CHYLLIA DIXON FOSBRE

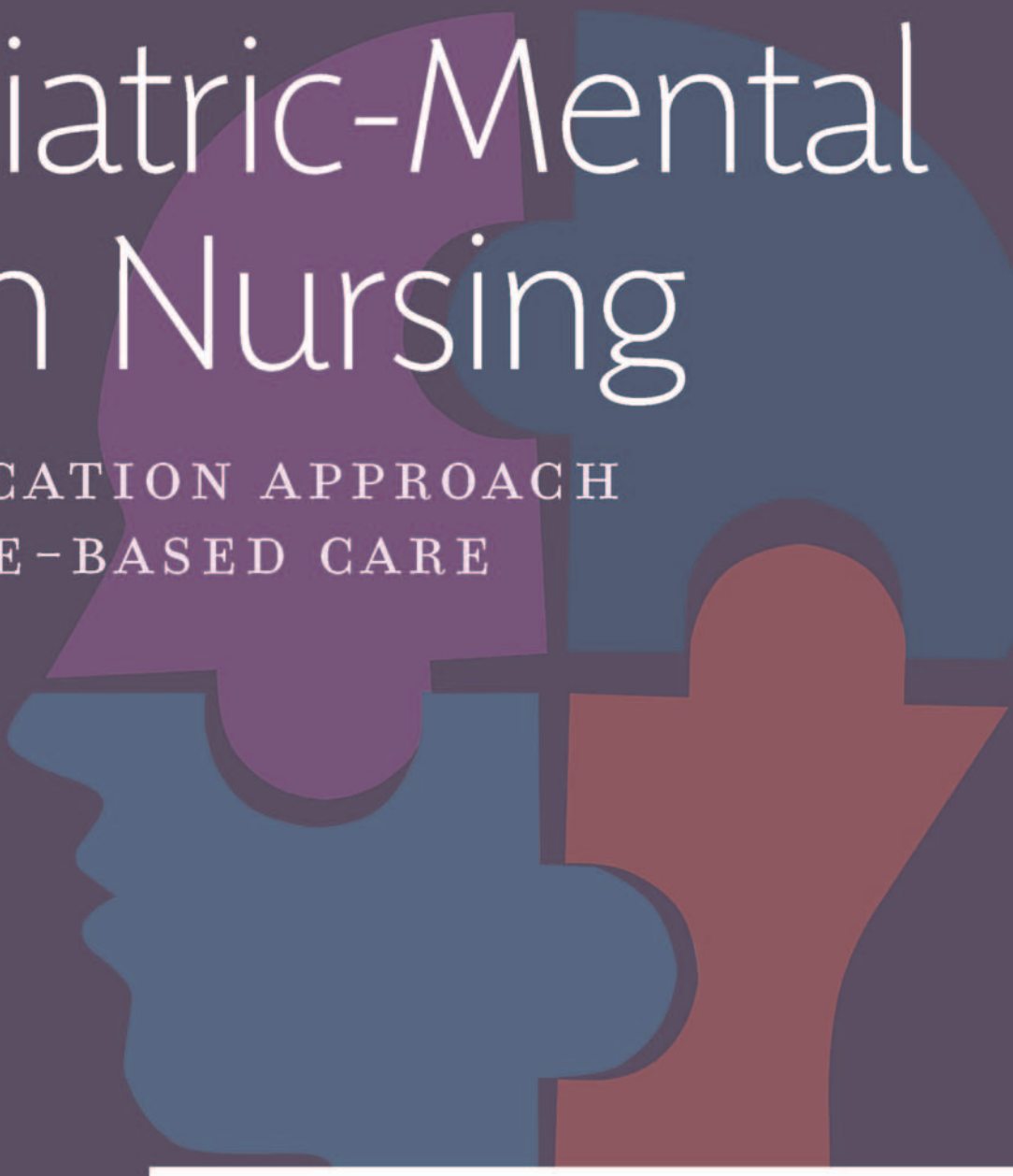
5TH edition

Varcarolis'

ESSENTIALS OF

Psychiatric-Mental Health Nursing

A COMMUNICATION APPROACH TO EVIDENCE-BASED CARE



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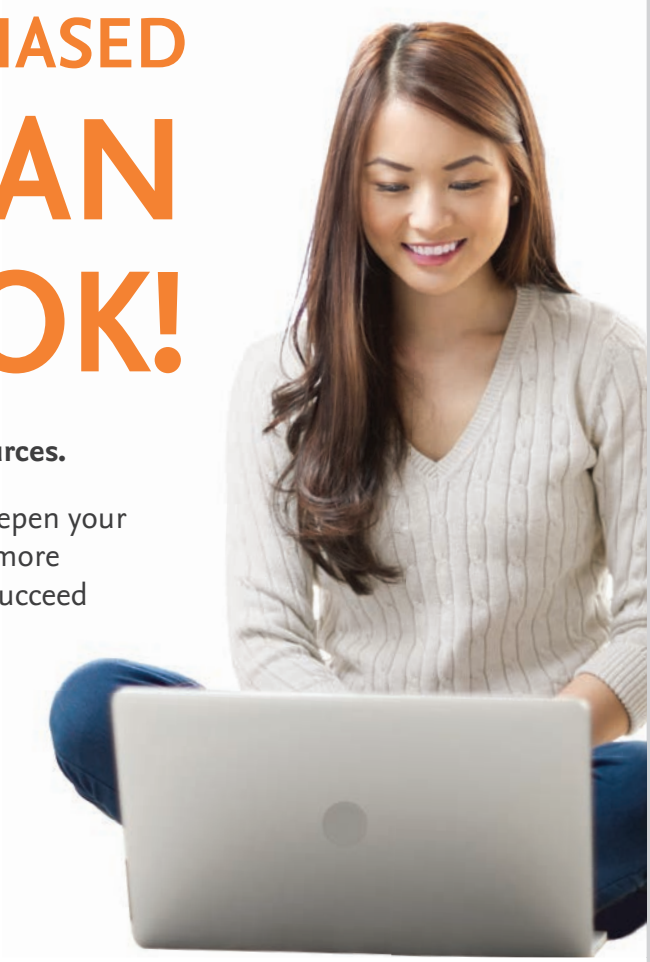

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FIFTH EDITION

Varcarolis' Essentials of Psychiatric-Mental Health Nursing

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FIFTH EDITION

Varcarolis' Essentials of Psychiatric-Mental Health Nursing

A Communication Approach to Evidence-Based Care

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VARCAROLIS' ESSENTIALS OF PSYCHIATRIC-MENTAL HEALTH NURSING: A COMMUNICATION APPROACH TO EVIDENCE-BASED CARE, FIFTH EDITION ISBN: 978-0-323-81030-2

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Printed in India

Last digit is the print number: 9 8 7 6 5 4 3 2 1

During the revision of the 4th edition, Elizabeth "Betsy" M. Varcarolis passed away. Her husband, Paul, was by her side, supporting her to the very end. Betsy has shaped the psychiatric nursing world through her numerous texts and years as a nursing instructor. Her fighting spirit and dedication to greatness will be missed.

To Betsy M. Varcarolis, thank you for trusting me with your life's work and for giving me an opportunity to carry it forward.

To my husband, Jonathan, who picked up the slack and supported me in taking on a challenge that, as Betsy said, would change our lives forever.

To the patients and families who have allowed me to be a part of their lives and share what I have learned as I've walked with them and then turn around and share that knowledge to shape the future of nurses.

Chyllia Dixon Fosbre

ACKNOWLEDGMENTS

Elizabeth "Betsy" Merrill Varcarolis is a prolific author and respected leader in the field of psychiatric-mental health nursing. She published her first *Foundations of Psychiatric/Mental Health Nursing* in 1990, which is now carried forward by Margaret Halter with the eighth edition. With this text, she has written four editions of *Essentials of Psychiatric Mental Health Nursing*. There are also six editions of her *Manual of Psychiatric Nursing Care Plans*. In addition to these major works, she has also contributed to *The American Handbook of Psychiatric Nursing* and wrote the computer-assisted course Emotional Disorders in Adolescents and Children.

Someone once said that life is a tragedy because it ends with death. I believe that life becomes a tragedy only if it's not well spent.

Betsy M. Varcarolis spent her life contributing to our planet and to the people she connected with. She cared about our world and its citizens.

She was a life enhancer and will be profoundly missed by all of the lives she touched. She left a positive, indelible footprint on our troubled globe.

Paul Varcarolis

Elizabeth is Professor Emeritus and former deputy chairperson at Borough of Manhattan Community College. She graduated with her bachelor of science in nursing from Cornell University in 1964 and worked in a variety of settings, including hospitals in London, Bermuda, Glasgow, Nigeria, and New York. She worked in hospitals during times of famine and war and dedicated herself to a career of service. She volunteered at home and abroad and served as a Major in the United States Army Reserve–Army Nurse Corps.

Her dedication to the field of mental health nursing is reflected in the passion and hard work she has put into publishing over a dozen textbooks over the past 30 years. It is without a doubt that Elizabeth has touched the lives of a countless number of nurses as they have relied on her textbooks. It is with deep respect that her work is carried forward by Margaret Halter and Chyllia D. Fosbre.

It has been an honor to work with Elizabeth (Betsy) Varcarolis as her content strategist for the past three editions of *Essentials of Psychiatric Mental Health Nursing*. As a professional and educator, Betsy was a pioneer in the field of psychiatric mental health nursing, and her texts continue to lead the way in providing undergraduate nursing students with the very best of content. With sincere gratitude and thanks to Betsy for her many years of dedication and hard work, we will strive to keep Betsy's voice alive in future editions of this textbook.

Yvonne Alexopoulos
Senior Content Strategist
Nursing Content
Global Content Partners

I would like to express my heartfelt thanks to Betsy Varcarolis as her senior content development manager for the past three editions of *Essentials of Psychiatric Mental Health Nursing*. She not only provided me with the opportunity to develop such a wonderful textbook, but she also was always very collaborative in her approach and never hesitated to let me know how much she valued my opinions and feedback. It is my hope that this edition is the best edition yet, Betsy!

Lisa P. Newton
Senior Content Development Manager
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As is always the case, I owe a huge debt of gratitude to many for their contributions and support.

First, I would like to thank Lorraine Chiappetta for her extensive review and updating of the clinical chapters.

I am also indebted to Dawn Scheick for the Applying the Art boxes found in all of the clinical chapters (Chapters 10–19). Dawn offered excellent examples of how a nurse can incorporate effective and insightful communication while working with patients who possess a variety of needs and display a wide range of behaviors.

Communication is one of the arts taught to all nursing students, and effective communication strategies are the cornerstone of psychiatric-mental health nursing. This text offers many pedagogical features that will benefit both cognitive learners and visual learners. It is hoped that the reader will gain fresh insights, attain a broader understanding, and learn effective tools for interactions with vulnerable individuals during their treatment toward a more mentally healthy quality of life.

I want to offer special thanks to the amazing authors who have contributed to this edition of *Essentials of Psychiatric-Mental Health Nursing* for their expertise and hard work. Sincere and profound thanks go to Peggy Halter, Jessica Gandy, Lois Angelo, Lorraine Chiappetta, Carol O. Long, and Lisa Baker, in order of the appearance of their chapters.

I have been fortunate to be part of a hardworking team. Those who work behind the scenes are always pivotal to the production of any successful text. These are the people who have provided support, kept the project on track, and solved myriad problems that are inherent to any production:

- Senior Content Strategist Yvonne Alexopoulos always provided support and everything needed to make the fifth edition of *Essentials* a success.
- Senior Content Development Manager Lisa P. Newton pulled together resources, provided support, and untangled dilemmas during the publication process.
- Senior Project Manager Kamatchi Madhavan managed consistency to the minutest detail and has made me look good throughout the process.
- Book Designer Brian Salisbury created a vivid, exciting, and reader-friendly design.

Chyllia Dixon Fosbre
Betsy M. Varcarolis

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PREFACE

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition *(DSM-5)* is well represented in the fifth edition of *Essentials of Psychiatric-Mental Health Nursing: A Communication Approach to Evidence-Based Care,* as are medications recently approved by the US Food and Drug Administration at this writing. The color plates depicting "The Neurobiology of Specific Disorders" come alive through animations on the Evolve website. This edition continues to provide the essential content for a shorter course without sacrificing either the current research or the nursing and psychotherapeutic interventions necessary for sound practice. In fact, all efforts have been made to ensure that research and psychotherapeutic interventions reflect current knowledge.

Essentials of Psychiatric-Mental Health Nursing, fifth edition, continues to provide a comprehensive but concise review of the prominent theorists and therapeutic modalities in use today, including milieu, group, and family therapies (Chapter 3, "Theories and Therapies"). Within each of the clinical chapters (Chapters 10–19), chapters that examine various psychiatric emergencies (Chapters 20–25), and chapters that address specific patient populations across the life span (Chapters 26–28), specific therapeutic modalities that have proven effective for each topic are covered thoroughly.

In addition to the overview of medication groups provided in Chapter 4 ("Biological Basis for Understanding Psychopharmacology"), specific medications are covered for each of the clinical disorders and include patient and family teaching guidelines. Integrative therapies are also included in each of the clinical chapters where they have proven effective.

To present the most essential base of knowledge for a shorter course, the pertinent information on some topics has been incorporated in the clinical chapters where applicable rather than discussed in a separate chapter. For example, rather than include a general chapter on culture, each of the clinical chapters incorporates relevant information on cultural aspects of the various clinical disorders, which can also help to give the reader a broader cultural perspective.

Forensic issues related to the nursing care of patients are included in specific chapters, especially Chapters 21 ("Child, Partner, and Elder Violence") and 22 ("Sexual Violence"). This discussion is in addition to Chapter 6 ("Legal and Ethical Basis for Practice").

THE SCIENCE AND ART OF PSYCHIATRIC-MENTAL HEALTH NURSING

The American Nurses Association's *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* begins with the following statement that stresses the importance of both the art and the science employed by nurses caring for patients with mental health problems and psychiatric disorders:

> *Psychiatric-mental health nursing, a core mental health profession, employs a purposeful use of self as its art and a wide range of nursing, psychosocial, and neurobiological theories and research evidence as its science.*

In *Essentials of Psychiatric-Mental Health Nursing: A Communication Approach to Evidence-Based Care*, fifth edition there is an effort to integrate and balance these two aspects of nursing care and to present all essential information on each so that students will be prepared to offer the best possible care when they enter practice.

The Science

Over the past few decades, we have seen remarkable scientific progress in our understanding of the workings of the brain and how abnormalities in the functioning of the brain are related to mental illness. As confidence in this research grew, the focus on scientific research expanded and led to more scientifically based treatment approaches, and the concept of *evidence-based practice* (EBP) became a dominant focus of mental health treatment.

While writing this text, great effort was made to provide the most current evidence-based information in the field while still keeping the material comprehensible and reader friendly. Relevant information drawn from science is woven throughout the text.

Chapter 1 (Science and the Therapeutic Use of Self in Psychiatric-Mental Health Nursing) introduces the student to the evolution of EBP and its mechanics and provides guidelines for where and how to gather information for applying EBP in psychiatric nursing practice.

New to this fifth edition is a focus on the new NGN case studies and item types and the end of the clinical chapters. These questions are designed to support higher-level critical-thinking skills and prepare students for the updated test format.

One of the unique features of this text is **Applying Evidence-Based Practice (EBP)**, which is introduced in Chapter 1 and runs throughout the clinical chapters. Each box poses a question, walks the readers through the process of gathering evidence-based data from a variety of sources, and presents a plan of care based on the evidence.

The Art

In comparison with the medical model, the **recovery model** is a more social, relationship-based model of care. The focus of the recovery model is a nurse–physician partner relationship. The recovery model began in the addiction field, in which the goal was for individuals to recover from substance abuse and addictions. Today the recovery model is gaining momentum in the larger mental health community. Its focus is on empowering patients by supporting hope, strengthening social ties, developing more effective coping skills, fostering the use of spiritual strength, and more.

By definition, nurses are primed to incorporate the biopsychosocial and cultural/spiritual approaches to care. Some nursing leaders express concern that the "art" of nursing is becoming marginalized by the emphasis on EBP. Chapter 1 covers some of these often minimized and uncharted interventions, such as the art of caring, the skill of attending, and patient advocacy. However, what also might be minimized and deemphasized is the tools that make nurses unique. Some of these tools include possessing effective communication skills, forming therapeutic relationships, and understanding ways of interviewing and assessing patients' needs. These areas are stressed in Chapters 8 ("Communication Skills: Medium for All Nursing Practice") and 9 ("Therapeutic Relationships and the Clinical Interview"). There is also a section in each of the clinical chapters on useful communication techniques for a specific disorder or situation.

Another unique feature that is included in the clinical chapters is **Applying the Art**, which depicts a clinical scenario demonstrating the interaction (both therapeutic and nontherapeutic) between a student and a patient, the student's perception of the interaction, and the identification of the mental health nursing concepts in play.

ORGANIZATION

Organized into five units, the chapters in the text have been grouped to emphasize the clinical perspective and to facilitate locating information. All clinical chapters are organized in a clear, logical, and consistent format, with the nursing process as the strong, visible framework. The basic outline for the clinical chapters is as follows:

- Prevalence and Comorbidity
  Knowing the comorbid disorders that are often part of the clinical picture of specific disorders helps students and clinicians to understand how to better assess and treat their patients.
- Theory
- Cultural Considerations
- Clinical Picture
- Application of the Nursing Process
  - **Assessment.** This section presents the appropriate assessments for specific disorders, including assessment tools and rating scales. The rating scales included help to highlight important areas in the assessment of a variety of behaviors and mental conditions. Because many of the answers are subjective, experienced clinicians use these tools in addition to their knowledge of their patients as a guide when planning care.
  - **Diagnosis.** This section includes the latest International Classification for Nursing Practice (ICNP) terminology.
  - **Outcomes Identification**
  - **Planning**
  - **Implementation.** Interventions follow the categories set by the American Nurses Association's *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (2014). Various interventions for each of the clinical disorders are chosen based on which most fit specific patient needs and include communication guidelines; health teaching and health promotion; milieu therapy; psychotherapy; and pharmacological, biological, and integrative therapies.
  - **Evaluation**

FEATURES

In addition to the **Applying Evidence-Based Practice (EBP)** and **Applying the Art** boxes described previously, the following features are included in the text to inform, heighten understanding, and engage the reader:

- Chapters open with **Objectives** and **Key Terms and Concepts** to orient the reader.
- Numerous **Vignettes** describing psychiatric patients and their disorders attract and hold the reader's interest.
- **Assessment Guidelines** are included in clinical chapters to familiarize readers with methods of assessing patients; these can also be used in the clinical setting.
- **Potential Nursing Diagnoses** tables based on ICNP terminology list several possible nursing diagnoses for a particular disorder, along with the associated signs and symptoms.
- **Nursing Interventions** tables list interventions for a given disorder or clinical situation, along with rationales for each intervention.
- ***DSM-5* criteria boxes** are provided for selected mental health disorders.
- **Neurobiology illustrations of selected mental health disorders and how medications help to mitigate classic symptoms** are included. These are also provided on the Student Resources of Evolve as Animations. See the Animation icon in the textbook.
- **Key Points to Remember** present the main concepts of each chapter in an easy-to-comprehend and concise bulleted list.
- **Applying Critical Judgment** questions at the end of all chapters introduce clinical situations in psychiatric nursing and encourage critical thinking processes essential for nursing practice.
- *NEW! **Next Generation NCLEX practice questions** at the end of clinical chapters.
- Next-Generation NCLEX™ Examination Style Case Studies at the end of the clinical chapters.
- **Chapter Review Questions** at the end of each chapter reinforce key concepts.
- The Appendix provides the **Answers to Chapter Review Questions.**

LEARNING AND TEACHING AIDS

For Students

The Evolve Student Resources for this text include the following:

- ***Animations*** of the neurobiology illustrations for selected mental health disorders and how medications help to mitigate classic symptoms. You can also find these illustrations in the textbook with the icon next to them.
- **Answer Key to Textbook Next-Generation NCLEX™ Examination Style Case Studies**
- ***Case Studies*** and ***Nursing Care Plans*** for clinical disorders
- ***Student Review Questions*** for each chapter

For Instructors

The Evolve Instructor Resources for this text include the following:

- ***TEACH for Nurses lesson plans,*** based on chapter Learning Objectives, serve as readymade, modifiable lesson plans and a complete roadmap to link all parts of the educational package. These concise and straightforward lesson plans can be modified or combined to meet your particular scheduling and teaching needs.
- ***Test Bank*** is found in ExamView format and features approximately 800 test items. This includes correct answers with rationale, cognitive level, nursing process step, appropriate NCLEX© label, and corresponding page within the text.
- ***PowerPoint Presentations*** with more than 600 customizable lecture slides
- ***Audience Response Questions*** for iClicker and other systems, with two to five multiple-answer questions per chapter to stimulate class discussion and assess student understanding of key concepts.

