or it can become pathological and interfere with a person's ability to function.
2. Historically, terms such as hysteria, anxiety neurosis, and shell shock were used to identify anxiety disorders.
3. Anxiety disorders, the most common and most costly psychiatric diagnosis in the United States, commonly occur with other conditions such as substance abuse and depression.
4. Anxiety disorders occur more commonly in women than in men and can contribute to illness and death through effects on the endocrine, immune, and nervous system.
5. Although panic disorder can occur spontaneously, it typically results after frightening experiences or prolonged stress. Patients with OCD use obsessions and compulsions to relieve anxiety. Patients with PTSD experience flashbacks and change behavior in an effort to avoid stimuli associated with a previous trauma.
6. Peplau identified four categories of anxiety: mild, moderate, severe, and panic.
7. Specific brain structures such as the amygdala and neurotransmitters such as GABA, norepinephrine, and serotonin have been associated with anxiety disorders. GABA is the primary neurotransmitter involved.
8. Various groups of medications can be used to treat anxiety disorders. SSRIs and SNRIs are the primary agents used. Benzodiazepines also may be used in conjunction with these agents.
9. Two herbal preparations are commonly used for self-medication with anxiety disorders. These include kava kava and valerian. Further research is needed to determine their effectiveness.
10. Although neurosurgery may be performed to treat OCD, deep brain stimulation (DBS), initially used for treating Parkinson's disease, is showing positive results for treating severe OCD.
11. Cognitive behavioral therapy requires that a patient focuses on the present and examines problem beliefs and thought patterns. The patient then learns through education, self-monitoring, and cognitive restructuring how to replace these problematic thought patterns with more rational and realistic views.
12. Exposure therapy can occur in real situations (in vivo exposure) or through the imagination (imaginal exposure).
13. Patients with anxiety disorders can learn techniques such as abdominal breathing, progressive muscle relaxation, and guided imagery and can use exercise, music, and diet to assist in reducing anxiety.
14. Nurses need to be self-aware of feelings related to anxiety disorders and how they display anxiety during their interactions with patients to prevent adding to the patient's already heightened state.

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

HYPERLINKS

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

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

CARE PLANNING PRACTICE

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

CHAPTER 14

PERSONALITY DISORDERS

KEY TERMS

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

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

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

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

Magical thinking: belief that thoughts are all-powerful

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

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

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

Splitting: individual tends to view reality in polarized categories

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

EXPECTED LEARNING OUTCOMES

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

1. Define personality.
2. Describe personality traits.
3. Identify the major personality disorders, including common components.
4. Describe the historical and epidemiologic perspectives related to personality disorders.
5. Distinguish among the characteristic behaviors for Clusters A, B, and C based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR)*.
6. Discuss the behaviors of individuals with different types of personality disorders.

7. Explain current psychosocial and biologic theories related to the etiology personality disorders.
8. Apply the nursing process from an interpersonal perspective to the care of patients with personality disorders.

NEED TO KNOW

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

HYPERLINKS

Borderline personality disorder. A client with borderline pesonality disorder is interviewd. Diagnotic criteria is discussed.

1. http://www.youtube.com/watch?v=eOphgCJX1FY

CARE PALNNING PRACTICE

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

CHAPTER 15

ADDICTIVE DISORDERS

KEY TERMS

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

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

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

Detoxification: process of managing a patient during withdrawal. Detoxification is composed of three components: evaluation, stabilization, and readiness for treatment.

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

5. Explain the various treatment options available for addiction disorders, including evidence-based strategies.
6. Apply the nursing process from an interpersonal perspective to the care of patients with anxiety disorder.