*New Next Generation NCLEX™ Examination Style Case Studies: Six NGN-style case studies focused on Psychiatric–Mental Health Nursing. I hope all of you find that *Essentials of Psychiatric-Mental Health Nursing: A Communication Approach to Evidence-Based Care,* Fifth Edition, provides you with the information you need to be successful in your practice of nursing. Good luck to you all.

Betsy M. Varcarolis and
Chyllia Dixon Fosbre

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UNIT I Essential Theoretical Concepts for Practice

UNIT V Age-Related Mental Health Disorders

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UNIT I

Essential Theoretical Concepts for Practice

Dr. Hildegard E. Peplau (1909–1999)
"Mother of Psychiatric Nursing"

Hildegard Peplau, known as the mother of psychiatric nursing, has had the most profound effect on the practice of nursing since Florence Nightingale. After earning her bachelor's degree in nursing and her master's degree and doctorate in psychology, she went on to become a certified psychoanalyst. She later joined the psychiatric nursing faculty at Rutgers University, where she developed the first program specifically for psychiatric nursing. She later worked with the World Health Organization (WHO), published extensively, served as executive director and president of the American Nurses Association, and was a visiting faculty and lecturer around the world (D'Antonio et al., 2014).

Peplau's theory of interpersonal relations, also known as psychodynamic nursing, was strongly influenced by Harry Stack Sullivan's interpersonal relationship theory and was the first to integrate concepts from other psychological and scientific fields into a nursing theory. Her interpersonal theory led to a paradigm shift in the nature of the nurse–patient relationship, now referred to as patient-centered care. Peplau's theory has been used as a framework for a wide variety of research topics, including patient education, depression, survivors of sexual violence, and research subject retention.

As you read through this textbook, you will learn about levels of anxiety, phases of the nurse–patient relationship, and the importance of observing your own thoughts and feelings within the context of the nurse–patient interaction. These indispensable tools used by competent nurses today are all contributions from Hildegard Peplau, and her theory continues to serve as a foundation for the development of therapeutic nursing interventions, including the therapeutic use of self, that positively affect patient outcomes. Peplau's influence goes beyond psychiatric nursing. She was a determined advocate of advanced practice nursing and the expansion of nursing from a job to a profession, which was a key aspect of the development of standards and credentialing. Every nurse is profoundly affected by the art and science that Peplau brought to nursing.

1

Science and the Therapeutic Use of Self in Psychiatric-Mental Health Nursing

Chyllia Dixon Fosbre

http://evolve.elsevier.com/Varcarolis/essentials

OBJECTIVES

1. Explain what is meant by evidence-based practice (EBP), recovery model, and trauma-informed care models.
2. Identify the 5 A's used in the process of integrating EBP into the clinical setting.
3. Discuss at least three dilemmas nurses face when attempting to utilize EBP.
4. Identify four resources that nurses can use as guidelines for best-evidence interventions.
5. Identify basic principles of therapeutic self and apply them as an art of nursing.
6. Defend why the concept of caring should be a basic ingredient in the practice of nursing and how it is expressed while giving patient care.
7. Discuss what is meant by being a patient advocate.

KEY TERMS AND CONCEPTS

5 A's, p. 3
attending, p. 7
caring, p. 7
clinical algorithms, p. 4
clinical/critical pathways, p. 5
clinical practice guidelines, p. 4
evidence-based practice, p. 2
patient advocate, p. 7
psychiatric-mental health nursing, p. 2
Quality and Safety Education for Nurses, p. 2
recovery model, p. 6
therapeutic use of self, p. 6
trauma-informed care, p. 6

CONCEPT: ADVOCACY: *Advocacy* is a signature aspect of professional identity among nursing and other professions and is a primary consideration for all decisions made within the health care environment. It involves a commitment to patients' health, well-being, and safety. The ability to speak out assertively and credibly on behalf of patients or families is critical to effective advocacy (Giddens, 2017). Psychiatric-mental health nurses also function as advocates when they advise patients of their rights, solve the prescription problems of the homeless patient, engage in public speaking, write articles, and lobby congressional representatives to help improve mental health care, among other actions. It can take a great deal of courage to advocate for patients when we witness behaviors or actions of health care professionals that could have serious consequences.

INTRODUCTION

Psychiatric-mental health nursing is a specialized area of nursing based on evidence related to the neurobiology of psychiatric disorders, psychopharmacology and the effects of medications, and therapeutic relationships using evidence-based models like the recovery-based model and trauma-informed care. It is one of the few areas of nursing found in nearly every other specialty area. Having knowledge of psychiatric mental health will benefit every nurse.

Like all nursing specialties, psychiatric-mental health nursing employs both the *science* and the *art* of nursing. Included in the *science* of nursing are the major concepts of **evidence-based practice (EBP)**, the recovery model, trauma-informed care, and **Quality and Safety Education for Nurses (QSEN)**, as well as theories from a range of nursing, psychological, and neurobiological research. The *art* of nursing includes concepts like communication, empathy, and connection. The *art* of nursing is "To quiet the chaos, to sort through the mess, to hold your patients' hands, to look beyond the surface (St. John, 2020)." (American Nurses Association [ANA], 2017).

EVIDENCE-BASED PRACTICE

With the increased understanding of the biology of psychiatric illnesses beginning in the 1990s (termed the "decade of the brain"), treatment approaches rapidly evolved into more scientifically grounded methods, now known as EBP. In psychiatry, the evidence-based focus extends to treatment approaches in which there is scientific evidence for psychological and sociological modalities, as well as evidence related to the neurobiology of psychiatric disorders and psychopharmacology. The emergence of evidence-based nursing in the United States originated from the EBP movement in the medical community in England and Canada during the 1980s and 1990s. A noteworthy concept differentiating EBP in nursing from medicine is that the approach utilized

in nursing incorporates more than clinical research. EBP should also include patient preferences and a nurse's clinical knowledge and skill (Duke University, 2020).

Basing nursing practice on a systematic approach to care is not new. Florence Nightingale (1820–1910), the founder of modern nursing, would observe and document evidence leading to best practices. It was under her watch that nurses began to notice soldiers with clean bandages had better survival rates and she would then advocate for better access to clean bandages and better hygiene (Reinking, 2020). In 1860, Nightingale made a proposal that resulted in "the first model for systematic collection of hospital data using a uniform classification of diseases and operations," eventually forming the basis of the coding system used worldwide, the *International Statistical Classification of Diseases and Related Health Problems (ICD)* (The Lancet, 2019). Historically, mental health professionals in the United States have used the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* classifications rather than the *ICD* system. However, in 2013, the *DSM* and the *ICD,* 10th Revision, Clinical Modification *(ICD-10)* codes were aligned.

Hildegard Peplau (1909–1999), considered the mother of psychiatric nursing, had a passion for clarifying and developing the art and science of professional nursing practice and believed that a scientific approach was essential to the practice of psychiatric nursing (National Association of Clinical Nurse Specialists [NACNS], 2020). Her contributions went far beyond what she brought to the field of psychiatric nursing. She introduced the concept of advanced nursing practice and promoted professional standards and regulation through credentialing, among a multitude of other foundational contributions to nursing (NACNS, 2020).

It should be noted that psychiatry was one of the first medical specialties to extensively use randomized controlled trials. One of the founding principles of clinical psychology in the 1950s was that practice should be based on the results of experimental comparisons of treatment methods (Jackson, 2011). However, with limited scientific evidence for practice at that time, much of nursing care was based on tradition, personal experience, unsystematic trial and error, and the earlier experiences of nurses and others in the health care profession (Jackson, 2011). During that time, there was an increase in the publication of research-related journals.

EBP is the process of making clinical decisions based on available evidence, clinical experience, and patient preference. The balance between evidence, nursing experience, and patient preferences and values are fluid and the weight of one or more area may increase or decrease depending on the situation (Wilkinson, 2019). There is no magic formula for determining which should carry more influence. Although EBP is equated with effective decision making, avoidance of habitual practice, and enhanced clinical performance, there may be a tendency to overlook practical knowledge that can provide useful information for individualized and effective practice.

Numerous definitions delineate the multistep process of integrating EBP into clinical practice. One that is simply stated and apt is referred to as the **5 A's** (Wichita State University Libraries, 2020):

1. **Ask a question.** Identify a problem or need for change for a specific patient or situation.
2. **Acquire literature.** Search the literature for scientific studies and articles that address the issue(s) of concern.
3. **Appraise the literature.** Evaluate and synthesize the research evidence regarding its validity, relevance, and applicability using criteria of scientific merit.
4. **Apply the evidence.** Choose interventions that are based on the best available evidence with the understanding of the patient's preference and needs.
5. **Assess the performance.** Evaluate the outcomes, using clearly defined criteria and reports, and document the results.

Evaluating the evidence is done through a hierarchical rating system (Fig. 1.1 and Table 1.1). Systematic reviews or meta-analyses of randomized controlled studies and evidence-based clinical practice

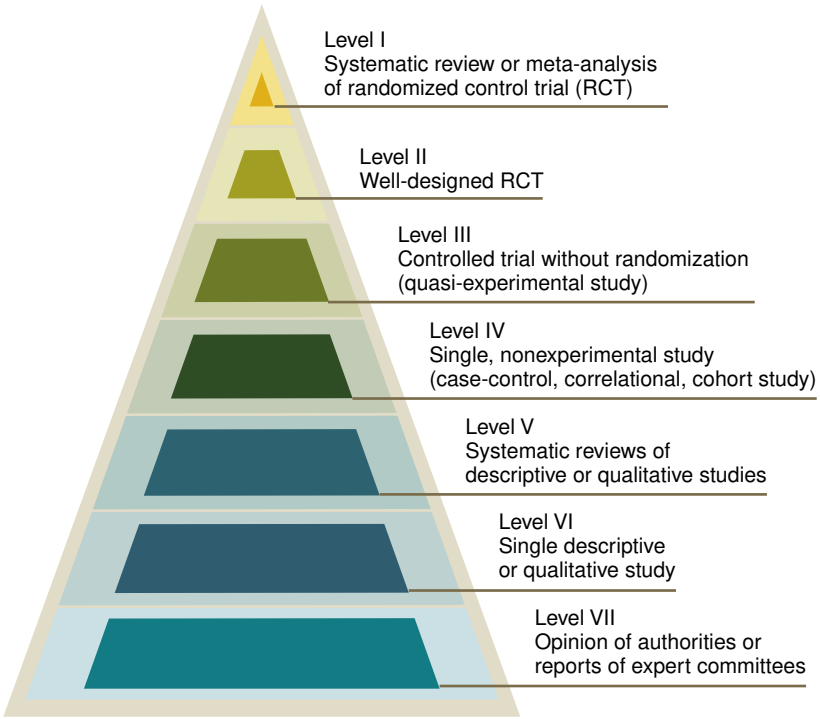

Fig. 1.1 Hierarchy of evidence. (From Melnyk, B. M., & Fineout-Overholt, E. [2014]. *Evidence-based practice in nursing & healthcare: A guide to best practice* [3rd ed.]. Philadelphia: Lippincott Williams & Wilkins; and Newhouse, R. P., Dearholt, S. L., Poe, S. S., et al. [2007]. *Johns Hopkins nursing: Evidence-based practice model and guidelines*. Indianapolis, IN: Sigma Theta Tau International.)

guidelines provide the strongest evidence on which to base clinical practice. In a randomized controlled trial (RCT), patients are chosen at random (by chance) to receive one of the clinical interventions or be in a control group with no treatment. One intervention would be the intervention under study, and another intervention might be the usual standard of care or a placebo. The weakest level of evidence includes expert committee reports, opinions, clinical experience, and descriptive studies. Although scientific evidence is ranked hierarchically, it is important to note the value of all types of evidence in clinical decision making.

The first Surgeon General's report published on the topic of mental health was in 1999 (U.S. Department of Health and Human Services [USDHHS], 1999). This landmark document was based on an extensive review of the scientific literature and created in consultation with mental health providers and consumers. The document concluded that there are numerous effective psychopharmacological and psychosocial treatments for most mental disorders. However, it raised some questions for psychiatric nurses, including the following:

- Are psychiatric nurses aware of the efficacy of the treatment and interventions they provide?
- Are they truly practicing evidence-based care?
- Is there documentation of the nature and outcomes of the care they provide?

TABLE 1.1 Hierarchy of Evidence and Grading of Recommendations[a]

HIERARCHY OF EVIDENCE		GRADING OF RECOMMENDATIONS	
Level	**Type of Evidence**	**Level**	**Type of Evidence**
Ia	Evidence from systematic reviews or meta-analyses of randomized controlled trials (RCTs)	A	Based on hierarchy I evidence
Ib	Evidence from at least one RCT		
IIa	Evidence from at least one controlled study without randomization	B	Based on hierarchy II evidence or extrapolated from hierarchy I evidence
IIb	Evidence from at least one other type of quasi-experimental study		
III	Evidence from nonexperimental descriptive studies, such as comparative studies, correlational studies, and case-control studies	C	Based on hierarchy III evidence or extrapolated from hierarchy I or II evidence
IV	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities	D	Directly based on hierarchy IV evidence or extrapolated from hierarchy I, II, or III evidence

[a]Each recommendation has been allocated a grading that directly reflects the hierarchy of evidence on which it has been based. Please note that the hierarchy of evidence and the recommendation gradings relate the strength of the literature, not the clinical importance.
From Hierarchy of evidence and grading of recommendations. (2004). *Thorax, 59*(Suppl. 1), i13–i14.

The emphasis on EBP is expanding. However, this approach does not provide easy answers. For example, consider the following points:

- Who interprets "best evidence"?
- Not all nursing problems can be reduced to a clear issue that is solvable by scientific experiments.
- Relatively little higher-level nursing research addressing psychiatric nursing interventions and practice has been available.
- Despite the expectation to use EBP, little education is provided in undergraduate programs or in the workplace to prepare nurses for this process.
- How do nurses who are practicing in complex environments of reduced staffing and budgetary constraints find time to research and evaluate the literature and make decisions on "best evidence"?

Three basic aspects (or prongs) of EBP are the following:

- Evidence gleaned in review of the literature
- Clinical knowledge of the nurse from training and experience
- The desires of patients and the values for their care.

Case-study examples of how evidence-based practice is applied are highlighted in the Applying Evidence-Based Practice boxes throughout the clinical chapters.

Resources for Clinical Practice

1. *Internet resources.* A number of websites provide mental health resources for information, treatment provisions, and the results of recent clinical studies. Some of the most extensive databases for psychiatric and medical resources include Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Cochrane reviews. There are self-tests for people to see if they may be experiencing symptoms of a specific disorder, such as depression, anxiety, or attention-deficit/hyperactivity disorder (ADHD). There are also resources for acquiring support and treatment. It is best to focus on sites that are maintained by professional societies, librarians, textbook publishers, or well-known organizations with a reputation for quality, evidence-based information.
2. *Clinical practice guidelines.* **Clinical practice guidelines** are based on appraising and summarizing the best evidence from literature review studies. They serve as tools for standardizing best evidence for formulating patient care and treatment plans. "Efficient and effective guidelines impact patient safety and quality by increasing the consistency of behavior and replacing idiosyncratic behaviors with best practices" (Keiffer, 2015, p. 328). The use of practice guidelines can increase the quality and consistency of care and facilitate outcome research. Essentially, practice guidelines (1) identify practice questions and explicitly identify all the decision options and outcomes; (2) identify the "best evidence" about prevention, diagnosis, prognosis, therapy, harm, and cost-effectiveness; and (3) provide decision points for deciding on a course of action. The *Clinical Practice Guidelines* of the American Psychiatric Association (APA) and the National Quality Measures Clearinghouse offer such guidelines. The U.S. Department of Health and Human Services sponsors a National Guidelines Clearinghouse of evidence-based guidelines pertaining to a wide range of medical and mental health conditions (http://www.guidelines.gov).
3. *Clinical algorithms.* **Clinical algorithms** are step-by-step guidelines prepared in a flowchart or decision-tree format. Alternative diagnostic and treatment approaches are described based on decision points using a large database relevant to the symptoms, diagnosis,

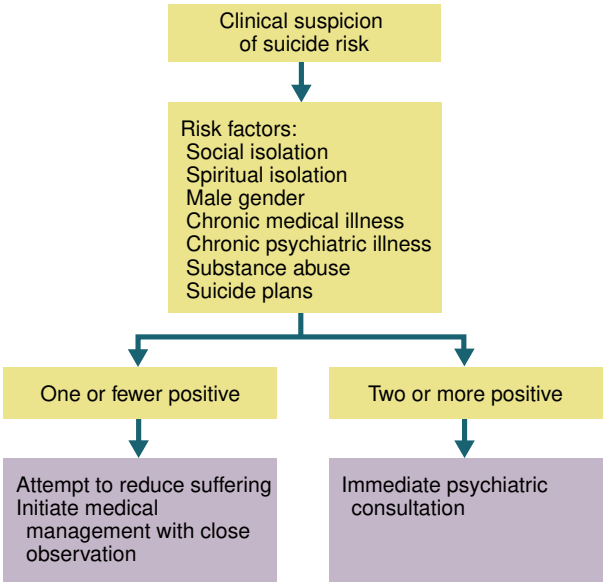

Fig. 1.2 Clinical algorithm for the suspicion of suicide risk. (Modified from Goldman, L., & Ausiello, D. [2008]. *Cecil medicine* [23rd ed.]. Philadelphia: Saunders.)

or treatment modalities. Fig. 1.2 depicts a clinical algorithm for the suspicion of suicide risk.

4. *Clinical/critical pathways.* **Clinical/critical pathways** are specific to the institution using them. These clinical pathways serve as a "map" for specified treatments and interventions to occur within specific time frames that have been shown to improve clinical outcomes. The interventions can include tests, health teaching, and medications. Each pathway lists the expected outcome using a measurable, time-specific format, and documentation is ongoing. Clinical pathways are one way that EBP can be integrated into clinical care.

The Research–Practice Gap

Unfortunately, there is a wide gap between the best-evidence treatments and their effective translation into practice. The need for continued research on how best to apply the findings of clinically relevant issues and their delivery into clinical practice has been the emphasis of the Institute of Medicine (IOM, 2006):

> … Research that has identified the efficacy of specific treatments under rigorously controlled conditions has been accompanied by almost no research identifying how to make these same treatments effective when delivered in usual settings of care … when administered by service providers without specialized education in the therapy. (p. 350)

A specialized area known as translational research looks at applying evidence to clinical or bedside practice.

Effective research is best reported in language that is understandable and free of unnecessary jargon:

- Simpler is better.
- Focus on what readers need to know.
- Reduce possible misinterpretations.

Despite the complexities and concerns that must be addressed when implementing best practice, evidence-based nursing is a standard and essential component of nursing practice.

To help the reader understand how best evidence is identified and applied to nursing interventions, this textbook contains a feature box titled **Applying Evidence-Based Practice.** It is hoped that this feature, presented in each of the clinical chapters, will underscore the importance of sound scientific inquiry and ignite the reader's interest in research.

APPLYING EVIDENCE-BASED PRACTICE (EBP)

Problem

A 63-year-old female patient was discharged from a psychiatric hospital. She was homeless and not enrolled in insurance or outpatient mental health services. The message number in the electronic health record (EHR) was no longer valid, so follow-up appointments were not scheduled. A week after discharge, the patient's medication was stolen, and she became suicidal and confused and called the crisis line at her community mental health clinic.

EBP Assessment

A. **What do you already know from experience?** Homeless patients have limited contact information and multiple health concerns.
B. **What does the literature say?** Some of the reasons cited for not attending follow-up appointments are illness, inadequate transportation, forgetting the appointment, and not feeling engaged with providers. Nurses can advocate for patients by addressing gaps in care.
C. **What does the patient want?** The patient wanted her medications and assistance with obtaining resources.

Plan

The crisis team assisted the patient in obtaining medications, finding transportation to a shelter, and enrolling in outpatient mental health services. The nurse practitioner (NP) developed a demographic page in the EHR designed to capture complex contact information for homeless patients, such as where they sleep and eat meals on specific days.

QSEN Prelicensure Knowledge, Skills, and Attitudes (KSAs) Addressed

Safety by minimizing the patient's risk through individual and system performance

Informatics by using technology to manage patient information and prevent error

From Batscha, C., McDevitt, J., Weiden, P., et al. (2011). The effect of an inpatient transition intervention on attendance at the first appointment post-discharge from a psychiatric hospitalization. *Journal of the American Psychiatric Nurses Association, 17*(5), 330–337; Cronenwett, L., Sherwood, G., Barnsteiner, J., et al. (2007). Quality and safety education for nurses. *Nursing Outlook, 55*(3), 122–131; Lamb, V., & Joels, C. (2014). Improving access to health care for homeless people. *Nursing Standard, 29*(6), 45–51; and National Healthcare for the Homeless Council. (2014). *Health reform & homelessness: Twelve key advocacy areas for the HCH community.* Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/2014-health-reform-policy-statement.pdf

Recovery Model

The mental health **recovery model** is more of a social model of disability than a medical model of disability. Therefore, the focus shifts from one of illness and disease to an emphasis on rehabilitation and recovery. The recovery model is focused on helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). The underlying principle is that people can recover from mental illness and substance abuse to lead full, satisfying lives.

The recovery model originated from the 12-step program of Alcoholics Anonymous and a grassroots advocacy initiative called the consumer/survivor/ex-patient movement during the 1980s and 1990s. It is now one of the leading models promoted by SAMHSA (2017). The concept of recovery refers primarily to managing symptoms, reducing psychosocial disability, and improving role performance (SAMHSA, 2017). Holistic interventions, such as encouraging supportive relationships, are designed to promote recovery, as evidenced by functioning in work, engagement in community/social life, and a reduction of symptoms (SAMHSA, 2017). Empowering patients to realize their full potential and independence within the limitations of their illness is the main goal of this model. Recovering from a mental illness is viewed as a personal journey of healing.

The focus of the recovery model has the following mandates (Jacob, 2015):

- Mental health care is to be consumer and family driven, with patients being partners in all aspects of care.
- Care must focus on increasing consumer success in coping with life's challenges and building resilience, not just managing symptoms.
- An individualized care plan is to be at the core of consumer-centered recovery.

Trauma-Informed Care

Another model that is gaining momentum is **trauma-informed care**, a framework developed by the National Center for Trauma-Informed Care (NCTIC), a division of SAMHSA. Trauma-informed care recognizes that trauma is almost universally found in the histories of mental health patients and is a contributor to mental health issues, substance abuse, chronic health conditions, and contact with the criminal justice system. Trauma occurs in many forms, including physical, sexual, and emotional abuse; war; natural disasters; and other harmful experiences. Trauma-informed care provides guidelines for integrating an understanding of how trauma affects patients into clinical programming. A main concept of this approach is a change in paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Key principles also include avoiding retraumatizing through restraints or coercive practices, an open and collaborative relationship between the patient and provider, empowerment, and cultural respect.

The ANA (2015), Institute of Medicine (IOM, 2006, 2011), and QSEN (2020) all support patient-centered care as best practice. Nurses are increasingly expected to understand and synthesize best practice from the literature, care models and theories, neurobiology of psychiatric disorders and medications, and other professional domains into clinical practice.

Quality and Safety Education for Nurses

There is a national initiative toward patient safety and quality, known as QSEN. The overall goal of QSEN is to prepare future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health care systems in which they work (QSEN, 2020). QSEN defines KSAs in each of the following six standards:

- Patient-centered care
- Teamwork and collaboration
- Evidence-based practice
- Quality improvement
- Safety
- Informatics.

Relevant standards or KSAs are referenced in the **Applying Evidence-Based Practice** boxes in the clinical chapters and woven throughout the text.

CONCEPT-BASED NURSING EDUCATION

A major trend in education in the United States, especially nursing education, is the move toward conceptual learning (Giddens, 2017). This move is encouraged and endorsed by major academic institutions, including the IOM, the National League for Nursing (NLN), the American Association of Colleges of Nursing, and the Carnegie Foundation. "Instead of the traditional method of learning which concentrates on the ability to recall specific facts in isolation, concept-based learning concentrates on the understanding of broader principles (concepts) that can be applied to a variety of specific examples" (Lippincott Nursing Education, 2017).

According to Elsevier (2018), the following are some benefits of a concept-based curriculum:

- Encourages students to think at more elevated levels
- Facilitates collaborative and active learning
- Helps streamline content
- Focuses on problems across disease categories and populations
- Supports systematic observations of events or conditions that influence a problem
- Underscores the relationships among events or conditions that impact a situation
- Emphasizes nursing actions and interdisciplinary efforts
- Meets the needs of diverse learners
- Causes higher levels of retention.

The Art of Nursing

Contemporary nursing relies on a scientific foundation and critical thinking. However, the art of nursing is equally important in delivering comprehensive and holistic care. Even the best evidence-based guidelines may not encompass the entire complexity of an individual patient, disorder, or situation. As Williams and Garner (2002, p. 8) conclude, "Too great an emphasis on evidence-based medicine oversimplifies the complex and interpersonal nature of clinical care." The arts of intuition, interpersonal skills, and cultural competence are indispensable parts of effective treatment.

The art of nursing can be difficult to measure or even describe. Terms like caring, professionalism, empathy, kindness, compassion, heart, and relationship are often brought up in describing the art of nursing and even the definitions of these terms can be elusive. Consequently, these attributes are often marginalized, undervalued, and demeaned. The arts of nursing are accomplished through the nurse's **therapeutic use of self**—"essentially, a healthcare provider's use of verbal and nonverbal communication, emotional exchange and other aspects of his or her personality to establish a relationship with the patient that promotes cooperation and healing" ("Therapeutic Use of Self," n.d.) that positively affects patient outcomes.

The health care professional uses self-reflection, self-awareness, and self-evaluation as tools for promoting cooperation, healing, and successful outcomes. It has long been noted that the deciding factor in

therapy outcomes is not the theoretical basis of the clinician/nurse but rather the strength of the clinician–patient relationship. The relationship is strengthened when the patient has developed a sense of safety and respect and feels free to share his or her problems (Shea, 2017). Three areas inherent in the art of nursing addressed here are (1) caring, (2) attending, and (3) advocating.

Caring

Caring is a natural, essential, and fundamental aspect of human existence. An early survey by Schoenhofer and colleagues (1998) used a group process method to synthesize what was meant by *caring* to the participants. The following three themes emerged:

1. Caring is evidenced by empathic understanding, actions, and patience on another's behalf.
2. Caring for another through actions, words, and presence leads to happiness and touches the heart.
3. Caring is giving of self while preserving the importance of self.

The caring nurse is first and foremost a competent nurse. Without knowledge and competence, the demonstration of compassion and caring alone is powerless to help those under a nurse's care. Without a base of knowledge and skills, care alone cannot eliminate another person's confusion, grief, or pain, but a response of care can transform fear, pain, and suffering into a tolerable, shared experience (Smith et al., 2013).

Dr. Jean Watson founded the Watson Caring Science Institute. Watson's caring theory has a spiritual and existential underpinning (Watson Caring Science Institute, 2015). The theory integrates 10 *caritas* (loving principles) that encourage altruism, loving kindness toward self and others, faith and hope, honor, nurturing individual beliefs, helping and trusting relationships, accepting feelings while authentically listening, creative scientific problem solving, teaching and learning using individual styles, physical and spiritual healing environment, assisting with basic human needs, and openness to mystery and miracles.

Comforting as a part of caring includes providing social, emotional, physical, and spiritual support for a patient consistent with holistic nursing care. The provision of comfort measures can be lifesaving and is a basic component of good care. Economic strain and nursing shortages are barriers to the practice of caring and comforting because nurses are burdened with greater workloads and higher-acuity patients. However, caring is both an attitude that one communicates (a way of being with a patient) and also a set of skills that can be learned and developed. Listening to patients takes time, but with practice and experience, nurses can develop the ability to attend to emotional and spiritual needs and get to know their patients while completing an assessment or other tasks.

Attending

Attending refers to an *intensity of presence,* being there for and in tune with the patient. The experience of emotional or physical suffering can be isolating. When a nurse is present and attentive, the feeling of isolation can be reduced. Being present is a practice of awareness, attention, and an intention to understand and connect and goes beyond acts of basic care. It can be shown through body language, posture, touch, reflective listening and eye contact (Gibson, 2020). It is through effective communication that we can fully understand another person's immediate experience, fears, perceptions, and concerns. Attending behaviors are learned and are inherent in a true therapeutic relationship. Chapter 9 discusses attending behaviors in more detail within the context of the nurse–patient relationship.

Advocating

Advocacy in nursing includes a commitment to patients' health, well-being, and safety across their life span; the alleviation of suffering; and the promotion of a peaceful, comfortable, and dignified death (ANA, 2017).

Patient advocacy can occur on many levels, including providing direct patient care; pleading for a course of action; and supporting change in institutional, global, and legislative arenas. The following are examples of patient advocacy activities:

- Providing informed consent, including refusal of treatment
- Respecting patient decisions, even those with which we disagree
- Protecting against threats to well-being
- Being informed about best practices.

These are especially critical when patients lack the knowledge, skills, or ability to speak for themselves.

Patients are afforded protection through providing privacy and confidentiality during participation in research, using standards and reviews, and taking action against questionable or impaired practice.

Lawyers are often viewed as advocates for their clients; however, in nursing, being a **patient advocate** is not a legal role but rather an ethical one. Ethics is an integral part of the foundation of nursing; refer to Chapter 6. The term *patient advocate* was first placed in the 1976 ANA *Code of Ethics for Nurses,* revision, and remains essentially unchanged up to the present. It reads:

> *The nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practices(s) by any member of the health team or the health care system itself, or any action on the part of others that places the rights or best interest of the patient in jeopardy. (ANA, 2015, 3.5)*

It can take a great deal of courage to advocate for patients when we witness behaviors or actions of health care professionals that could have serious consequences.

Advocating demonstrates respect and value for human life while saving lives or bringing comfort to those who are dying. Psychiatric-mental health nurses also function as advocates when they engage in-public speaking, write articles, and lobby congressional representatives to help improve and expand mental health care (ANA, 2017). Throughout the text, a special feature titled **Applying the Art** gives the reader a glimpse of a nurse–patient interaction and the nurse's thought processes while attending to the patient's concerns.

KEY POINTS TO REMEMBER

- Nursing integrates both scientific knowledge and caring arts into a holistic practice.
- Evidence-based practice (EBP) is a process by which the best available research evidence, clinical expertise, and patient preferences are synthesized while making clinical decisions.
- The 5 A's process of integrating best evidence into clinical practice includes (1) asking, (2) acquiring, (3) appraising, (4) applying, and (5) assessing.
- Application of the recovery model assists people with psychiatric disabilities in effectively managing symptoms, reducing psychosocial disability, and finding a meaningful life in a community of their choosing.
- Trauma-informed care recognizes that various traumas contribute to mental illness and substance abuse. Awareness of trauma can assist health care providers in giving appropriate care and avoiding retraumatization of patients.
- Some sources for obtaining research findings are (1) Internet resources, (2) clinical practice guidelines, (3) clinical algorithms, and (4) clinical/critical pathways.
- The art of nursing is accomplished through the *therapeutic use of self.*
- Three specific areas are inherent within the art of nursing: (1) caring, (2) attending, and (3) advocating.

APPLYING CRITICAL JUDGMENT

1. A friend of yours has recently returned from military service. You are startled when you encounter him on the street in a disheveled state. He appears frightened, seems to be talking to himself, and jumps when a car backfires nearby. You are astounded because there is such a change in his demeanor from the last time you saw him. When you approach him, he seems wary and guarded.
   - **A.** How would the contribution of evidence-based practice (EBP) be helpful to learn about your friend's symptoms of posttraumatic stress disorder (PTSD)?
   - **B.** What might be some specific needs that could be met under the recovery model?
   - **C.** What insight could the trauma-informed care model provide into what your friend is experiencing?
   - **D.** Discuss how nurses can incorporate EBP and care models in their practice.
2. A friend of yours says that he heard about a new practitioner in the area who is going to teach individuals with alcohol dependence how to safely drink in moderation. You state that from all you have read, and from what you know from your friends' experiences, controlled drinking is not thought to be an acceptable practice. Your friend contends that the practitioner has stories and testimonials from individuals with alcohol dependence who are able to drink in a controlled manner. You tell him that there is no strong evidence for this practice.
   - **A.** How would you, as a nurse, evaluate this claim? Explain the five steps you would take to determine the strength of this claim.
   - **B.** Using Table 1.1, what would you say about the quality of the evidence given?
   - **C.** If your friend was in recovery and thinking of trying this treatment, what would you say that would make a strong argument against such a decision?
3. You are a new nursing student, and a friend of yours says, "What on earth is the 'art of nursing'? Isn't that some weird new-age stuff?"
   - **A.** Discuss three components that are inherent in the art of nursing.
   - **B.** Explain the concept of the therapeutic use of self in applying the art of nursing.
   - **C.** Give your friend an example of how nurses demonstrate comfort or caring in the clinical area.
   - **D.** Explain why patients need to have nurses act as their advocate. Can you think of an example from your clinical experience?
4. Go to the Centre for Evidence-Based Mental Health at http://www.cebmh.com and review at least one available clinical trial.

CHAPTER REVIEW QUESTIONS

1. In which scenario is it most urgent for the nurse to act as a patient advocate?
   - **a.** An adult cries and experiences anxiety after a near-miss automobile accident on the way to work.
   - **b.** A homeless adult diagnosed with schizophrenia lives in a community expecting a category 5 hurricane.
   - **c.** A 14-year-old girl's grades decline because she consistently focuses on her appearance and social networking.
   - **d.** The parents allow the prescription to lapse for 1 day for their 8-year-old child's medication for attention-deficit/hyperactivity disorder.
2. The nurse interacts with a veteran of World War II. The veteran says, "Veterans of modern wars whine and complain all the time. Back when I was in service, you kept your feelings to yourself." Select the nurse's best response.
   - **a.** "American society in the 1940s expected World War II soldiers to be strong."
   - **b.** "World War II was fought in a traditional way, but the enemy is more difficult to identify in today's wars."
   - **c.** "We now have a better understanding of how trauma affects people and the importance of research-based, compassionate care."
   - **d.** "Intermittent explosive devices (IEDs), which were not in use during World War II, produce traumatic brain injuries that must be treated."
3. A patient reports sleeplessness, fatigue, and sadness to the primary care provider. In our current health care climate, what is the most likely treatment approach that will be offered to the patient?
   - **a.** Group therapy
   - **b.** Individual psychotherapy
   - **c.** Complementary therapy
   - **d.** Psychopharmacological treatment
4. The nurse prepares outcomes to the plan of care for an adult diagnosed with mental illness. Which strategy recognizes the current focus of treatment services for this population?
   - **a.** The patient's diagnoses are confirmed using advanced neuroimaging techniques.
   - **b.** The nurse confers with the treatment team to verify the patient's most significant disability.

c. The nurse prioritizes the patient's problems in accordance with Maslow's hierarchy of needs.
d. The patient and family participate actively in establishing priorities and selecting interventions.

5. Which scenario best demonstrates empathic caring?
a. A nurse provides comfort to a colleague after an error of medication administration.
b. A nurse works a fourth extra shift in 1 week to maintain adequate unit staffing.
c. A nurse identifies a violation of confidentiality and makes a report to an agency's privacy officer.
d. A nurse conscientiously reads current literature to stay aware of new evidence-based practices.

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Mental Health and Mental Illness

Chyllia Dixon Fosbre

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OBJECTIVES

1. Summarize factors that can affect the mental health of an individual, and explain how they influence a holistic nursing assessment.
2. Discuss dynamic factors (including social climate, politics, cultural beliefs, myths, and biases) that make it difficult to formulate a clear-cut definition of mental health.
3. Identify the processes leading to stigmatization of an individual or group, and discuss some of the effects that stigma can have on medical and psychological well-being.
4. Compare and contrast a *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition *(DSM-5)* diagnosis with a nursing diagnosis.
5. Give examples of how cultural influences and norms can affect making an accurate *DSM-5* diagnosis.

KEY TERMS AND CONCEPTS

culture-bound syndromes (or culture-related syndromes), p. 15
***Diagnostic and Statistical Manual of Mental Disorders,* 5th edition, p. 11**
disability, p. 14
distress, p. 14
epidemiology, p. 12
mental disorders, p. 12
mental health, p. 10
mental illness, p. 10
myths and misconceptions, p. 12
prevalence rate, p. 12
psychiatry's definition of mental health, p. 12
psychobiological disorder, p. 15
resiliency, p. 12
stigma, p. 16

CONCEPT: FUNCTIONAL ABILITY: *Functional ability* refers to the individual's ability to perform the normal activities of life to meet basic needs; fulfill usual roles in the family, workplace, and community; and maintain health and well-being (Giddens, 2017). Mental illnesses are medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Unfortunately, there is a myth about the mentally ill that they function in a different and odd way. Another misconception is that to be mentally healthy, a person must function logically and rationally at all times. There is no obvious, consistent line between mental illness and mental health functioning. As humans, we are far more similar than different, despite any diagnosis.

INTRODUCTION

Mental health and mental illness are not specific entities, but rather, they exist on a continuum. The mental health continuum is dynamic and shifting, ranging from mild to moderate to severe (Fig. 2.1). The diagnosis is an important factor; for example, schizophrenia is generally considered more impairing than anxiety. However, this is not always the case. An individual with schizophrenia with a good support system and treatment plan may be functioning at a higher level than someone with generalized anxiety who is in an abusive relationship with no mental health treatment. In addition, the same individual may function at different levels from week to week or year to year. Many biological and environmental factors influence mental health.

The U.S. Department of Health and Human Services (USDHHS, 2020) explains that **mental health** is multifaceted and involves our emotional, psychological, and social well-being. It can be affected by a variety of influences, such as genetics, brain chemistry, and life experiences (e.g., trauma or abuse or a family history of mental health issues). Positive mental health leads to reaching full potential, coping with stressors, increased productivity, and making meaningful contributions to society (USDHHS, 2020). According to the National Alliance on Mental Illness (NAMI, 2021a), **mental illnesses** affect a person's thinking, feeling, and mood, which can make it difficult to relate to others and maintain daily functioning. Basically, mental illness can be seen as the result of flawed biological, psychological, or social processes. Fortunately, mental illness is treatable, and individuals can experience symptom relief and a return to a high level of functioning (NAMI, 2021a).

In this chapter, the reader is introduced to the concepts of mental health and mental illness, the idea of mental disorders as medical conditions, the categorization of mental illness using the *Diagnostic and Statistical Manual of Mental Disorders*, and the use of cultural beliefs to determine the factors that constitute normal and abnormal behavior.