NEED TO KNOW

1. Compulsive drug seeking and use that leads to harmful consequences is termed addiction
2. Addiction is a disease affecting the brain and its chemistry. Both substances and behavioral or process addictions activate the same neurotransmitters and use the same reward pathways.
3. The *DSM-IV-TR* classifies substance disorders as substance use and substance-induced disorders. Substance use disorders are further classified as substance abuse and substance dependence. Substance-induced disorders are further classified as substance intoxication and substance withdrawal.
4. Psychological, environmental, and neurobiological influences and shared experiences play a role in whether or not a person develops an addiction.
5. Alcoholics Anonymous is the oldest and most notable of the 12-step programs. Confidentiality, anonymity, and a desire to remain sober are key components of AA.
6. Numerous medications are used to treat addiction. Some medications are used to control the symptoms that occur during detoxification and withdrawal. Other medications are used to promote continued abstinence.
7. During assessment, the nurse must be ever vigilant in monitoring him- or herself for conflicts and countertransference. The nurse also uses active listening to gain an understanding of the patient's experience.
8. The nurse uses reliable and validated screening tools to provide for early detection of substance disorders.
9. Although nursing diagnoses may vary, a common nursing diagnosis for a patient with addiction is defensive coping.
10. Detoxification involves evaluation, stabilization, and entry into treatment.

HYPERLINKS

Cocain, A teenager discusses his struggles with cocain addiction.

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

CARE PALNNING PRACTICE

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

CHAPTER 16

COGNITIVE DISORDERS

KEY TERMS

Delirium: an acute disruption in consciousness and cognitive function

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

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

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

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

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

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

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

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

Senile dementia: memory loss as part of normal aging

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

EXPECTED LEARNING OUTCOMES

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

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

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

NEED TO KNOW

1. ***Delirium*** occurs suddenly and is the result of an underlying medical condition. ***Dementia*** occurs gradually and involves multiple problems of memory and cognition.
2. Delirium is the most commonly occurring cognitive disorder. Dementia of the Alzheimer's type accounts for more than half of all dementias globally.
3. Although signs and symptoms may vary in patients with dementia of the Alzheimer's type, often progressive memory loss is noticed first.
4. Frontotemporal dementia is manifested by changes in behavior and language.
5. Pathologic changes involved with dementia of the Alzheimer's type include neurofibrillary tangles, beta-amyloid plaques, and apolipoprotein E. Acetylcholine deficiency, referred to as the cholinergic hypothesis, is also implicated in the etiology of dementia of the Alzheimer's type. Other neurotransmitters, such as a deficiency of serotonin and dopamine also may be involved.
6. Cholinesterase inhibitors are used to treat dementia of the Alzheimer's type. These agents do not cure the disease; rather, they are believed to help slow the progression of cognitive decline.
7. Validation therapy focuses on the premise that past conflicts can be resolved by validating the person's reality.
8. Reminiscence therapy can be formal, using a structured activity, or informal, using a specific event to stimulate discussion of past events.
9. The Enriched Model of Dementia focuses on minimizing the damaging negative social and psychological environment (termed "malignant social psychology") and maximizing the supportive aspects (termed "positive person work").
10. A person with dementia experiences a diminished stress threshold. The PLST Model focuses on modifying the environment to reduce stress for the patient with dementia who is nearing his or her stress threshold.
11. Assessment of a patient with dementia requires patient, family, and caregiver involvement to ensure that enough information is collected to develop a complete picture of the patient's status.
12. Providing care for a family member with dementia can be highly stressful and overwhelming. Family caregivers need to receive adequate preparation and support when caring for the individual.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=ICNLwa-Q6kY
2. http://www.youtube.com/watch?v=K52tHgJCQkc
3. http://www.youtube.com/watch?v=7-GZRZbM-UM&feature=related

CARE PLANNING PRACTICE

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

CHAPTER 17

IMPULSE CONTROL DISORDERS

KEY TERMS

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

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

Kleptomania: recurrent failure to resist the impulse to steal

Pathological gambling (PG): persistent maladaptive gambling behavior

Pyromania: fire-setting for pleasure and gratification

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

EXPECTED LEARNING OUTCOMES

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

1. Identify the disorders that can be described as impulse control disorders.
2. Discuss the history and epidemiology of impulse control disorders.
3. Distinguish among the *Diagnostic and Statistical Manual of Mental Disorder, 4th edition, Text Revision* (*DSM-IV-TR*) diagnostic criteria for impulse control disorders.
4. Describe possible theories related to the etiology of impulse control disorders.
5. Explain various treatment options for persons experiencing impulse control disorders.
6. Discuss common assessment strategies for individuals with impulse control disorders.
7. Apply the nursing process from an interpersonal perspective to the care of patients with impulse control disorders.