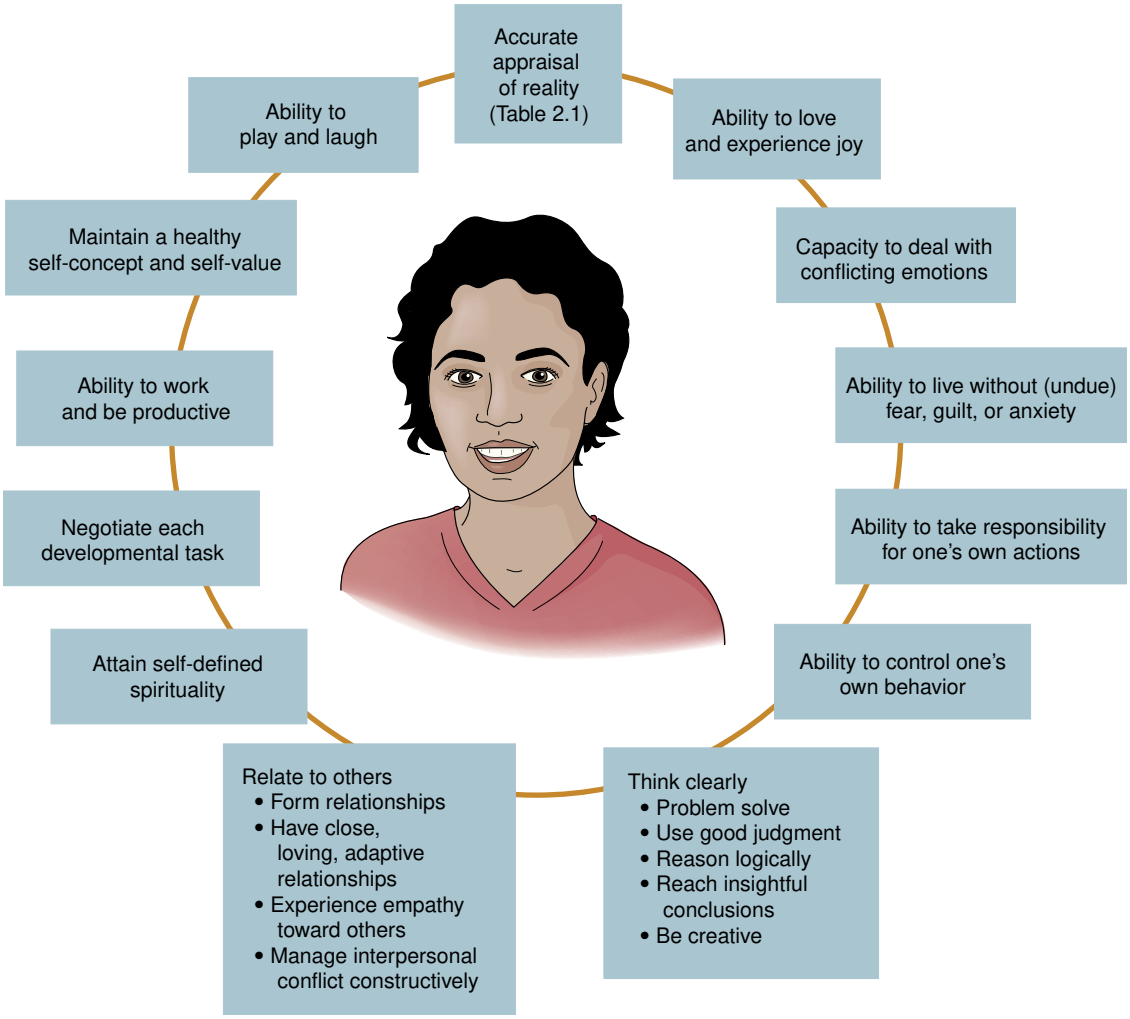

Fig. 2.1 Some attributes of mental health.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

The ***Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)*** is the current official guidebook for categorizing and diagnosing psychiatric mental health disorders in the United States (American Psychological Association [APA], 2013). *The DSM-5 provides clinicians, researchers, regulatory agencies, health insurance companies, pharmacological companies, and policy makers with a standard language and criteria for the classification of mental disorders.* The *DSM-5* is used by psychiatrists, psychiatric nurse practitioners, therapists, and other clinicians as a guide for assessing, diagnosing, and planning care. The *DSM-5* lists specific diagnostic criteria for each mental disorder, which were developed using research and clinical observation. The *DSM-5* is the most recent edition, being published in 2013 after 10 years of professional discussion and debate, and some notable changes were made in this edition. One of these changes was the deletion of the five-axis system of diagnosis utilized in prior versions of the *DSM*. The intent of the axis system was to provide a global picture of an individual's functioning. Another significant change is that the coding system now mirrors *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision, Clinical Modification *(ICD-10)* codes, which are often used as part of the billing and tracking process. Although the axis system is no longer in use, it may be found in older medical documents, so a basic understanding may be helpful:

- **Axis I** lists the psychiatric diagnosis or diagnoses, for example, major depressive disorder, schizophrenia, and alcohol dependence.
- **Axis II** lists personality disorders and mental retardation to ensure long-standing issues that may co-occur with the Axis I disorders are considered, such as borderline personality disorder.
- **Axis III** lists any medical conditions the patient may have, which may or may not influence the mental health diagnosis (e.g., coronary artery disease and hypothyroidism).
- **Axis IV** lists psychosocial stressors in a brief narrative form (e.g., homelessness, going through divorce or job loss, parent–child relationship problems, or educational problems).
- **Axis V** contains the Global Assessment of Functioning (GAF). The GAF is rated on a scale of 1 to 100 and indicates the patient's level of functioning. The higher the score, the higher the level of functioning.

CONCEPTS OF MENTAL HEALTH AND ILLNESS

The Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services (2018) identifies mental illness as one of the leading causes of disability in the United States. Over 18% of years lost to disability are attributed to mental illness. Unfortunately, our understanding of mental illness is plagued by various

myths and misconceptions. One myth is that to be mentally ill is to be different or odd. Another misconception is that to be mentally healthy, a person must be logical and rational at all times. Everyone experiences stressing events, events that cause changes in our mood, or things that impair our ability to function at 100%. There is no obvious and consistent line between mental illness and mental health, and as humans, we are far more similar than different despite any diagnosis or label.

Psychiatry's definition of mental health evolves over time and reflects changes in cultural norms, society's expectations and values, professional biases, individual differences, and even the political climate of the time. For example, criticisms have arisen from various groups that believe that they have been stereotyped in the psychiatric community, with an emphasis on the group's psychopathology rather than on health attributes. At points in history, women who worked outside of the home and homosexuals were considered mentally ill. In today's society, these groups are considered normal. You will find many attributes of mental health in people with mental illness. It is important to develop and encourage these strengths. Additionally, persons who are "normal" may also experience dysfunction during their lives. We are all different and reflect different cultural influences, even within the same culture. We grow at different rates, intellectually, emotionally, and spiritually. Understandably, then, there can be no one definition of mental health that fits all. The mental health and mental illness continuum is depicted in Table 2.1.

An important characteristic of mental health is the concept of resiliency. **Resiliency** is the ability to bounce back from stressful circumstances (Stanford Medicine, 2021). Research has demonstrated that this ability to recover from painful experiences is not an unusual quality but is a trait possessed by many people and can be developed in almost everyone. Disasters occur all too frequently, such as terrorist attacks, natural disasters, or senseless shootings. Being resilient does not mean that people are unaffected by stressors. Rather than becoming paralyzed by the negative emotions, resilient people recognize the feelings, readily deal with them, and learn from the experience. A successful transition through a crisis builds resilience for the next difficult trial.

EPIDEMIOLOGY AND PREVALENCE OF MENTAL DISORDERS

Epidemiology studies the distribution (numbers of cases) of disorders in human populations. Epidemiologists can use this quantitative information to identify high-risk groups and factors and to learn about the etiology (cause) of **mental disorders**. In the field of *clinical* epidemiology, studies are conducted using groups of individuals with particular mental illnesses, symptoms, or treatments. The results of these studies are included in the *DSM-5* to help clinicians understand the frequency and factors associated with a specific diagnosis. For example, epidemiological studies have demonstrated that depression is a significant risk factor for death in patients with cardiovascular disease and breast cancer.

The **prevalence rate** is the proportion of a population with a mental disorder at a given time. One in five adults will experience one or more mental health conditions in a year (NAMI, 2021b). Many individuals have more than one mental disorder at a time, known as dual diagnoses

TABLE 2.1 Continuum of Mental Health and Mental Illness

Ability to Function ⟷	Disability/Dysfunction
Happiness	
Finds life enjoyable	Loss of interest or pleasure
Optimistic about needs being met	Discouraged or hopeless mood
Control Over Behavior	
Ability to recognize cues and act appropriately	Aggressive or violent behaviors
Appraisal of Reality	
Sees environment accurately	Inaccurate perceptions of environment
Understands consequences	Hallucinations or delusions
Effectiveness in Work	
Performs within abilities	Deterioration in work performance
Recovery from minor failures	Inability to maintain steady employment
Healthy Self-Concept	
Reasonable self-confidence	Lacks self-confidence
Resourcefulness	Inability to function independently
Satisfying Relationships	
Stable, strong relationships	Unstable or intense relationships
Variety of social supports	Lack of support
Effective Coping Strategies	
Ability to problem solve and cope in ways that are not harmful (deep breathing, meditation)	Poor coping that creates further dysfunction (substance abuse, self-harm)

Modified from Redl, F., & Wattenberg, W. (1959). *Mental hygiene in teaching* (pp. 198–201). New York: Harcourt, Brace & World; Pierre, J. M. (2012). Mental illness and mental health: Is the glass half empty or half full? *Canadian Journal of Psychiatry, 57*(11), 651–658; and Winzer, R., Lindblad, F., Sorjonen, K., et al. (2014). Positive versus negative mental health in emerging adulthood: a national cross-sectional survey. *BioMed Central Public Health, 14,* 1238.

TABLE 2.2 Prevalence and Epidemiology of Psychiatric Disorders in the United States

Disorder	Prevalence Over 12 Months (%)	Estimated Number of People Affected by Disorder in the United States	Epidemiology
Schizophrenia	0.64	3.5 million	Affects men and women equally; appears earlier in men
Major depressive disorder	8	21.1 million	Leading cause of disability in the United States; nearly twice as many women
Bipolar affective disorder	2.8	8.2 million	Affects men and women equally
Anxiety disorders; includes panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder (PTSD), generalized anxiety disorder, and phobias	19.1	40 million	Frequently co-occurs with depressive disorders, eating disorders, and/or substance abuse
Obsessive-compulsive disorder	1.2	3.2 million	First symptoms begin in childhood or adolescence
PTSD	3.6	11.0 million	Can develop immediately or be delayed onset; approximately 30% of Vietnam veterans experienced PTSD; common after the 9/11/01 terrorist attacks
Generalized anxiety disorder	3.1	9.8 million	Risk is highest between childhood and middle age
Social phobia	6.8	21.4 million	Typically begins in childhood or adolescence
Agoraphobia	0.8	2.5 million	
Specific phobia	8.7	27.4 million	
Any substance abuse	9.4	24.6 million	
Alcohol dependence	6.3	16.5 million	
Serious thoughts of suicide	4.8	8.7 million	There are 2.5 times more suicides than homicides
Any mental illness	20.6	51.1 million	

Data from National Alliance on Mental Illness. (2021a). *Mental health conditions*. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions; and National Alliance on Mental Illness. (2021b). *Mental health by the numbers*. Retrieved from https://www.nami.org/mhstats; and Congressional Research Service. (2018). *Prevalence of mental illness in the United States: Data sources estimates*. Retrieved June 20, 2018 from https://www.fas.org/sgp/crs/misc/R43047.pdf.

or co-occurring disorders. The lifetime prevalence rate for mental illness in the United States is approximately 50% (Centers for Disease Control and Prevention [CDC], 2018), and the World Health Organization (WHO, 2018) reports that underdeveloped countries have even higher rates of mental illness.

Table 2.2 shows the epidemiology and prevalence rates of selected psychiatric disorders. Supported by the National Institute of Mental Health (NIMH), the study of epidemiology in mental health has progressed over the past 2 decades from simply counting the number of cases to delineating and understanding comorbidities, disease burden, and effective treatment.

Only 43.8% of people with a mental illness receive treatment in a given year (NAMI, 2021a). Delay to first treatment is about 11 years from the time symptoms first appear (NAMI, 2021a). Patients are more likely to receive help from a general medical professional or spiritual advisor than a psychiatrist because of already-established relationships and a shortage of psychiatric professionals. This illustrates that, as a nurse, you will encounter psychiatric components in your career regardless of the specialty area or clinical setting.

MENTAL ILLNESS POLICY AND PARITY

In 1996 the Mental Health Parity Act was passed by Congress, and a series of laws and commissions supporting parity followed over the next decade. This legislation required insurers to offer mental health benefits at the same level provided for medical coverage. In 2000 the Government Accountability Office found that although 86% of health plans complied with the 1996 law, they also imposed limits on mental health coverage. This has since improved with the implementation of the Affordable Care Act (ACA), which banned annual dollar limits on medical and mental health care and eliminated the lack of coverage for preexisting conditions that had been put into effect by insurance companies during this time (USDHHS, 2015). At the writing of this text, there have been proposed budget changes that are causing some concern, with cuts in funding to the Substance Abuse and Mental Health Services Administration, a major government organization focused on the identification and treatment of mental illness and substance abuse. However, there are some additional budget items that target the opioid crisis and provide programs for people diagnosed with a serious mental illness (USDHHS, 2018).

Many of the most prevalent and disabling mental disorders have been found to have strong biological influences. Some of these include schizophrenia, bipolar disorder, depression, posttraumatic stress disorder, autism, and anorexia. We can look at these disorders as "diseases" with an underlying biological component. However, this interpretation overlooks many other influences that affect the severity and progress of a mental illness and can affect a "normal" person's mental status as well. Some of these factors include support systems, family influences, developmental events, cultural beliefs and values, health practices, and negative influences impinging on an individual's life (Fig. 2.2).

The *DSM-5* cautions that the emphasis on the term *mental disorder* implies a distinction between "mental" disorder and "physical" disorder, which is an outdated concept, and stresses mind–body dualism. In physical health there is a component of mental health, and in mental health there is a physical component. The two cannot be separated as one versus another (APA, 2013).

Fig. 2.2 Factors affecting mental health.

MEDICAL DIAGNOSIS AND NURSING DIAGNOSIS IN MENTAL ILLNESS

To perform their professional responsibilities, clinicians and researchers need clear and accurate guidelines for identifying and categorizing mental illness. Such guidelines help clinicians plan and evaluate treatment for their patients. A necessary element for categorization includes agreement regarding which constellation of symptoms indicates a mental illness.

Medical Diagnoses and the *DSM-5*

In the *DSM-5,* the mental disorders are clinically significant behavioral or psychological syndromes or patterns that occur in an individual and that are associated with **distress** (a painful symptom); **disability** (impairment in one or more important areas of functioning); or an increased risk of suffering death, pain, disability, or a loss of freedom or independence. This syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, such as grief after the death of a loved one, but rather a manifestation of behavioral, psychological, or biological dysfunction in the individual as identified within the individual's cultural boundaries. Deviant behavior (e.g., political, religious, or sexual) and conflicts between the individual and society are not considered mental disorders according to the *DSM-5* unless the deviance or conflict is a symptom of a dysfunction in the individual.

It is important to stress that the *DSM-5* classifies disorders that people have, not the person. For this reason, the *DSM-5* avoids the use of expressions such as "a schizophrenic" or "an alcoholic" and instead uses the more accurate terms "an individual with schizophrenia" or "an individual with alcohol dependence." There is a recent movement in which people with an illness prefer to identify with that illness, such as individuals referring to themselves as an "Aspie" instead of a person with Asperger's. Terms like this should be used with caution and only when accepted by the individual being referred to by such a term. The *DSM* system began with the *DSM-I* in 1952 and included descriptions of 106 disorders called "reactions." The publication has progressed through extensive collaboration among experts to arrive at the current version, the *DSM-5,* published in 2013. The revision process from the *DSM-IV* and *DSM-5* took a decade and brought together hundreds of international scientists during conferences supported by the National Institutes of Health (NIH). This current version delineates almost 300 diagnoses, with well-organized listings of diagnostic criteria, and is used for clinical assessment, teaching, and research purposes.

The *DSM-5* in Culturally Diverse Populations

Special efforts have been made in the *DSM-5* to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Most anthropologists agree that culture includes traditions of thought, behavior, knowledge, and practices that are socially acquired, shared, and passed on to new generations (APA, 2013). The concept of culture is most often considered with racial or ethnic minority groups. However, the concept of culture also includes sexual orientation, age groups, physical abilities or disabilities, gender, religion, or socioeconomic status. Almost any group of persons with some type of shared belief can be included in the definition of culture. Therefore clinicians are urged to consider these influences when evaluating individuals (Gopalkrishnan, 2018). Assessment can be especially challenging when a clinician from one ethnic/cultural group evaluates an individual from a different group. The *DSM-5* and prior versions are strongly biased toward a Western view of what is acceptable behavior. Some criteria considered as mental illness could, in fact, be normal in another culture. One way the *DSM-5* attempts to correct for this is through the inclusion of the Cultural Formulation Interview (CFI). The CFI assesses the client's cultural perception of distress; social supports such as family and religion; and relationship factors between the patient and provider, including language and discrimination experiences in the societal majority. The *DSM-5* also provides a brief glossary of cultural concepts of distress, which includes culture-bound symptoms such as *ataque de nervios* ("attack of the nerves") or *sustos* ("fright") in Latino cultures and *shenjing shuairuo* ("weakness of the nervous system") in Mandarin Chinese culture.

Nursing Diagnoses

The psychiatric community uses the *DSM-5* to identify a common language for mental health providers and researchers. It is a way to describe and identify types of mental illness. The International Council of Nurses (2018) provides a common language called the International Classification for Nursing Practice (ICNP). This allows nurses to identify nursing diagnoses and interventions. Having a common language supports global communication, research, and policy making (International Council of Nurses, 2018). Terms are internationally accepted, which fosters communication between different regions or specialties. This text uses the ICNP terms and definitions as a reference to create a common language for the nursing process. This text will use the ICNP terms throughout, but it is good to keep in mind that, although this text is focused on mental health and appropriate nursing diagnoses within this specialty, there are terms that encompass any area of nursing. Many students may be familiar with NANDA International terms, which are very similar to those used by ICNP.

INTRODUCTION TO CULTURE AND MENTAL ILLNESS

As previously discussed, the *DSM-5* includes information related to culture in the discussion of each individual disorder, in the glossary of cultural concepts of distress, and by providing the CFI.

Health care providers must consider the influence of culture in determining the mental health or mental illness of the individual. Culture can influence how symptoms are viewed, the ability to cope with

symptoms, and health-seeking behaviors (Gopalkrishnan, 2018). In developed countries, the culture supports the thought that a biological basis for mental illness and treatment is sought from health professionals such as therapists, nurse practitioners, and psychiatrists. In indigenous cultures, there is often a spiritual foundation to mental illness, and care is more likely to come from healers, such as curanderos, shamans, or other traditional practitioners. Eye contact can differ from culture to culture and should be considered during assessments. In some cultures, making eye contact is a sign of respect. In some Native American cultures, avoiding eye contact is a sign of respect. In Hispanic cultures, *mal de ojo* or the "evil eye" is caused by a look that inflicts injury, illness, or bad luck. In autism, delayed or impaired social skills, such as making eye contact, can be viewed as an indicator of the disorder. Something seemingly simple like eye contact can have a wide range of meanings.

A number of **culture-bound syndromes** (**or culture-related syndromes**) appear only in particular cultures and do not appear globally in all societies or parts of the world. For example, one form of mental illness recognized in parts of Southeast Asia is *running amok,* in which someone (usually a male) runs around engaging in furious, almost indiscriminate violent behavior. *Pibloktoq* is an uncontrollable desire to tear off one's clothing and expose oneself to severe winter weather; it is a recognized form of psychological disorder in parts of Greenland, Alaska, and the Arctic regions of Canada. In our own society, we recognize *anorexia nervosa* as a **psychobiological disorder** that entails voluntary starvation. This disorder is well known in Europe, North America, and Australia but is unheard of in many other societies.

What is to be made of the fact that certain disorders occur in some cultures but are absent in others? One interpretation is that the conditions necessary for causing a particular disorder occur in some places but are absent in others. Another interpretation is that people learn certain kinds of abnormal behavior by imitation. However, the fact that some disorders may be culturally determined does not prove that all mental illnesses are culturally based. The best evidence suggests that schizophrenia and bipolar affective disorders are found throughout the world. The symptom patterns of schizophrenia have been observed among indigenous Greenlanders and West African villagers, as well as in Western cultures. Schizophrenia could be interpreted as possession or even a positive spiritual connection in some societies.

PSYCHIATRY AND SPIRITUALITY/RELIGION

An important part of any culture is religious or spiritual beliefs. Historically, Western psychiatry tended to respect the medical approach while largely ignoring the importance of religion or spirituality in an individual's mental health. The profession of nursing has traditionally held a more holistic focus, which includes recognizing religious and/or spiritual needs of patients. Nursing leaders have contributed significantly to the body of research surrounding this concept. In more recent years, psychiatry has acknowledged and integrated the importance of religious and spiritual beliefs in the philosophy of health and healing.

Spirituality can include but is not limited to religion. Spirituality can be defined as a belief in a higher power, connection to the universe or universal energy, feeling "one" with nature, or calling on ancestors for wisdom and can include practices such as meditation, prayer, and helping others. There are many ways to achieve a spiritual connection that must be considered during assessment and diagnosis. For example, among certain cultural groups, hearing or seeing a deceased relative during bereavement is common and accepted, yet this may be misdiagnosed as a psychotic disorder by an unknowing clinician. These types of cultural misunderstandings have contributed to the distrust that minority or immigrant groups can hold toward psychiatric professionals.

Altered states of consciousness, such as those achieved through mysticism, meditation, and mindfulness, can be spiritually enriching and bring peace and serenity into people's lives but should not be confused with dissociative states caused by trauma. Meditation has many health benefits, is a valuable tool for dealing with chronic pain and stress, is a component of dialectic behavioral therapy (DBT) and stress-reduction programs, and plays a role in many other types of therapy.

Prayer is a widely used religious/spiritual ritual. Individuals pray for comfort, to make requests, and to offer praise. Prayer may incorporate singing, dancing, jumping, reciting prescribed words, and praying at certain locations or times. Prayer represents a way to connect with God or a supreme spiritual being or natural energy and to find support and meaning in life. Numerous studies show positive effects on anxiety, depression, posttraumatic stress disorder, and other mental health conditions (Davis, 2020).

A traditional helping strategy that is also identified as evidence-based practice is the use of storytelling. A tribal leader in indigenous cultures or a therapist in Western cultures can use a metaphor to offer a social message, create a narrative to help a child understand and cope with trauma, or help older adults reconnect with positive memories from the past.

APPLYING EVIDENCE-BASED PRACTICE (EBP)

Problem

An elementary school child is having difficulty focusing in class and turning in homework and is disruptive. The child was evaluated and diagnosed with attention-deficit/hyperactivity disorder (ADHD). The parents are refusing to have the child treated because they do not want the child to "be labeled or on medications that will cause him to be addicted."

EBP Assessment

A. **What do you already know from experience?** Parents can be reluctant to admit problems with their children because of embarrassment, fear, and lack of knowledge. Errors can occur in both overmedicating and undermedicating patients. When needed, medications can make a remarkable difference.
B. **What does the literature say?** Stigma and discrimination against people with mental illness are major barriers to success in relationships, treatment, and employment. Patients often avoid treatment as a result of stigma. Research shows that properly treated patients with ADHD are *less* likely to have addiction problems.
C. **What does the patient want?** The child in this case study wanted treatment because of decreasing self-esteem and performance at school. The parents are reluctant and refusing.

Plan

Educate the parents in a nonjudgmental fashion about the benefits of medication and therapy, including preserving the child's self-esteem, social functioning, and school performance. Ultimately, the parents understood the need to help their child and accepted treatment. Medication times were scheduled so that the child did not have to take medication at school, maintaining confidentiality. Unfortunately, stigma remains a concern for anyone receiving mental health treatment.

QSEN Prelicensure Knowledge, Skills, and Attitudes (KSAs) Addressed

Patient-Centered Care by seeing the situation through both the child's and parents' perspectives and maintaining confidentiality

Evidence-Based Practice by using current research to help educate the parents and develop a plan of care that addresses their concerns

STIGMA

Closely related to culture and spirituality is the concept of stigma. **Stigma** is the negative view or stereotypical view of someone with mental illness. It creates prejudice and discrimination. Stigma can be individualized with people having a personal and negative attitude toward those with mental illness. People with mental illness may carry self-stigma, which can show up as a negative attitude and shame towards oneself. There is also an institutional stigma that can be seen in policies of organizations that may limit opportunities or funding for those with mental illness (American Psychological Association [APA], 2020). Stigma has been acknowledged as a major barrier to mental health treatment and recovery. Stigma contributes to fear, rejection, and discrimination against the mentally ill. Stereotyping, labeling, and separating can occur on an individual or institutional level, resulting in an imbalance of power. Stigma can have harmful effects on an individual and family and result in social isolation and reduced opportunities. For example, the stigma of mental illness interferes with the person's ability to establish and maintain friendships, employment, and housing. It also leads to health care disparities, which affect the person's ability to obtain psychological and general medical treatment. Health care disparities are gaps in care for various subcultures.

An example of the cultural influence of stigmatizing in psychiatry is the inclusion of homosexuality as a disorder in earlier versions of the *DSM,* even though research consistently failed to demonstrate that people with a homosexual orientation were any more maladjusted than heterosexuals. Change occurred in the medical and psychiatric communities only through the efforts of gay rights activists. Stigma and bias also affect minority groups, the elderly, children, and women.

Biases are often reflected in our organizational structures and political systems. Awareness of the dangers inherent in stereotyping and stigmatizing attitudes has enormous implications for nursing practice, especially in the field of mental health. It is important to remember that a patient is first and foremost a human being and not the patient's diagnosis. Although diagnoses are used to structure treatment and for billing purposes, labeling should be avoided whenever possible.

KEY POINTS TO REMEMBER

- Mental illness can be difficult to define. The *DSM-5* and cultural norms must be considered in evaluating mental health and illness.
- There are many myths surrounding mental illness, which contribute to the stigmatization of individuals. The stereotyping, discrimination, and rejection accompanying stigma contribute to poor self-image, isolation, and mental anguish. Stigma erects barriers to obtaining employment, housing, and health services. Nurses can use sensitivity and compassion to bridge the shame patients feel and encourage them to seek care.
- Mental health can be conceptualized along a continuum, from mild to moderate to severe to a profound degree of impairment in functioning.
- There are various components and influences that contribute to mental health, which are identified in Fig. 2.1.
- The study of epidemiology can help identify high-risk groups and behaviors and lead to enhanced understanding of causes and best treatment. Prevalence rates help us identify the proportion of a population with a mental disorder at a given time.
- With the current knowledge that many common mental disorders are biologically based, they are now recognized as medical diseases.
- Identifying a common language or set of terms, as has been done with the *DSM-5* and International Nursing Council definitions, helps to improve communication and coordination of care.

APPLYING CRITICAL JUDGMENT

1. A 23-year-old male was brought to the emergency department by ambulance after a suicide attempt. He has been extremely depressed since his girlfriend died in a car accident 5 months ago. He was the driver. Since the accident, he has not been attending college. He has also not shown up for his tutoring job. The patient's existing seizure disorder has worsened since the accident, but he refuses treatment. He states he deserves to be punished for "killing my girlfriend."
   - **A.** What evidence can you identify indicating a decline in the patient's level of functioning?
   - **B.** How might the patient's religious beliefs hinder and/or help his recovery?
   - **C.** Formulate one nursing diagnosis and two interventions reflective of his mental health needs.
   - **D.** Identify a concept from this chapter, such as stigma, support system, or culture, and relate it to this scenario.
   - **E.** Using the mental health continuum, would you rate this patient's symptoms as mild, moderate, or severe?
2. Reflect on an encounter you had with someone from an unfamiliar background in your personal or work life. What did you learn from the experience? How was the person's background similar to or different from your own? How could this affect the therapeutic nursing relationship?
3. Before your first day of clinical in the mental health setting, briefly describe in writing your current thoughts and attitudes about people with mental illnesses and working with them. Where or how do you think you developed these perceptions? After the clinical day, reflect upon the experience. Have your perceptions changed, and if so, in what way?

CHAPTER REVIEW QUESTIONS

1. A mentally ill gunman opens fire in a crowded movie theater, killing six people and injuring others. Which comment about this event by a member of the community most clearly shows the stigma of mental illness?
   a. "Gun control laws are inadequate in our country."
   b. "It's frightening to feel that it is not safe to go to a movie theater."
   c. "All these people with mental illness are violent and should be locked up."
   d. "These events happen because American families no longer go to church together."
2. The nurse presents a class about mental health and mental illness to a group of fourth graders. One student asks, "Why do people get mentally ill?" Select the nurse's best response.
   a. "There are many reasons why mental illness occurs."
   b. "The cause of mental illness is complicated and very hard to understand."
   c. "Sometimes a person's brain does not work correctly because something bad happens or he or she inherits a brain problem."
   d. "Most mental illnesses result from genetically transmitted abnormalities in cerebral structure; however, some are a consequence of traumatic life experiences."
3. An adult experienced a spinal cord injury resulting in quadriplegia 3 years ago and now lives permanently in a skilled care facility. Which comment by this person best demonstrates resiliency?
   a. "I often pray for a miracle that will heal my paralysis so I will be whole again."
   b. "I don't know what I did to deserve this fate or whether I am tough enough to endure it."
   c. "My accident was a twist of fate. I suppose there are worse things than being paralyzed."
   d. "Being paralyzed has taken things from me, but it hasn't kept me from being mentally involved in life."
4. A nursing assistant says to the nurse, "The schizophrenic in room 226 has been rambling all day." When considering the nurse's responsibility to manage the ancillary staff, which response should the nurse provide?
   a. "It is more respectful to refer to the patient by name than by diagnosis."
   b. "Thank you for informing me about that. I will document the behavior."
   c. "It is not unusual for schizophrenics to do that. It's just part of their illness."
   d. "You have a difficult job. I'm glad you are so accepting of our patients' behaviors."
5. Which scenario meets the criteria for "normal" behavior?
   a. An 8-year-old child's only verbalization is "No, no, no."
   b. A 16-year-old girl usually sleeps for 3 or 4 hours per night.
   c. A 43-year-old man cries privately for 1 month after the death of his wife.
   d. A 64-year-old woman has difficulty remembering the names of her grandchildren.

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3

Theories and Therapies

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http://evolve.elsevier.com/Varcarolis/essentials

OBJECTIVES

1. Discuss the contributions of theories and therapies from a variety of disciplines and areas of expertise.
2. Choose two of the major theories that you believe are among the most relevant to psychiatric and mental health nursing care and defend your choice, giving examples.
3. Identify the origins and progression of dominant theories and treatment modalities.
4. Discuss the relevance of these theories and treatments to the provision of psychiatric and mental health care.
5. Demonstrate a comprehensive understanding of Peplau's theoretical base for practice that is beneficial to all settings.
6. Identify three different theoretical models of mental health care, and demonstrate how each could be used in specific circumstances.
7. Distinguish models of care used in clinical settings, and cite benefits and limitations of these models.

KEY TERMS AND CONCEPTS

autocratic leader, p. 28
automatic thoughts, p. 24
aversion therapy, p. 22
behavioral therapy (or behavior modification), p. 22
biofeedback, p. 22
boundaries, p. 30
cognitive-behavioral therapy, p. 24
cognitive distortions, p. 24
community meetings, p. 30
conscious, p. 19
conservation, p. 25
countertransference, p. 21
curative factors, p. 29
democratic leader, p. 29
ego, p. 19
egocentric thinking, p. 25
group content, p. 28
group development, p. 28
group process, p. 28
id, p. 19
interpersonal therapy, p. 22
laissez-faire leader, p. 29
leadership style, p. 28
Maslow's hierarchy of needs theory, p. 22
object permanence, p. 25
person-centered therapy, p. 23
preconscious, p. 19
psychotherapy, p. 19
psychoanalytic therapy, p. 19
psychodynamic therapy, p. 21
recovery model, p. 27
schemata, p. 24
self-actualization, p. 23
self-transcendence, p. 23
superego, p. 19
systematic desensitization, p. 22
transference, p. 21
unconscious, p. 19

CONCEPT: FAMILY DYNAMICS: *Family dynamics* is defined as the forces at work within a family that produce particular behaviors or symptoms. The dynamic is created by the way in which family members live and interact with one another. That dynamic, whether positive or negative, supportive or destructive, nurturing or damaging, changes who people are and influences how they view and interact with the world outside of the family (Giddens, 2017). Family therapy is an adjunct to individual treatment and refers to the treatment of the family as a whole. The major goals of family therapy are to improve family communication skills, heighten awareness and sensitivity to other family members' emotional needs, and strengthen the family's ability to cope with major life stressors and traumatic events.

INTRODUCTION

We expect others (and ourselves) to behave in certain ways, and we seek explanations for behavior that deviates from what we believe to be normal. What causes excessive sadness or extreme happiness? How do we explain mistrust, anxiety, confusion, or apathy, degrees of which may range from mildly disturbing to incapacitating? It is by understanding a problem that we can begin to devise solutions to treat or eradicate it. Mental illness has long defied explanation, even as other so-called physical illnesses were being quantified and often controlled.

It was not until the late 1800s that psychological models and theories were conceived, developed, and disseminated into mainstream

TABLE 3.1 Major Theories of Psychiatric Care

Theory	Theorist	Tenets	Therapeutic Model
Psychoanalytic	Freud	Unconscious thoughts; psychosexual development.	Psychoanalysis to learn unconscious thoughts; therapist is nondirective and interprets meaning.
Interpersonal	Sullivan	Relationships are the basis for mental health or illness.	Therapy focuses on the here and now and emphasizes relationships; therapist is an active participant.
Behavioral	Pavlov, Watson, Skinner	Behavior is learned through conditioning.	Behavioral modification addresses maladaptive behaviors by rewarding adaptive behavior.
Cognitive	Beck	Negative and self-critical thinking cause depression.	Cognitive-behavioral therapists assist in identifying negative thought patterns and replacing them with rational ones; therapy often involves homework.
Biological	Many	Psychiatric disorders are heavily influenced by and/or cause changes to the brain and/or neurotransmitter(s), resulting in changes in thinking and behavior.	Neurochemical imbalances are corrected through medication and talk therapy (e.g., cognitive-behavioral therapy).

thinking. They provided structure for considering developmental processes and possible explanations for our thoughts, feelings, and behaviors. The theorists believed that if complex workings of the mind could be understood, they could also be treated, and from these models and theories, therapies evolved.

Early practitioners used various forms of talk therapy, formally known as **psychotherapy**, that focused on the complexity and inner workings of the mind. These early talk therapies emphasized environmental influences on mental health and illness. Beginning in the early 20th century, biological explanations for mental alterations began to gain acceptance. Currently, the dominant belief is that psychiatric disorders and conditions are the result of both genetic variables and environmental factors.

Mental health professionals continue to rely on theoretical models as a basis for treating psychiatric alterations. This chapter provides an overview of therapeutic models and related treatments and discusses the potential connection between them and the provision of psychiatric nursing care. Table 3.1 provides a snapshot of the major theories.

PROMINENT THEORIES AND THERAPEUTIC MODELS

Psychoanalytic Theory

Sigmund Freud (1856–1939), an Austrian neurologist, is considered the "father of psychiatry." His work was based on psychoanalytic theory, in which Freud claims that most psychological disturbances are the result of early trauma or incidents that are often not remembered or recognized.

Freud (1961) identified three layers of mental activity: the conscious, the preconscious, and the unconscious mind. The **conscious** mind is your current awareness—thoughts, beliefs, and feelings. However, most of the mind's activity occurs outside of this conscious awareness, like an iceberg with its bulk hidden under the water. The **preconscious** mind lies immediately below the surface. Although its content is not currently the subject of our attention, it is accessible with conscious effort. The deepest and biggest chunk of the iceberg is referred to as the unconscious mind. The **unconscious** is where our most primitive feelings, drives, and memories reside, especially those that are unbearable and traumatic. The conscious mind is then influenced by the preconscious and unconscious mind (Fig. 3.1).

One of Freud's later and widely known constructs concerns the interactive agents within the brain known as the id, the ego, and the superego (see Fig. 3.1).

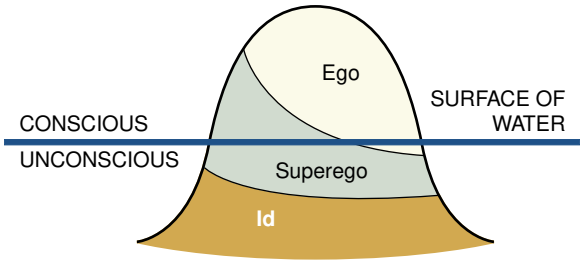

Fig. 3.1 The mind as an iceberg.

- The **id** is the primitive, pleasure-seeking, and impulsive part (according to Freud, predominantly sexual pleasure) of our personalities that lurks in the unconscious mind.
- The **ego** is the problem solver and reality tester that navigates in the outside world. It acts as an intermediary between the id and reality by using ego defense mechanisms, such as repression, denial, and rationalization.
- The **superego** represents the moral component of the personality that Freud referred to as our conscience (our sense of what is right or wrong). The superego is greatly influenced by parents' or caregivers' moral and ethical stances.

In healthy individuals, the three systems of the personality work together under the administrative leadership of the ego. The ego is able to realistically evaluate situations, limit the id's primitive impulses, and keep the superego from becoming too rigid and obsessive.

Freud believed that personality development is based on stages. During these stages, the id focuses on an erogenous zone of the body. These zones are oral, anal, and phallic. Fixation through overindulgence or frustration results in pathological conditions and personality disorders. Freud's work has been criticized for a variety of reasons. One of the harshest criticisms stems from the concept of penis envy, in which females suffer from feelings of inferiority for not having male genitalia. Table 3.2 provides a summary of Freud's developmental stages, along with Sullivan's and Erikson's, two other models that are discussed later in this chapter.

Therapeutic Model

Psychoanalytic therapy was Freud's answer for a scientific method to relieve emotional disturbances. An often time-consuming (e.g., three to five times a week for many years), expensive, and emotionally painful process, the goal of this therapy is to know and understand what is happening at the unconscious level in order to uncover the truth.