NEED TO KNOW

1. Impulse control disorders are characterized by the inability to control or suppress acting on an impulse that has the potential for harm to one's self or others.
2. Intermittent explosive disorder and pyromania are more common in males; kleptomania and trichotillomania are more common in females. Two-thirds of those with pathological gambling are male.
3. The impulse response follows a predictable pattern: an increase in stress followed by an increase in arousal, which leads to the act and subsequent experience of pleasure, gratification, and release of tension followed by feelings of regret, self-reproach, or guilt.

4. Alterations in neurotransmitter levels, such as serotonin, are associated with the etiology of impulse control disorders.
5. SSRIs are commonly used to treat impulse control disorders
6. A common priority nursing diagnosis for a patient with an impulse control disorder is risk for other-directed violence.

HYPERLINKS

Intermintent explosive disorder, A short film describing intermontent explosive disorder and how it is diagnosed.

1. http://www.youtube.com/watch?v=zs0JtjqR3dY

CARE PLANNING PRACTICE

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

CHAPTER 18

SEXUAL DISORDERS AND DYSFUNCTIONS

KEY TERMS

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

Human sexuality: how people experience themselves as sexual beings

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

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

NEED TO KNOW

1. Difficulties with sexual functioning typically are classified as sexual disorders or sexual dysfunctions. Sexual disorders involve intense sexual urges, fantasies, or behaviors, whereas sexual dysfunctions involve disruptions in the sexual response cycle.
2. Sexuality is viewed on a continuum from exclusively heterosexual to exclusively homosexual.
3. Sexual problems occur in approximately 31% of men and 43% of women.
4. Emotional stressors, such as anxiety or depression, medical illnesses, and medications that alter the brain's chemistry, have been linked to development of sexual disorders and dysfunctions.
5. Nurses need to be aware of the messages they are sending—verbally and nonverbally—when assessing patients about their sexual functioning.
6. The nurse needs to obtain permission from the patient before proceeding with an assessment of sexual functioning.
7. Psychoeducation and acting as a patient advocate are two key nursing interventions for patients with sexual dysfunction.

HYPERLINKS

Compulsive sexual behavior, How to know if you're a sex addict is a breif film describing warning signs of this compulsice problem.

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

CARE PLANNING PRACTICE

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

CHAPTER 19

EATING DISORDERS

KEY TERMS

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

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

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

Eating disorder: a serious disturbance in behaviors associated with eating

Obesity: a body mass index greater than or equal to 30 (kg/m^2)

Overweight: a body mass index (BMI) ≥25 (kg/m^2)

EXPECTED LEARNING OUTCOMES

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

1. Define eating disorders.
2. Discuss the history and epidemiology of eating disorders.
3. Identify the different eating disorders.
4. Distinguish among the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR*) diagnostic criteria for eating disorders.
5. Discuss possible theories related to the etiology of eating disorders, differentiating the biological, sociocultural, familial influences, psychological and individual risk factors associated with these disorders.
6. Explain various treatment options for persons experiencing eating disorders.
7. Apply the nursing process from an interpersonal perspective to the care of patients with eating disorders.

NEED TO KNOW

1. Numerous factors affect an individual's eating patterns. Eating provides nutrition but also other functions.
2. Anorexia is more commonly found in females than in males. It occurs more frequently in adolescents and young adults, usually under the age of 25 years. Bulimia, also more common in females, occurs more frequently in individuals between the ages of 14 and 40 years.
3. Anorexia is characterized by a low body weight (less than 85% of minimally normal weight for age and height), intense fear of gaining weight or becoming fat, disturbed perception of the body, and amenorrhea for at least three consecutive menstrual cycles.

4. CBT is the treatment of choice for individuals with bulimia nervosa.
5. Nurses need to perform a comprehensive physical assessment of individuals with eating disorders because acute and chronic complications can occur that can affect any body system.
6. A key component of assessment is determining how motivated the patient is to change and his or her readiness to change.
7. When implementing interventions, a strong trusting interpersonal relationship between the nurse and individual experiencing the eating disorder is necessary to ensure effective outcomes.

HYPERLINKS

Anorexia, A students video about the illness and main diagnostic features.

1. http://www.youtube.com/watch?v=N1GOVpCfFEg

CARE PLANNING PRACTICE

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

CHAPTER 20

PSYCHOLOGICAL PROBLEMS OF PHYSICALLY ILL PERSONS

KEY TERMS

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

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

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

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

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

Delirium: an acute disruption in consciousness and cognitive function

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

8. Apply the nursing process from an interpersonal perspective to a physically ill patient with mental health issues.

NEED TO KNOW

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

HYPERLINKS

Therapeutic communication in the medical surgical unit. Brief film highlighting the importance of interpersonal relationships in the medical surgical population.

1. http://www.youtube.com/watch?v=Nipj7PwCjTc

CARE PLANNING PRACTICE

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

CHAPTER 21

WORKING WITH CHILDREN

KEY TERMS

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

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

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

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

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

Echolalia: parrot-like repetition of another's words

Libido: the id; driving force behind specific behavior

Magical thinking: belief that thoughts are all-powerful

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

1. Discuss the major theories related to growth and development in children.

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

NEED TO KNOW

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

16. A thorough understanding of childhood development is necessary when conducting an assessment of a child with a mental health disorder.

HYPERLINKS

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

1. http://www.ehow.com/video_5574570_recognize-signs-mental-illness-children.html

CHAPTER 22

CONCERNS REGARDING ADOLESCENTS

KEY TERMS

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. The development of self-esteem and identity are important developmental tasks in adolescence. Peer relationships play a major role in achieving these tasks.
2. Assessment of an adolescent requires sensitivity and use of appropriate language to determine the adolescent's view of the problem from his or her frame of reference.
3. Adolescents often experience mental health disorders that are the same as those in adults. Depression, mania, self-harm, suicidal ideation, alcohol and drug use, eating disorders, and anxiety disorders, such as obsessive compulsive disorder, are common in adolescence.
4. An adolescent who engages in self-harm behaviors may or may not be experiencing suicidal ideation. Self-harm behaviors without suicidal intent result from a multitude of reasons and are not attempts to gain attention.

5. Typically, warning signs of suicide are present before an adolescent attempts suicide. Assessment focuses on the lethality of the method, location, motive, evidence of suicidal communication, previous attempts, and information related to a continued wish to die.
6. Alcohol is the most common mood-altering drug used by adolescents. Cannabis and amphetamines are the most common illicit substances used.
7. Social phobia can lead to the development of poor social skills and low self-esteem, thus affecting the adolescent's development.
8. Ability to interact in a group environment, suitability for a group, and level of group functioning must be considered when determining if group work would be appropriate for an adolescent.
9. Psychopharmacology is considered only as a last resort when treating adolescents because of the increased risk for suicide.
10. Therapeutic communication skills including active listening are essential to the development of the therapeutic relationship with an adolescent. The adolescent needs to be treated as an individual whose input is valued.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=berxf5t1H9w
2. http://www.youtube.com/watch?v=czoS-zSdA5M
3. http://www.youtube.com/watch?v=635Moor7fTw
4. http://www.youtube.com/watch?v=L0l0507–1VY

CHAPTER 23

ISSUES SPECIFIC TO THE ELDERLY

KEY TERMS

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

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

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

Insomnia: difficulty initiating or maintaining sleep

Loneliness: an unnoticed inability to do anything while alone

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Quality of life is a key indicator of an individual's overall health, but especially the overall health of an elderly individual.
2. Typically, physical changes in the elderly are dismissed as normal, age-related changes. However, they can significantly impact the person's mental health, leading to social isolation, anxiety, and depression.