TABLE 3.2 Development of Personality According to Freud, Sullivan, and Erikson[9]

Freud	Sullivan	Erikson
Oral: Birth to 1½ Years ***Pleasure–pain principle*** ***Id,*** the instinctive and primitive mind, is dominant Demanding, impulsive, irrational, asocial, selfish, trustful, omnipotent, and dependent Primary thought processes Unconscious instincts—source–energy–aim–object Mouth—primary source of pleasure Immediate release of tension/anxiety and immediate gratification through oral gratification ***Task***—develop a sense of trust that needs will be met	**Infancy: Birth to 1½ Years** Mothering object relieves tension through empathic intervention and tenderness, leading to decreased anxiety and increased satisfaction and security; mother becomes symbolized as "good mother" Goal is biological satisfaction and psychological security Denial of tension relief creates anxiety, and mother becomes symbolized as "bad mother" Anxiety in mother yields anxiety and fear in child via empathy These states are experienced by the child in a diffuse and undifferentiated manner ***Task***—learn to count on others for satisfaction and security to trust	**Infancy: Birth to 1½ Years** ***Trust vs. mistrust*** Egocentric ***Danger***—during second half of first year, an abrupt and prolonged separation may intensify the natural sense of loss and may lead to a sense of mistrust that may last throughout life ***Task***—develop a basic sense of trust that leads to hope Trust requires a feeling of physical comfort and a minimal experience of fear or uncertainty; if this occurs, the child will extend trust to the world and self
Anal: 1½–3 Years ***Reality principle***—postpone immediate discharge of energy and seek actual object to satisfy needs Learning to defer pleasure Gaining satisfaction from tolerating some tension-mastering impulses Focus on toilet training—retaining/letting go; power struggle ***Ego development***—functions of the ego include problem-solving skills, perception, ability to mediate id impulses ***Task***—delay immediate gratification	**Childhood: 1½–6 Years** Muscular maturation and learning to communicate verbally Learning social skills through consensual validation Beginning to develop self-esteem via reflected appraisals: • Good me • Bad me • Not me Levels of awareness: • Awareness • Selective inattention • Dissociation ***Task***—learn to delay satisfaction of wishes with relative comfort	**Early Childhood: 1½–3 Years** ***Autonomy vs. shame/doubt*** Develop confidence in physical and mental abilities that leads to the development of an autonomous will ***Danger***—development of a deep sense of shame/doubt if child is deprived of the opportunity to rebel; learns to expect defeat in any battle of wills with those who are bigger and stronger ***Task***—gain self-control of and independence within the environment
Phallic: 3–7 Years ***Superego develops*** via incorporating moral values, ideals, and judgments of right and wrong that are held by parents; superego is primarily unconscious and functions on the **reward and punishment principle** (sexual identity attained via resolving oedipal conflict) Conflict differs for boy and girl; masturbatory activity ***Task***—develop sexual identity through identification with same-sex parent		**Play Age: 3–6 Years** ***Initiative vs. guilt*** Interest in socially appropriate goals leads to a sense of purpose Imagination is greatly expanded because of increased ability to move around freely and increased ability to communicate Intrusive activity and curiosity and consuming fantasies, which lead to feelings of guilt and anxiety Establishment of conscience ***Danger***—may develop a deep-seated conviction that he or she is essentially bad, with a resultant stifling of initiative or a conversion of moralism to vindictiveness ***Task***—achieve a sense of purpose and develop a sense of mastery over tasks
Latency: 7–12 Years Desexualization; libido diffused Involved in learning social skills, exploring, building, collecting, accomplishing, and hero worship Peer-group loyalty begins Gang and scout behavior Growing independence from family ***Task***—sexuality is repressed during this time; learn to form close relationship(s) with same-sex peers	**Juvenile: 6–9 Years** Absorbed in learning to deal with ever-widening outside world, peers, and other adults Reflections and revisions of self-image and parental images ***Task***—develops satisfying interpersonal relationships with peers that involve competition and compromise **Preadolescence: 9–12 Years** Develop intimate interpersonal relationship with person of same sex who is perceived to be much like oneself in interests, feelings, and mutual collaboration ***Task***—learn to care for others of same sex who are outside the family; Sullivan called this the "normal homosexual phase"	**School Age: 6–12 Years** ***Industry vs. inferiority*** Develops a healthy competitive drive that leads to confidence In learning to accept instruction and to win recognition by producing "things," the child opens the way for the capacity of work enjoyment ***Danger***—the development of a sense of inadequacy and inferiority in a child who does not receive recognition ***Task***—gain a sense of self-confidence and recognition through learning, competing, and performing successfully

TABLE 3.2 Development of Personality According to Freud, Sullivan, and Erikson[a]—cont'd

Freud	Sullivan	Erikson
Genital Phase (Adolescence): 13–20 Years Fluctuation regarding emotional stability and physical maturation Very ambivalent and labile, seeking life goals and emancipation from parents Dependence vs. independence Reappraisal of parents and self; intense peer loyalty ***Task***—form close relationships with members of the opposite sex based on genuine caring and pleasure in the interaction	**Adolescence: 12–20 Years** *Early adolescence: 12–14 years* Establishing satisfying relationships with opposite sex *Late adolescence: 14–20 years* Interdependent and establishing durable sexual relations with a select member of the opposite sex ***Task***—form intimate and long-lasting relationships with the opposite sex and develop a sense of identity	**Adolescence: 12–20 Years** ***Identity vs. role confusion*** Diffusion Differentiation from parents leads to fidelity (sense of self) Physiological revolution that accompanies puberty (rapid body growth and sexual maturity) forces the young person to question beliefs and to refight many of the earlier battles ***Danger***—temporary identity diffusion (instability) may result in a permanent inability to integrate a personal identity ***Task***—integrate all the tasks previously mastered into a secure sense of self **Young Adulthood: 20–30 Years** ***Intimacy and solidarity vs. isolation*** Maturity and social responsibility result in the ability to love and be loved As people feel more secure in their identity, they are able to establish intimacy with themselves (their inner lives) and with others, eventually in a love-based, satisfying sexual relationship with a member of the opposite sex ***Danger***—fear of losing identity may prevent intimate relationship and result in a deep sense of isolation ***Task***—form intense long-term relationships and commit to another person, cause, institution, or creative effort **Adulthood: 30 to 65 Years** ***Generativity vs. self-absorption*** Interest in nurturing subsequent generations creates a sense of caring, contributing, and generativity ***Danger***—lack of generativity results in self-absorption and stagnation ***Task***—achieve life goals and obtain concern and awareness of future generations **Senescence: 65 Years to Death** ***Integrity vs. despair*** Acceptance of mortality and satisfaction with life leads to wisdom Satisfying intimacy with other human beings and adaptive response to triumphs and disappointments Marked by a sense of what life is and was and its place in the flow of history ***Danger***—without this "accrued ego integration," there is despair, usually marked by a display of displeasure and distrust ***Task***—derive meaning from one's whole life and obtain/maintain a sense of self-worth

[a]Developed from original sources by Freud, Sullivan, and Erikson.

The analyst is nondirective but does give his or her interpretations of symbols, thoughts, and dreams. *Free association* is used to search for forgotten and repressed memories. The patient is encouraged to say anything that comes to mind in response to a word or phrase. For example, "What do you think of when I say 'water'?" A patient may respond, "Warm … June … darkness … can't breathe," revealing a long-forgotten and traumatic near-drowning incident.

Psychodynamic therapy is theoretically related to psychoanalytic therapy and views the mind in essentially the same way. It tends to be shorter, about 10 to 12 sessions. The therapist takes a more active role because the therapeutic relationship is part of the healing process.

Transference occurs as the patient projects intense feelings onto the therapist related to unfinished work from previous relationships. Safe expression of these feelings is crucial to successful therapy. An example of this would be when a patient acts more immature when in the presence of a therapist who reminds the patient of his or her mother. Psychodynamic therapists are taught to recognize that they, too, have unconscious emotional responses to the patient. This **countertransference** must be scrutinized in order to prevent damage to the therapeutic relationship.

Interpersonal Theory

Interpersonal theory focuses on what occurs between people, as opposed to psychoanalytic theory, which is rooted in what occurs in the mind. Herbert "Harry" Stack Sullivan (1892–1949), an American psychiatrist, believed that social forces and interpersonal problems were the cause of psychiatric alterations.

According to Sullivan (1953), human beings are driven by the need for interaction. In fact, loneliness is considered the most painful human experience. He emphasized the early relationship with the *significant other* (primary parenting figure) as crucial for personality development and believed that healthy relationships are necessary for a healthy personality.

Despite our need for human interaction, Sullivan believed that interaction is the source of anxiety. In the earliest relationship, anxiety is transmitted from the significant other to the child. The child's anxiety is also based on perceived degrees of approval or disapproval of the primary caregiver. According to Sullivan, all behavior is aimed at avoiding anxiety and threats to self-esteem.

One of the ways that we avoid anxiety is by focusing on positive attributes, or the *good me* ("I'm a good skier"), and hiding the negative aspects, the *bad me* ("I failed an exam"), of ourselves from others and maybe even from ourselves. The *not me* is used to separate us from parts of ourselves that we cannot bear to acknowledge that are pushed deep into the unconscious and disassociated from our sense of self. An example is a female adolescent from a strict and conservative family who begins to have stirrings of attraction toward girls, yet firmly maintains (and believes) that she has feelings for and interest in boys.

Sullivan's theory of development echoes that of Freud's in that personalities are influenced by the social environment as children, particularly as adolescents. He believed that personality is most influenced by the mother but that personality can be molded even in adulthood. Table 3.2 summarizes Sullivan's interpersonal theory of development.

Therapeutic Model

Interpersonal therapy (IPT) is a hands-on system in which therapists actively guide and challenge maladaptive behaviors and distorted views. The premise for this work is that if people are aware of their dysfunctional patterns and unrealistic expectations, they can modify them. The focus is on the here and now, with an emphasis on the patient's life and relationships at home, at work, and socially. The therapist becomes a "participant observer" and reflects on the patient's interpersonal behavior, including responses to the therapist.

Behavioral Theories

As the psychoanalytic movement was developing in the 20th century, so, too, was the behaviorist school of thought. Ivan Pavlov (1927) is famous for investigating *classical conditioning,* in which involuntary behavior or reflexes can be conditioned to respond to neutral stimuli. Pavlov's dogs became accustomed to receiving food after a bell was rung. Later, these dogs salivated in response to the sound of the bell alone. For human beings, classical conditioning can occur under such circumstances as when a baby's crying induces a milk let-down reflex or when a rape victim begins to hyperventilate and sweat when she hears footsteps behind her.

John B. Watson (1930) rejected psychoanalysis and sought an objective therapy that did not focus on unconscious motivations. He contended that personality traits and responses, adaptive and maladaptive, are learned. In a famous and ethically awful experiment, Watson conditioned Little Albert, a 9-month-old child, to be terrified at the sight of white fur or hair. He concluded that through behavioral techniques, anyone could be trained to be anything, from a beggar to a merchant.

B. F. Skinner (1938) conducted research on operant conditioning in which voluntary behaviors are learned through consequences of positive reinforcement (a consequence that causes the behavior to occur more frequently) or negative reinforcement or punishment (a consequence that causes the behavior to occur less frequently). An example of positive reinforcement is studying hard, which results in good grades and increases the chances that studying will continue to occur. An example of negative reinforcement is driving too fast, which may result in a speeding ticket. This ticket should decrease the chances that speeding will occur in the future.

Therapeutic Models

Behavioral therapy, or behavior modification, uses basic tenets from each of the behaviorists described previously. It attempts to correct or eliminate maladaptive behaviors or responses by rewarding and reinforcing adaptive behavior.

Systematic desensitization is based on classical conditioning. The premise is that learned responses can be reversed by first promoting relaxation and then gradually facing a particular anxiety-provoking stimulus. This method has been particularly successful in extinguishing extreme fears, or phobias. Agoraphobia, the fear of open places, can be treated by initially visualizing trips outdoors while using relaxation techniques. Later, the individual can practice actual excursions that gradually increase in length, thereby eliminating or reducing agoraphobia.

Aversion therapy is based on both classical and operant conditioning. It is used to eradicate unwanted habits by associating unpleasant consequences with them. One pharmacologically based aversion therapy is disulfiram (Antabuse). People who take this medication and then ingest alcohol become extremely ill, with nausea, vomiting, and dizziness. Aversion therapy has also been used with sex offenders, who may, for example, receive electric shocks in response to arousal from child pornography.

Biofeedback is a technique in which individuals learn to control physiological responses such as breathing rates, heart rates, blood pressure, brain waves, and skin temperature. This control is achieved by providing visual or auditory biofeedback of the physiological response and then using relaxation techniques such as slow, deep breathing or meditation. There is a recent emergence of smartphone apps and wearable devices that provide this immediate physiological feedback.

Humanistic Theory

Humanists rejected the psychoanalysts' focus on unconscious conflicts, which they considered too pessimistic. They also rejected the behaviorists' focus on learning, which they considered too scientific. The humanists developed a psychological science concerned with the human potential for development, knowledge attainment, motivation, and understanding.

Maslow's hierarchy of needs theory was introduced by the American psychologist Abraham Maslow (1971). Needs are placed conceptually on a pyramid, with the most basic and important needs on the lower level (Fig. 3.2). The higher levels, the more distinctly human needs, occupy the top sections of the pyramid. According to Maslow, when deficiencies at the lower levels are fulfilled, higher-level needs can emerge.

- *Physiological needs.* The most basic needs are the physiological drives, including the need for food, oxygen, water, sleep, sex, and a constant body temperature. If all levels in the pyramid were deprived, this level would take priority.
- *Safety needs.* Once physiological needs are met, safety needs take precedence. Safety needs include security, protection, and freedom from fear and chaos. Safety needs include seeking law, order, and limits.

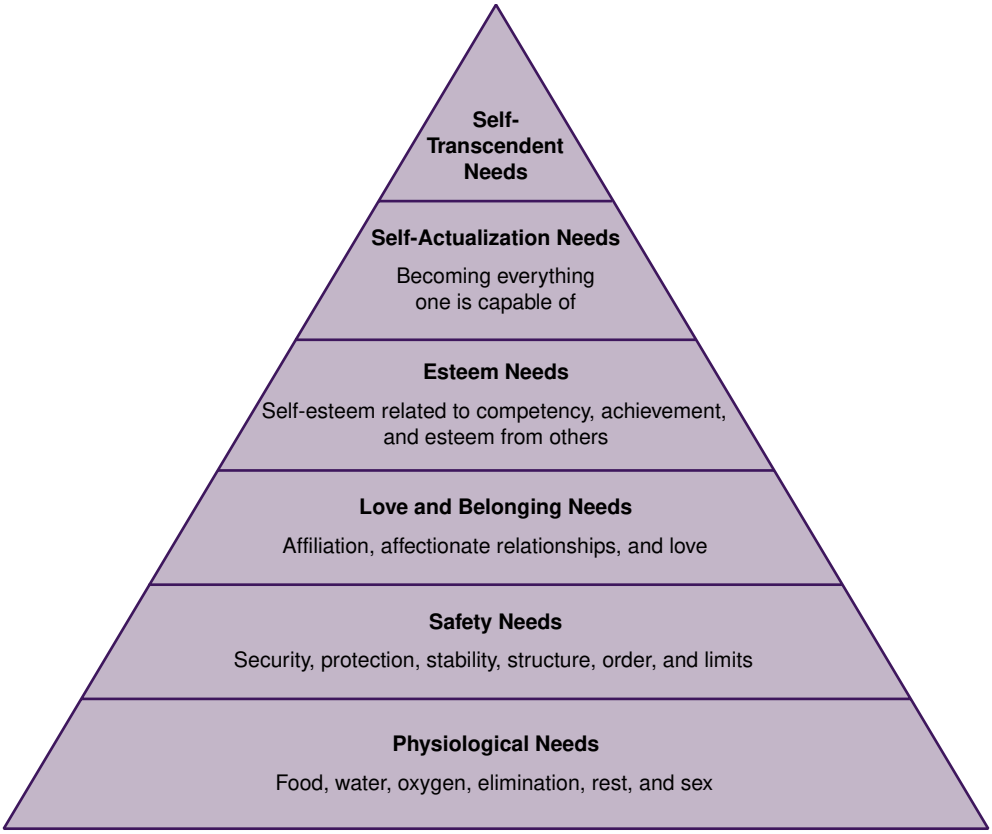

Fig. 3.2 Maslow's hierarchy of needs. (Adapted from Maslow, A. H. [1971]. *The farther reaches of human nature*. New York, NY: Viking.)

- *Belonging and love needs.* People seek belonging, intimate relationships, love, and affection to overcome loneliness and alienation. Maslow stresses the importance of having a family, having a home, and being part of identifiable groups.
- *Esteem needs.* People need to have a positive self-regard and have it reflected to them from others. If self-esteem needs are met, we feel confident, valued, and valuable. When self-esteem is compromised, we feel inferior, worthless, and helpless.
- ***Self-actualization.*** According to Maslow, we are hard-wired to be everything that we are capable of becoming, to fulfill our own potential. He said, "What a man *can* be, he *must* be." What we are capable of becoming is highly individual—an artist must paint, a writer must write, and a healer must heal. The drive to satisfy this need is felt as a sort of restlessness, a sense that something is missing.
- ***Self-transcendence.*** Self-transcendence refers to the drive to go beyond the personal self. This moving beyond oneself is evident in mystical, aesthetic, and emotional peak experiences of seeking a higher truth, often in the service of other people, other species, nature, and the cosmos.

Maslow later added two other interrelated needs: cognitive and aesthetic. The acquisition of knowledge and the need to understand are inborn and essential drives. Human beings are hard-wired to be curious, explore, and find meaning. In much the same way, aesthetic needs result in a craving and a search for beauty and symmetry and the contemplation of these qualities.

Therapeutic Model

Carl Rogers, an American psychologist, popularized **person-centered therapy** in the 1940s. Rogers, unlike Freud, saw people as basically healthy and good. He identified people and all living organisms as having innate self-actualizing tendencies to grow, develop, and realize their full potential (Rogers, 1986). He believed that clients (he did not call them patients) were in the best position to explore, understand, and identify solutions to their own problems. He uses the analogy of teaching a child to ride a bicycle. It is not enough to tell the child how to ride; it is imperative that the child tries to ride the bike. (See Chapter 9 for further discussion on Rogers's use of therapeutic relationships.)

Patient-centered therapy is an existentially based therapy. The emphasis is on self-awareness and the present because the past has already happened, and the future has not yet occurred. The role of the therapist is that of a nondirective facilitator who seeks clarification and provides encouragement in this process. Three essential qualities in the therapist are congruence (genuineness), empathy, and respect. If these three qualities are present, the patient will improve; without them, there is little chance that the therapy will be successful.

Cognitive Theory

Aaron T. Beck was convinced that depressed people generally have standard patterns of negative and self-critical thinking (Beck, 1963). He believed that cognitive appraisals of events lead to emotional responses; it is not the event itself that causes the response but, instead, one's evaluation of the event. An example of the stimulus–appraisal–response relationship would be a woman whose sister had been depressed since their tumultuous and unsteady childhoods. In response to a question about how she and her sibling handled their parents' divorce and subsequent move to a small apartment, one of the siblings observed: "My sister fell apart. She retreated, barely talked. Mom asked me how I was

TABLE 3.3 Examples of Cognitive Distortions

Distortion	Definition	Example
All-or-nothing thinking	Thinking in black and white, reducing complex outcomes into absolutes	Cheryl got the second-highest score in the cheerleading competition. She considers herself a loser.
Overgeneralization	Using a bad outcome (or a few bad outcomes) as evidence that nothing will ever go right again	Marty had a traffic accident. She refuses to drive and says, "I shouldn't be allowed on the road."
Labeling	A form of generalization where a characteristic or event becomes definitive and results in an overly harsh label for self or others	"Because I failed the advanced statistics exam, I am a failure. I might as well give up."
Mental filter	Focusing on a negative detail or bad event and allowing it to taint everything else	Anne's boss evaluated her work as exemplary and gave her a few suggestions for improvement. Anne obsessed about the suggestions and ignored the rest.
Disqualifying the positive	Maintaining a negative view by rejecting information that supports a positive view as being irrelevant, inaccurate, or accidental	"I've just been offered the job I've always wanted. No one else must have applied."
Jumping to conclusions	Making a negative interpretation despite the fact that there is little or no supporting evidence	"My fiancé, Mike, didn't call me for 3 hours; therefore, he doesn't love me."
a. Mind reading	Inferring negative thoughts, responses, and motives of others	The grocery store clerk was grouchy and barely made eye contact. "I must have done something wrong."
b. Fortune-telling error	Anticipating that things will turn out badly as an established fact	"I'll ask her out, but I know she won't have a good time."
Magnification or minimization	Exaggerating the importance of something (e.g., a personal failure or the success of others) or reducing the importance of something (e.g., a personal success or the failure of others)	"I'm alone on a Saturday night because no one likes me. When other people are alone, it's because they want to be."
a. Catastrophizing	An extreme form of magnification in which the very worst is assumed to be a probable outcome	"If I don't make a good impression on the boss at the company picnic, she will fire me."
Emotional reasoning	Drawing a conclusion based on an emotional state	"I'm nervous about the exam. I must not be prepared. If I were, I wouldn't be afraid."
"Should" and "must" statements	Rigid self-directives that presume an unrealistic amount of control over external events	"My patient is worse today. I should give better care so that she will get better."
Personalization	Assuming responsibility for an external event or situation that was likely out of personal control	"I'm sorry that your party wasn't more fun. It's probably because I was there."

Adapted from Burns, D. D. (1989). *Feeling good: The new mood therapy*. New York, NY: William Morrow.

doing. I told her I was excited to get a new bedroom and make new friends. And I was telling the truth."