3. The presence of pain, its effect on functioning, and the associated treatment can predispose the elderly patient to mental health problems such as changes in cognition, mood, and sleep patterns.
4. Elderly individuals experience a wide range of losses, both physical and emotional, that can occur as single or multiple events, placing them at risk for decreased self-esteem and depression.
5. Loneliness, an individual response to unfulfilled needs for intimacy or social contacts, occurs in two forms: social loneliness, which is related to a loss of contact with peers, friends, or groups that have shared and supported the elderly individual's social needs; and emotional loneliness, which is associated with the loss of intimacy with a partner, family member, or friend who can no longer support the elderly individual's emotional needs.
6. Depression in the elderly is reaching epidemic proportions, with estimates indicating depression as the major underlying cause for the increased cost of health care in this population.
7. Treatment of generalized anxiety disorder in the elderly typically involves psychotherapy with psychopharmacology, or cognitive behavioral therapy followed by psychopharmacology if not successful.
8. Polypharmacy is a major problem with the elderly population with the use of multiple medications commonly used to treat unresolved pain, depression, or anxiety.
9. Factors influencing the elderly individual's use of mental health services in the community include: the person's belief in and desire for the services, the ability to pay for the services, the ability to physically access the services, and the availability of programs to meet the changing needs of the elderly.
10. When assessing the elderly individual, the nurse interacts with the patient on a humanistic level to promote trust and foster an atmosphere of genuine interest, acceptance, and positive regard.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=OlbaOU3STJU&feature=related
2. http://www.youtube.com/watch?v=uDQaQD4hBxg&feature=related
3. http://www.youtube.com/watch?v=c_XyFGFr29c&feature=related

CHAPTER 24

VICTIMS AND VICTIMIZERS

KEY TERMS

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

Battering: striking someone repeatedly with violent blows

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

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

Intimate partner violence: violence among spouses or domestic partners

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Abuse reflects a means for exerting power and control over another person.
2. The four types of abuse are physical, emotional or psychological, sexual, and economic (or financial) abuse.

3. Domestic abuse historically was viewed as a family problem. However, increasing public pressure has led to legislation, recognizing domestic violence as a crime.
4. Anyone can be a victim or perpetrator of abuse. However, victims most often are females and victimizers are most often males.
5. The common belief surrounding abuse is that it is a learned behavior, occurring most commonly in households where individuals have grown up being exposed to violence.
6. The cycle of violence consists of three phases: tension-building phase, acute battering (or explosive) phase, and the honeymoon (or love-contrition) phase.
7. The Power and Control Wheel emphasizes the responsibility of the individual abuser and the community for controlling the abuser.
8. Nurses typically provide care for both the victims of abuse and their victimizers. Therefore, self-awareness of feelings and responses for victims of abuse and victimizers is crucial to ensuring the development of a therapeutic relationship.
9. Nurses are legally mandated to report suspicions of child abuse, usually within 24 hours.
10. When assessing a victim of intimate partner violence, the nurse interviews the victim separately from the victimizer.
11. A nurse must never force or coerce a victim of intimate partner violence to leave an abusive relationship. This decision is entirely the victim's choice.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=rt7JZSrDJA8
2. http://www.youtube.com/watch?v=UJXRf31Idq8&feature=fvsr

CHAPTER 25

PSYCHIATRIC-MENTAL HEALTH NURSING ACROSS THE CONTINUUM OF CARE

KEY TERMS

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. The continuum of care covers the range from illness to wellness and requires coordination of care and services for the patient to achieve optimal health.
2. Like medical emergency care, psychiatric emergency care, often involves life and death situations. The safety of the patient and those around him or her is the priority.
3. A partial hospitalization program provides a structured treatment program during the day, with the patient returning to his or her living environment at night.

4. Residential services are used for patients experiencing seriously persistent mental illness, such as persistent and unremitting psychotic or mood disorders.
5. With outpatient care, the patient's symptoms are managed as he or she is integrated back into the community.
6. Primary care is often used to treat uncomplicated cases of depression, anxiety, and substance abuse.
7. Personal care homes are most often used for patients who are elderly, have physical or mental disabilities, or cannot care for themselves but would not require medical or nursing home care.
8. Behavioral ambulatory care is classified into three levels, with Level 1 being appropriate for patients experiencing disabling to severe symptoms.
9. Telehealth includes services provided by telephone, computers, email, and interactive video sessions.

HYPERLINKS

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

1. http://www.youtube.com/watch?v=fG8kACiNvYI

CHAPTER 26

VULNERABLE POPULATIONS AND THE ROLE OF THE FORENSIC NURSE

KEY TERMS

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

1. Identify certain populations as being legally classified as vulnerable.
2. Describe the role of nurses in working with these populations.
3. Demonstrate understanding of the challenges experienced by vulnerable populations related to care access and provision.
4. Explain the specialty practice of forensic nursing.