Therapeutic Model

Cognitive-behavioral therapy (CBT) is a popular, effective, and well-researched therapeutic tool. It is based on both cognitive and behavioral theory and seeks to modify negative thoughts that lead to dysfunctional emotions and actions. Several concepts underlie this therapy. One is that we all have **schemata**, or unique assumptions about ourselves, others, and the world around us. For example, if someone has a schema that no one can be trusted, this person will question everyone's motives and expect deception in relationships. Other dominant forms of negative schemata include incompetence, abandonment, evilness, and vulnerability.

Typically, people are unaware of their basic assumptions. However, their beliefs and attitudes will make the assumptions apparent. Rapid, unthinking responses based on these schemata are known as **automatic thoughts**. These responses are particularly intense and frequent in psychiatric disorders such as depression and anxiety. Often these automatic thoughts, or **cognitive distortions**, are irrational because people make false assumptions and misinterpretations. Common cognitive distortions are listed in Table 3.3.

The goal of CBT is to identify the negative patterns of thought that lead to negative emotions. Once the maladaptive patterns are identified, they can be replaced with rational thoughts. A particularly useful technique in CBT is to use a four-column format to record the precipitating event or situation, the resulting automatic thought, the ensuing feeling(s) and behavior(s), and finally, a challenge to the negative thoughts based on rational evidence and thoughts. This is sometimes referred to as the *ABCs of irrational beliefs* and is a good exercise for you to try for yourself (Box 3.1).

BOX 3.1 Example of ABCs of Irrational Beliefs

Activating Event
Jack has been in counseling for depression. His therapist's administrative assistant called and canceled this week's appointment.

Belief
My therapist is disgusted with me and wants to avoid me.

Consequence
Sadness, rejection, and hopelessness. Decides to call off work and just go back to bed.

Reframing
There is no evidence to believe the therapist finds me disgusting. Would the therapist have called to reschedule if he really didn't want to see me again?

Biological Theory

Psychiatric care is dominated by the biological model, in which mental disorders are believed to have physical causes. If mental disorders have

physical causes, then they will respond to physical treatment. Sigmund Freud himself researched neurological causes for mental illness and considered cocaine a possible treatment.

In the 1950s a surgeon noticed that surgical patients were calmed by the administration of chlorpromazine (Thorazine) as a preanesthetic agent. It soon became widely used for the treatment of schizophrenia and dramatically reduced the use of restraint and seclusion. This discovery spurred the development of other drug-based treatments and the adoption of a chemical-imbalance theory of psychiatric disorders.

If chemical imbalances exist, how do they develop? Twin studies have been useful to support the genetic transmission of certain disorders. Whereas only 1% of the population has schizophrenia, among identical twins, the concordance rate (the percentage of the time that both twins will be affected) is about 33% (Hilker et al., 2017). Although this indicates genetic involvement, it cannot be the whole story. If it were, the concordance rate of schizophrenia in identical twins would be 100%. It is likely that the environment exerts an influence on the developing embryo or child. Research has proposed toxins, viruses, hostile environments, and brain trauma as possible catalysts for the development of psychiatric disorders (see Chapter 4).

Biological Therapy

Psychopharmacology is the primary biological treatment for mental disorders. (Refer to Chapter 4 for a full discussion of the biological basis for understanding psychopharmacology.) Major classifications of medications are antidepressants, antipsychotics, antianxiety agents, mood stabilizers, and psychostimulants. Clinicians recognize the importance of optimizing other biological variables, such as correcting hormone levels (as in hypothyroidism), regulating nutritionally deficient diets, and balancing inadequate sleep patterns. (Refer to Chapters 10 to 19 for relevant uses of psychopharmacology.)

Electroconvulsive therapy (ECT) has proven to be an effective treatment for severe depression and other psychiatric conditions. ECT is a procedure that uses electrical current to induce a seizure and is thought to work by affecting neurotransmitters and neuroreceptors (see Chapter 15 for more discussion regarding ECT).

Besides ECT, other brain-stimulation therapies are increasingly being used in psychiatry. Repetitive transcranial magnetic stimulation (rTMS) uses an electromagnetic device to deliver a rapidly pulsed magnetic field to the cerebral cortex to activate neurons. Magnetic seizure therapy (MST) uses higher-frequency electronic pulses instead of electricity to induce a seizure. Vagus nerve stimulation (VNS) works by stimulating the vagus nerve, which results in improved levels of neurotransmitters. Deep-brain stimulation (DBS) relies on surgically implanted electrodes stimulating a specific area of the brain.

Most mental health professionals combine biological approaches with talk therapy. Research indicates that the use of medication and CBT is an extremely effective treatment for many psychiatric disorders, especially major depression (Feng, et al., 2020). If a hostile environment can trigger negative brain chemistry or transmission, then a positive environment may reverse and improve the process.

A Note on How Psychotherapy Changes the Brain

Numerous studies have indicated that all mental processes are derived from the brain. Therefore psychotherapeutic outcomes, such as changes in symptoms, psychological abilities, personality, or social functioning, are generally accepted to be attributed to brain changes brought about either by medication or psychotherapy. Numerous studies compiled by Karlsson (2011) substantiate positive treatment responses with various psychotherapies resulting in brain changes for the following disorders: major depressive disorder (MDD), anxiety disorders (panic disorder, social anxiety disorder, specific phobias), posttraumatic stress disorder (PTSD), borderline personality disorder, and obsessive-compulsive disorder (OCD). These studies suggest that currently, the most effective therapies for treating the aforementioned disorders resulting in brain changes are CBT, dialectic behavior therapy (DBT), psychodynamic psychotherapy, and interpersonal psychotherapy (IP).

OTHER MAJOR THEORIES

Theory of Cognitive Development

Jean Piaget (1896–1980) was a Swiss psychologist and researcher. Piaget noticed that children consistently gave wrong answers on intelligence tests that revealed a maturational pattern of cognitive processing. He concluded that cognitive development was a progression from primitive awareness to complex thought and responses (Piaget & Inhelder, 1969).

An understanding of cognitive development assists nurses in tailoring care to suit the cognitive level of the patient. For example, the concept of dying is difficult to grasp for the 5-year-old child who has lost a parent. Support for a child of this age will require different skills than those required for a 10-year-old child, who can understand the permanence of death. A summary of developmental stages is provided in Table 3.4.

Theory of Psychosocial Development

German-born American Erik Erikson (1902–1994) was a child psychoanalyst who described development as occurring in eight predetermined life stages, whose levels of success are related to the preceding stage (see Table 3.2).

Developmental tasks during these stages ideally result in a successful resolution. For example, from the ages of 7 to 12, the child's task is to understand his or her own abilities and competence and expand relationships beyond the immediate. The attainment of this task *(industry)* brings about confidence. The inability to gain a mastery of age-appropriate tasks and make connections with peers results in failure *(inferiority)*.

TABLE 3.4 Stages of Cognitive Development

Stage	Features
Sensorimotor (birth to 2 years)	Begins with basic reflexes and culminates with purposeful movement, spatial abilities, and hand–eye coordination. Around 9 months, **object permanence** is achieved, and the child can conceptualize objects that are no longer visible.
Preoperational (2–7 years)	Language develops, yet children think in a concrete fashion. Expecting others to view the world as they do is called **egocentric thinking**. Children begin to think in images and symbols and engage in such activities as playing house.
Concrete operational (7–11 years)	The child is able to think logically and use abstract problem solving. He or she is able to see another's point of view and is able to see a variety of solutions to a problem. **Conservation** is possible. For example, two small cups of liquid can be seen to equal a tall glass. The child is able to classify by characteristics, order objects in a pattern, and understand the concept of reversibility.
Formal operational (11 years to adulthood)	Conceptual reasoning begins at approximately the same time as puberty. At this stage, the child's basic abilities to think abstractly and problem solve are similar to those of an adult.

Each stage does not depend on completely integrating the positive characteristic and completely abandoning the negative. Ideally, harmony is achieved between the two characteristics. For example, we would not want a person to be 100% trusting—a degree of mistrust is essential for safety.

Theory of Object Relations

The theory of object relations was developed by interpersonal theorists who emphasize past relationships in influencing a person's sense of self as well as the nature and quality of relationships in the present. The term *object* refers to another person, particularly a significant person.

Margaret Mahler (1897–1985) was a Hungarian-born child psychologist who developed a framework for studying how an infant transitions from complete self-absorption, with an inability to separate from its mother, to a physically and psychologically differentiated toddler. Mahler believed that psychological problems were largely the result of a disruption of this separation.

During the first 3 years, the significant other (e.g., the mother) provides a secure base of support that promotes enough confidence for the child to separate. This confidence is achieved through a balance of holding (emotionally and physically) the child enough to feel safe while encouraging independence and natural exploration.

Problems may arise in this process. For example, if a toddler leaves his mother on the park bench and wanders off to the sandbox, the child should be encouraged with smiles and reassurance, such as, "Go on, honey; it's safe to go away a little." The mother should be reliably present when the child returns, thereby rewarding his efforts. Mahler notes that raising healthy children does not require that parents never make mistakes and that "good-enough parenting" will promote successful separation and individuation.

Theories of Moral Development

Lawrence Kohlberg (1927–1987) was an American psychologist who applied Piaget's theory to moral development. Based on interviews with youths, Kohlberg developed a theory of how people progressively develop a sense of morality (Kohlberg & Turiel, 1971). His theory helps us understand the progression from black-and-white thinking to a context-dependent decision-making process regarding the rightness or wrongness of an action.

Carol Gilligan (born in 1936) is an American psychologist, ethicist, and feminist who worked with Kohlberg. She later criticized his work for being male based. Gilligan also believed that the scoring method favored males' methods of reasoning. Based on Gilligan's critique, Kohlberg revised his scoring methods, which resulted in a greater similarity between girls' and boys' scores.

Gilligan's ethics of care theory emphasizes the importance of forming relationships and putting the needs of those for whom we care above the needs of strangers. Like Kohlberg, Gilligan asserts that moral development progresses through three major divisions: preconventional, conventional, and postconventional. These transitions are dictated by personal development and changes in the sense of self. Kohlberg's and Gilligan's stages of moral development are summarized in Table 3.5.

NURSING MODELS

We have been examining theories and therapies developed by professionals from a variety of disciplines that date back to the late 1800s. It was not until the 1950s that the profession of nursing began to develop, record, and test theories (Alligood, 2013). The drive to create these theories began as a result of nursing education being moved from hospital-based programs to college- and university-based programs where nurses became involved in research. This research became the impetus for nurses to develop theories and a strong scientific body of knowledge.

Hildegard Peplau's work in the early 1950s is most often associated with psychiatric nursing, and her work will be presented in the following section. However, most nursing theories are applicable and of value to psychiatric nursing because interpersonal relations, caring, and communication are key aspects of the foundation of nursing. A summary of selected nursing theorists, the focus of their theoretical works, and examples of how their contributions can be utilized in psychiatric nursing is provided in Table 3.6. It is worth noting that among all the nurse theorists, psychiatric nurses are well represented.

Interpersonal Relations in Nursing

Hildegard Peplau's (1909–1999) seminal work *Interpersonal Relations in Nursing* was first published in 1952 and has served as a foundation for understanding and conducting therapeutic nursing relationships ever since. Peplau based her work on Sullivan's interpersonal theory and emphasized that the nature of the nurse–patient relationship strongly influenced the outcome for the patient.

Peplau made an extremely useful contribution to understanding anxiety by conceptualizing the four levels still in use today:

1. Mild anxiety is a day-to-day alertness (e.g., "I'm awake and taking care of business"). Stimuli in the environment are perceived and understood, and learning can easily take place.

TABLE 3.5 Stages of Moral Development According to Kohlberg and Gilligan

Level	Kohlberg's Stages	Gilligan's Stages
Preconventional	Stage 1: Obedience and punishment—a focus on rules and listening to authority to avoid punishment. Stage 2: Individualism and exchange—growing awareness that not everyone thinks the same. Breaking rules is a personal choice.	The goal is individual survival. Characterized by selfishness.
Conventional	Stage 3: Good interpersonal relationships—rightness or wrongness is based on individual motivations, personality, or the goodness or badness of the person. People should get along and have similar values. Stage 4: Maintaining the social order—rules are rules. Listening to authority maintains the social order.	Self-sacrifice is good. A responsibility for others develops.
Post-conventional	Stage 5: Social contract and individual rights—social order is important, but it also must be *good*. A corrupt social order should be changed. Stage 6: Universal ethical principles—actions should create unbiased results for everyone. We are obliged to break unjust laws.	The principle of nonviolence and not hurting others or self is essential. A balance of caring for self with caring for others emerges.

TABLE 3.6 Nursing Theoretical Works Relevant to Psychiatric Nursing

Theorist	Model/Theory	Focus of Nursing	Example
Dorothy Johnson	Behavioral system	Helping a patient return to a state of equilibrium when exposed to stressors by reducing or removing them and by supporting adaptive processes (Johnson, 1980)	Providing prn antianxiety medication and encouraging slow, deep breathing for a patient who is experiencing panic attacks
Imogene King	Goal attainment	Developing an interpersonal relationship and helping the patient achieve their goals based on the patient's roles and social contexts (King, 1981)	Sitting with a new mother who is experiencing depression and developing a discharge plan in the context of childcare and financial deficits
Madeleine Leininger[a]	Culture care	Promoting health and helping people to cope with illness while recognizing cultural issues and their importance to health (Leininger, 1995)	Including the family in the plan of care for an Amish man who has recently attempted suicide
Betty Neuman[a]	System model	Developing a nurse–patient relationship; assessing and intervening with the person's response to stress (Neuman, 1982)	Considering the impact of shingles and graduate school stressors on a person diagnosed with generalized anxiety disorder
Dorothea Orem	Self-care deficit	Addressing self-care deficits and encouraging patients to be actively involved in their own care (Orem, 2001)	Temporarily helping a person with an exacerbation of paranoia to meet their hygiene needs
Ida Orlando[a]	Dynamic nurse–patient relationship	Addressing the patient's immediate need for help; the longer the unmet need, the more stress will be experienced (Orlando, 1990)	Asking, "Would you like to talk?" to a man who has begun pacing in the hallway and shaking his head
Hildegard Peplau[a]	Interpersonal relations	Using the interpersonal environment as a therapeutic tool for healing and in reduction of anxiety (Peplau, 1992)	Sitting quietly beside a new father who has recently lost his job and attempted suicide and does not want to talk
Jean Watson[a]	Transpersonal caring	Caring is as important as procedures and tasks; developing a nurse–patient relationship that results in a therapeutic outcome (Watson, 2007)	Taking time from a busy assignment to meet a patient's husband

[a]Psychiatric nursing background.

2. Moderate anxiety is felt as a heightened sense of awareness, such as when you are about to take an exam. The perceptual field is narrowed, and an individual hears, sees, and understands less. Learning can still take place, although it may require more direction.
3. Severe anxiety interferes with clear thinking, and the perceptual field is greatly diminished. Nearly all behavior is directed at reducing the anxiety. An example of this is your response to your car skidding on wet pavement.
4. Panic anxiety is overwhelming and results in either paralysis or dangerous hyperactivity. An individual cannot communicate, function, or follow directions. This is the sort of anxiety that is associated with the terror of panic attacks.

Refer to Chapter 11 for application of these levels to the nursing process.

One of the most useful constructs of Peplau's theory is in providing structure for how we view the therapeutic relationship, which she divided into four phases. Each of these overlapping and interlocking phases includes tasks, the expression of needs by the patient, and the interventions facilitated by the nurse. Refer to Chapter 9 for more information on the phases of the nurse–patient relationship.

Influence of Theories and Therapies on Nursing Care

Other theories and therapies presented earlier in this chapter are also relevant to nursing care. Nurses constantly borrow concepts and carry out interventions that are supported by these models. Some examples of how they may be used are as follows:

- **Behavioral:** Promoting adaptive behaviors through reinforcement can be valuable and important in working with patients, especially when working with a pediatric population. These patients look forward to positive reinforcement for good behavior and will work hard for gold stars or other privileges.
- **Cognitive:** Helping patients identify negative thought patterns is a worthwhile intervention in promoting healthy functioning and improving neurochemistry. Workbooks are available to aid in the process of identifying these cognitive distortions.
- **Psychosocial development:** Erikson's theory provides a structure for understanding critical junctures in development. The older adult who has suffered a stroke may be depressed and despairing because he can no longer take care of his house. In this case, the nurse and patient could explore ways of optimizing the patient's remaining strengths and talents, such as by nurturing and tutoring young people or by developing attainable goals such as getting the mail, taking out the trash, and so forth.
- **Hierarchy of needs:** Maslow's theory is useful in prioritizing nursing care. When working with actively suicidal patients, students sometimes think it is rude to ask if the patients are thinking about killing themselves. However, safety supersedes this potential threat to self-esteem. Although the "must-dos" in nursing begin with physical care (e.g., providing medication and hydration through intravenous [IV] fluids), the goal should also include higher-level needs, which can be obtained by listening, observing, and collaborating with the patient in the development of the plan of care.

The Mental Health Recovery Model in Psychiatric Nursing

Although we tend to think of recovery as regaining health or being cured of an episode of illness, the term *recovery* in this model has a different meaning. The mental health **recovery model** is not a focus on a cure but, instead, emphasizes living adaptively with chronic mental illness. It is viewed as both an overarching philosophy of life for people with mental illness and an approach to care for use by those who treat, finance, and support mental health care. It is also an effective approach to dealing with substance abuse.

A diagnosis of mental illness once meant that you listened to health care professionals and relied upon them to chart your course in treatment. This medical model approach often results in apathy

and discouragement: "They want me to take medication for the rest of my life; I don't like it and won't take it." The recovery model shifts the responsibility for care from the provider to the individual: "I will discuss the medication side effects with my friends who have similar problems and then talk to my nurse practitioner about my options and preferences."

This model emphasizes hope, social connection, empowerment, coping strategies, and meaning in life. A recovery approach to care has been embraced by the American Psychiatric Association from a service perspective. The US Department of Health and Human Services uses recovery concepts to guide federal and state initiatives, particularly as they relate to empowering mental health consumers (people with mental illness) and in campaigns to reduce mental illness stigma.

The use of the recovery model in psychiatric nursing is a natural extension of what we have traditionally done. Peplau (1952) set the standard by providing a structure for developing a therapeutic interpersonal relationship with a patient. The recovery model moves this relationship from a nurse–patient relationship to a nurse–patient partnership.

Therapies for Specific Populations

Group Therapy

This therapeutic method is commonly derived from interpersonal theory. It operates under the assumption that interaction within the group can provide support or bring about desired change among individual participants.

The American Psychological Association (APA, 2020) defines a group as a collection of two or more individuals who influence one another who share a degree of cohesiveness and shared goals. Experts disagree on the ideal size of the group, but it is usually somewhere between 6 and 10 members. A group that is too small will limit the diversity of opinion and put pressure on members to participate. Overly large groups reduce the members' ability to share, especially if some members dominate the group.

Setting. Settings for groups are important. The room should be private, and the seating should be comfortable and arranged so that people can see one another. Using tables is discouraged because they can be psychological barriers between group members. One of the worst arrangements for discussion is the traditional classroom seating with everyone facing a central speaker, thereby limiting free interaction among participants.

Groups possess both content and process dimensions. **Group content** refers to the actual dialogue between members or the type of information that can be transcribed (written or recorded) in minutes of meetings. **Group process** includes all the other elements of human interaction, such as nonverbal communication, adaptive and maladaptive roles, energy flow, power plays, conflict, hidden agendas, and silence. Although the content is essential to the group's work, it is the process that becomes the real challenge for leaders as well as participants.

Group development tends to follow a sequential pattern of growth and requires less leadership with time. Understanding this pattern is especially helpful to the leader in order to anticipate distinct phases and provide guidance and interventions that are most effective. Tuckman's (1965) model of group development has four stages: forming, storming, norming, and performing. A fifth stage, adjourning (mourning), was later added (Tuckman & Jensen, 1977). These stages are comparable to human development from infancy into old age, accompanied by varying levels of maturity, confidence, and need for direction (Table 3.7).