NEED TO KNOW

1. When working with vulnerable populations, nurses function as advocates for those populations and work to ensure the safety of all involved.
2. Populations at the opposite ends of the age spectrum, that is, children and the elderly, are considered vulnerable.
3. Access to and availability of mental health services is limited for many minority groups.
4. Individuals with intellectual disabilities vary in their functional ability. Regardless of the severity of the disability, the nurse advocates for the individual and works to protect the rights of the individual.

5. Veterans account for a significant number of homeless individuals. These veterans often experience the effects of posttraumatic stress disorder.
6. PMHNs working in correctional facilities administer psychopharmacology, engage in groups, perform medical functions such as drawing specimens for testing, follow up with individuals with chronic illnesses, perform treatment, and provide education.
7. Forensic nurses typically require a graduate level education and work as forensic psychiatric nurses, correctional nurses, legal nurse consultants, forensic sexual assault nursing examiners, nurse attorneys, nurse coroners, death investigators, and clinical nurse specialists in trauma, transplant, and emergency, and critical care.

HYPERLINKS

Mentally ill incarcerated, Documentary regarding housing of the vulnerable mentally ill in prison systems.

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

CHAPTER 27

CULTURAL, ETHNIC, AND SPIRITUAL CONCEPTS

KEY TERMS

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

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

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

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

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

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

1. Identify the core concepts associated with culture.
2. Describe the impact of ethnic and cultural factors on the delivery of mental health care.

3. Explain the concept of spirituality as it relates to health, including mental health.
4. Integrate concepts of cultural competence into interpersonal modes of practice.
5. Demonstrate culturally sensitive and congruent care to different patient populations.

NEED TO KNOW

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

HYPERLINKS

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

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

CHAPTER 28

ETHICAL AND LEGAL PRINCIPLES

KEY TERMS

Autonomy: capacity to make decisions and act on them

Beneficence: ethical principle involving doing what is best

Competence: the degree to which a patient possesses the cognitive ability to understand and process information

Ethics: collection of philosophical principles that examine the rightness and wrongness of decisions and conduct as human beings.

Fidelity: ethical principle focusing on acting as promised

Involuntary commitment: involuntary admission; the patient admitted against his or her wishes.

Justice: ethical principle focusing on fair and equal treatment

Kantianism: ethical theory focusing on performing one's duty rather than the "rightness" or "wrongness" of the out

Nonmaleficence: ethical principle focusing on doing no harm

Seclusion: placement of the patient in a safe room alone

Self-determination: freedom to make decisions without consulting others

Utilitarianism: ethical theory in which decisions should be based on producing the best outcome or the greatest happiness for the greatest number of people.

Veracity: ethical principle focusing on honesty and truthfulness

Voluntary admission: patient agrees or consents to admission

EXPECTED LEARNING OUTCOMES

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

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

7. Discuss the responsibilities of the psychiatric-mental health nurses (PMHN) in providing ethical and legal nursing care.

NEED TO KNOW

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

HYPERLINKS

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

1. http://www.youtube.com/watch?v=9VRPMJUyE7Y

CHAPTER 29

POLICY, POLICYMAKING AND POLITICS FOR PROFESSIONAL PSYCHIATRIC NURSES

KEY TERMS

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

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

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

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

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

EXPECTED LEARNING OUTCOMES

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

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

NEED TO KNOW

1. Political action is accomplished by a group of people organizing themselves to influence others to make changes.
2. Theory building and policy making are very similar processes.
3. Florence Nightingale not only influenced change in hospital systems but also in how the mentally ill were cared for.
4. All nurses, regardless of their preparation, can become politically active and influence legislative and regulatory processes if they understand how the game is played in specific sectors.

HYPERLINKS

Debbie Burton discusses the role of the nurse and politics
http://www.youtube.com/watch?v=4HMww5mao6w

Brief film of how nurses became involved in the 2008 campaign and influenced outcomes.

1. http://www.youtube.com/watch?v=Rd9OjW40EkY