Roles of Group Members. Studies of group dynamics have identified informal roles of members that are necessary to develop a successful group. The most common descriptive categories for these roles are task, maintenance, and individual roles (Benne & Sheats, 1948). Task roles serve to keep the group focused and attend to the business at hand.

TABLE 3.7 Tuckman's Stages of Group Development and Comparable Life Phases

Stage	Comparable Life Phase	Description
Forming	Infancy	The task and/or purpose of the group is defined. Connecting with others, desiring acceptance, and avoiding conflict define early groups. Members gather commonalities and differences as they attempt to know one another. The leader is the main connection and necessary for direction.
Storming	Adolescence	Important issues are being addressed, and conflict begins to surface. Personal relations may interfere with the task at hand. Some members will dominate, and some will be silent. Rules and structure are helpful. Members may challenge the role of the leader, who has the opportunity to model adaptive behavior.
Norming	Early adulthood	Members know one another, and rules of engagement (norms) are evident. There is a sense of group identity and cohesion. Members resist change, which could lead to a group breakup or a return to the discomfort of storming. Leadership is shared.
Performing	Mature adulthood	Groups who reach this stage are characterized by loyalty, flexibility, interdependence, and productivity. There is a balance between focus on work and focus on the welfare of group members.
Adjourning (mourning)	Older adult years	Groups in this stage are ready to disband, tasks are terminated, and relationships are disengaged. Accomplishments are recognized, and members are pleased to have been part of the group. A sense of loss is an inevitable consequence.

From Tuckman, B. W., & Jensen, M. A. (1977). Stages of small-group development revisited. *Group & Organization Management, 2,* 419–427.

Maintenance roles function to keep the group together and provide interpersonal support. Individual roles are not related to group goals but, rather, to specific personalities. These roles can interfere with the group's functioning. Table 3.8 describes the roles of group members.

Roles of the Group Leader. The group leader has multiple responsibilities in starting, maintaining, and terminating a group. In the initial forming phase, the leader defines the structure, size, composition, purpose, and timing for the group. The leader facilitates communication and ensures that meetings start and end on time. In the adjourning phase, the leader ensures that each member summarizes individual accomplishments and gives positive and negative feedback regarding the group experience.

Leadership style depends on group type. A leader should select the style that is best suited to the needs of a particular group. The **autocratic leader** exerts control over the group and does not encourage

TABLE 3.8 Roles of Group Members

Role	Function
Task Roles	
Coordinator	Connects various ideas and suggestions
Initiator-contributor	Offers new ideas or a new outlook on an issue
Elaborator	Gives examples and follows up on meaning of ideas
Energizer	Encourages group to make decisions or take action
Evaluator	Measures group's work against a standard
Information/opinion-giver	Shares opinions, especially to influence group values
Orienter	Notes progress of the group toward goals
Maintenance Roles	
Compromiser	In a conflict, yields to preserve group harmony
Encourager	Praises and seeks input from others; warm and accepting
Follower	Attentive listener and integral to the group
Gatekeeper	Ensures participation, encourages participation, points out commonality of thought
Harmonizer	Mediates conflicts constructively among members
Standard setter	Assesses explicit and implicit standards for group
Individual Roles	
Aggressor	Criticizes and attacks others' ideas and feelings
Blocker	Disagrees with group issues, opposes others, stalls the process
Help seeker	Asks for sympathy of group excessively, self-deprecating
Playboy/playgirl	Distracts others from the task; jokes, introduces irrelevant topics
Recognition seeker	Seeks attention by boasting and discussing achievements
Monopolizer	Dominates conversation, thereby preventing equal input
Special-interest pleader	Advocates for a special group, usually with own prejudice or bias

Data from Benne, K. D., & Sheats, F. (1948). Functional roles of group members. *Journal of Social Issues, 4*(2), 41.

much interaction among members. In contrast, the **democratic leader** supports extensive group interaction in the process of problem solving. A **laissez-faire leader** allows the group members to behave in any way they choose and does not attempt to control the direction of the group. For example, the staff leading a community meeting with a fixed, time-limited agenda may tend to be more autocratic. In an educational group, the leader may be more democratic to encourage members to share their experiences. In a creative group, such as an art or horticulture group, the leader may choose a laissez-faire style, giving minimal direction to allow for a variety of responses.

Types of Groups. Educational groups form for the purpose of imparting information and require active expert leadership and careful planning. Task groups are typically time limited and have a common goal, and the role of the leader is to facilitate team building and cooperation. Support groups bring together people with common concerns and may be facilitated by a supportive leader or by group members. Therapy groups are led by professional group therapists whose styles may range from a directive and confrontational approach to a more hands-off approach in which the therapist lets the group members learn from one another.

TABLE 3.9 Yalom's Curative Factors of Group Membership

Curative Factor	Definition	Example
Altruism	Giving appropriate help to other members	"We've spent all this time talking about me. Lou needs to talk about his visit with his dad. Let's focus on him."
Cohesiveness	Feeling connected to other members and belonging to the group	"People in our group always listen to each other. We've been polite since the first day."
Interpersonal learning	Learning from other members	"Sammi said it takes 2 weeks for Prozac to really work. I should give it more time."
Guidance	Receiving help and advice	"I've also had that feeling where I just had to have a drink, Don. Just pick up the phone and call me next time it happens."
Catharsis	Releasing feelings and emotions	A new mother of twins begins to cry and says, "It sounds terrible, but sometimes I wish I'd never had children."
Identification	Modeling after member or leader	David notices that the leader projects confidence by speaking clearly, making good eye contact, and sitting up straight. David does the same.
Family reenactment	Testing new behaviors in a safe environment	"I learned to always smile and agree so that Dad wouldn't go off on me. I don't have to be cheery, and I can speak my mind here."
Self-understanding	Gaining personal insights	Dale realizes that his negativity has kept him from getting the friends he wants.
Instillation of hope	Feeling hopeful about one's life	"Sue has managed to stay sober for 2 years. I think I can do this."
Universality	Feeling that one is not alone	Aaron, a quiet group member, finally comments, "My son has schizophrenia, too, and it helps to hear that other people have the same worries I do."
Existential factors	Coming to understand what life is about	"I guess I've been obsessing about being a perfect housekeeper and haven't noticed that my children are growing up without me."

From Yalom, I. D. (1985). *The theory and practice of group psychotherapy.* New York, NY: Basic Books.

Benefits of Group Therapy. One of the benefits of group therapy is that it is more efficient, both pragmatically and financially, than individual therapy. This efficiency is due to the fact that many people can engage in therapy at once. However, it is the nature of the interaction between people with common concerns and frames of references that seems to provide the greatest benefit to members. Yalom (1985) identified 11 benefits, or **curative factors**, of group membership (Table 3.9).

Roles of Nurses. Psychiatric-mental health nurses are involved in a variety of therapeutic groups in acute care and long-term treatment settings. For all group leaders, a clear theoretical framework provides a structure for understanding group interaction. Coleadership of groups is a common practice and has several benefits:

- Provides training for less experienced staff
- Allows for immediate feedback between the leaders after each session
- Gives two role models for teaching communication skills to members

Basic-level registered nurses have biopsychosocial educational backgrounds. Psychiatric-mental health registered nurses (PMH-RNs) gain experience and expertise in caring for individuals who have physical, psychological, mental, and spiritual distress (American Psychiatric Nurses Association, International Society of Psychiatric-Mental Health Nurses, & American Nurses Association, 2014). PMH-RNs are ideally suited to teach a variety of health subjects. *Psychoeducational groups* are established to support and teach patients and families ways to help prevent relapse. These groups may be time limited or may be supportive for long-term treatment. Generally, written handouts or audiovisual aids are used to focus on specific teaching points. Psychiatric-mental health nurses commonly lead the following psychoeducational groups:

- **Medication education groups** allow patients to hear the experiences of others who have taken medication and to have an opportunity to ask questions without the fear of being judged; these groups also allow patients to learn to take the medications correctly.
- **Dual-diagnosis groups** focus on co-occurring psychiatric illness and substance abuse. The PMH-RN may colead this group with a dual-diagnosis specialist (master's level clinician).
- **Symptom management groups** are designed for patients to share coping skills regarding a common problem, such as cognitive distortions or substance use. New and alternate skills can be learned to help patients develop more effective strategies for reducing symptoms and preventing relapse.
- **Stress management groups** teach members about various relaxation techniques, including deep breathing, exercise, music, and spirituality.
- **Self-care groups** focus on activities of daily living, such as bathing and grooming.

Psychiatric mental health advanced practice registered nurses (PMH-APRNs) may lead any of the groups described earlier as well as psychotherapy groups. Psychotherapy groups require specialized training in techniques that allow for deep self-reflection, disclosure, sharing, confrontation, and healing among participants.

Therapeutic Milieu

A therapeutic milieu (mil-yoo), or healthy environment, combined with a healthy social structure within an inpatient setting or structured outpatient clinic, is essential to supporting and treating those with mental illness. Within these small versions of society, people are safe to test new behaviors and increase their ability to interact adaptively with the outside community.

Community meetings or goal-setting meetings are frequently held at the beginning of the day. They usually include all patients and the treatment team. Functions include orienting new members to the unit, encouraging patients to engage in treatment, and evaluating the treatment program. Nursing staff often lead these groups and are in a strong position to give valuable feedback to the team about group interactions.

Other therapeutic milieu groups aim to help increase patients' self-esteem, decrease social isolation, encourage appropriate social behaviors, and educate patients in basic living skills. These groups are often led by occupational or recreational therapists, although nurses frequently colead them. Examples of therapeutic milieu groups are recreational groups, physical activity groups, creative arts groups, and storytelling groups.

BOX 3.2 Central Concepts to Family Therapy

- **Boundaries**: ***Clear boundaries*** maintain distinctions among individuals within the family and between the family and the outside world. Clear boundaries allow for a balanced flow of energy among members.
  - ***Diffuse*** or ***enmeshed boundaries*** are those in which there is a blending of the roles, thoughts, and feelings of the individuals so that clear distinctions among family members fail to emerge.
  - ***Rigid*** or ***disengaged boundaries*** are those in which the rules and roles are followed in spite of the consequences.
- **Triangulation:** The tendency, when two-person relationships are stressful and unstable, to engage a third person to stabilize the system through the formation of a coalition in which two members are pitted against the third.
- **Scapegoating:** A form of displacement in which a family member (usually the least powerful) is blamed for another family member's distress. The purpose is to keep the focus off the painful issues and the problems of the blamers.
- **Double bind:** A double bind is a no-win situation in which you are "darned if you do, darned if you don't."
- **Hierarchy:** The function of power and its structures in families, differentiating parental and sibling roles, and generational boundaries.
- **Differentiation:** The ability to develop a strong identity and sense of self while maintaining an emotional connectedness with one's family of origin.
- **Sociocultural context:** The framework for viewing the family in terms of the influence of gender, race, ethnicity, religion, economic class, and sexual orientation.
- **Multigenerational issues:** The continuation and persistence from generation to generation of certain emotional interactive family patterns (e.g., reenactment of fairly predictable patterns; repetition of themes or toxic issues; and repetition of reciprocal patterns such as those of overfunctioner and underfunctioner).

Family Therapy

Family therapy developed around the mid-20th century. It is used as an adjunct to individual treatment and refers to the treatment of the family as a whole. Family therapists are trained at the graduate level. They use a variety of theoretical models to reduce or eliminate dysfunctional patterns of behavior and interaction. Some therapists may focus on the present, whereas others may rely more heavily on the family's history and reports of interactions between sessions. Terms related to family therapy are listed in Box 3.2.

Although therapists may use a wide variety of therapeutic methods, the goals of family therapy are basically the same. These goals include the following (Varghese, Kirpekar, & Loganathan, 2020):

- Improve communication
- Understand and manage special family situations like traumatic events, chronic or acute illness
- Improve the functioning of the home environment
- Identify and shift dysfunctional interactions and dynamics within the family structure
- Mobilize the family strengths and resources
- Strengthen family problem-solving behavior

Complementary and Alternative Treatments

Alternative treatments for psychiatric conditions and disorders have grown in popularity over recent decades. The National Center for Complementary and Integrative Health (NCCIH) is part of the National Institutes of Health and is the lead organization for research on practices and products that are not generally considered part of conventional medicine. The terminology used in the NCCIH name refers to:

- Complementary approaches in which nontraditional treatments are provided in addition to conventional medical treatments
- Integrative health care in which conventional and complementary approaches are brought together in a coordinated way.

These approaches are often helpful and have the potential for even more benefits in the future. However, nurses need to recognize that, unlike prescription medications, the US Food and Drug Administration (FDA) does not review or approve most of them. See Appendix A for a summary of complementary and integrative health care treatments and their uses in treating psychiatric disorders.

KEY POINTS TO REMEMBER

- Theoretical models and therapeutic strategies provide a useful framework for the delivery of psychiatric nursing care.
- The psychoanalytic model is based on unconscious motivations and the dynamic interplay between the primitive brain (id), the sense of self (ego), and the conscience (superego). The focus of psychoanalytic theory is on understanding the unconscious mind.
- The interpersonal model maintains that the personality and mental health disorders are created by social forces and interpersonal experiences. Interpersonal therapy aims to provide positive and repairing interpersonal experiences.
- The behavioral model suggests that because behavior is learned, behavioral therapy should improve behavior through rewards and reinforcement of adaptive behavior.
- The humanist model is based on human potential, and therapy is aimed at maximizing this potential. Maslow developed a theory of personality that is based on the hierarchical satisfaction of needs. Rogers's person-centered theory uses self-actualizing tendencies to promote growth and healing.
- The cognitive model posits that disorders, especially depression, are the result of faulty thinking. Cognitive-behavioral therapy is empirically supported and focuses on the recognition of distorted thinking and its replacement with more accurate and positive thoughts.
- The biological model is currently the dominant model and focuses on physical causation for personality problems and psychiatric disorders. Medication is the primary biological therapy.
- Various nursing theories are useful in psychiatric nursing. Hildegard Peplau developed an important interpersonal theory for the provision of psychiatric nursing care.
- Group therapy offers the patient significant interpersonal feedback from multiple people.
- Groups transition through predictable stages, benefit from therapeutic factors, and are characterized by members filling specific roles.
- The therapeutic milieu refers to the safe and therapeutic physical and social environment in which psychiatric care is provided.
- Family therapy is based on various theoretical models and aims to decrease emotional reactivity among family members and encourage differentiation among individual family members.

APPLYING CRITICAL JUDGMENT

1. How could the theorists discussed in this chapter influence your nursing care? Specifically:
   - **A.** How do Freud's concepts of the conscious, preconscious, and unconscious affect your understanding of patients' behaviors?
   - **B.** What are the implications of Sullivan's focus on the importance of interpersonal relationships for your interactions with patients?
   - **C.** Can you think of anyone who seems to be self-actualized or self-transcendent? What is your reason for this conclusion?
   - **D.** How do you utilize Maslow's hierarchy of needs in your nursing practice?
   - **E.** What do you think about the behaviorist point of view that to change behaviors is to change personality?
2. Which of the therapies described here do you think can be the most helpful to you in your nursing practice? What are your reasons for this choice?

CHAPTER REVIEW QUESTIONS

1. A nurse plans a group meeting for adult patients in a therapeutic milieu. Which topic should the nurse include?
   - **a.** Coping with grief and loss
   - **b.** The importance of handwashing
   - **c.** Strategies for money management
   - **d.** Staffing shortages expected over the next 3 days
2. Considering Maslow's pyramid, which comment indicates that an individual is motivated by one of the higher levels of need?
   - **a.** "Even though I'm 40 years old, I have returned to college so that I can get a better job."
   - **b.** "I help my community by volunteering at a thrift shop that raises money for the poor."
   - **c.** "I recently applied for public assistance in order to feed my family, but I hope it's not forever."
   - **d.** "My children tell me I'm a good parent. I feel happy being part of a family that appreciates me."
3. Which patient is likely to achieve maximum benefit from cognitive-behavioral therapy (CBT)?
   - **a.** Older adult diagnosed with stage 3 Alzheimer's disease
   - **b.** Adult diagnosed with schizophrenia and experiencing delusions
   - **c.** Adult experiencing feelings of failure after losing the fourth job in 2 years
   - **d.** School-age child diagnosed with attention-deficit/hyperactivity disorder (ADHD)

4. An adult plans to attend an upcoming 10-year high school reunion. This person says to the nurse, "I am embarrassed to go. I will not look as good as my classmates. I haven't been successful in my career." Which comment by the nurse addresses this cognitive distortion?
   a. "You look fine to me. Do you think you will have fun at your reunion?"
   b. "Everyone ages. Other classmates have had more problems than you."
   c. "Do you think you are the only person who has aged and faced difficulties in life?"
   d. "I think you are doing well in the face of the numerous problems you have endured."

5. A distraught 8-year-old girl tells the nurse, "I had a horrible nightmare and was so scared. I tried to get in bed with my parents, but they said, 'No.' I think I could have gone back to sleep if I had been with them." Which family dynamic is likely the basis of this child's comment?
   a. Boundaries in the family are rigid.
   b. The family has poor differentiation of roles.
   c. The girl is enmeshed in part of a family triangle.
   d. Generational boundaries in the family are diffuse.

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4

Biological Basis for Understanding Psychopharmacology

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http://evolve.elsevier.com/Varcarolis/essentials

OBJECTIVES

1. Identify at least three major brain structures and eight major brain functions that can be altered by mental illness and psychotropic medications.
2. Describe how evidence-based neuroimaging is helpful in understanding abnormalities of brain function, structure, and receptor pharmacology. **QSEN: Evidence-Based Practice**
3. Explain the basic process of neurotransmission and synaptic transmission using Figs. 4.5, 4.6, and 4.7.
4. Identify the main neurotransmitter systems affected by the following psychotropic drugs:
   a. Antidepressants
   b. Antianxiety agents
   c. Sedative-hypnotics
   d. Mood stabilizers
   e. Antipsychotic agents
   f. Anticholinesterase drugs
5. Explain the relevance of psychodynamic and psychokinetic drug interactions in the delivery of safe, effective nursing care. **QSEN: Safety**
6. Discuss safety concerns related to dietary and drug restrictions with monoamine oxidase inhibitors (MAOIs).
7. Compare and contrast typical and atypical antipsychotic drugs with regard to side-effect profile and quality of life.
8. Discuss the relationship between the immune system and the nervous system in mental health and mental illness.
9. Describe how genes and culture affect an individual's response to psychotropic medication.

KEY TERMS AND CONCEPTS

acetylcholine, p. 39
acetylcholinesterase inhibitors, p. 42
agonist, p. 40
agranulocytosis, p. 46
α_1-receptors, p. 46
amygdala, p. 34
antagonist, p. 40
antianxiety or anxiolytic drugs, p. 34
autonomic nervous system, p. 36
basal ganglia, p. 35
bupropion, p. 43
buspirone, p. 45
carbamazepine, p. 46
circadian rhythms, p. 36
corticotropin-releasing hormone, p. 36
cross-cultural psychopharmacology, p. 48
divalproex sodium, p. 45
dopamine, p. 40
dopamine receptor agonists, p. 46
extrapyramidal symptoms, p. 35
first-generation antipsychotics/typical agents, p. 35
5-HT_2 receptors, p. 46
fluphenazine, p. 46
γ-aminobutyric acid, p. 39
glutamate, p. 39
H_1 receptors, p. 46
hippocampus, p. 34
histamine, p. 42
hypertensive crisis, p. 44
hypnotic, p. 45
hypothalamus, p. 36
lamotrigine, p. 46
limbic system, p. 34
lithium, p. 45
monoamine oxidase, p. 37
monoamine oxidase inhibitors, p. 44
monoamines, p. 37
muscarinic cholinergic receptors, p. 46
neurohormones, p. 36
neuroimaging, p. 37
neuroleptics, p. 46
neurons, p. 34
neurotransmission, p. 37
neurotransmitter, p. 37
norepinephrine, p. 42
paliperidone, p. 47
parasympathetic nervous system, p. 36
pharmacodynamic interactions, p. 42
pharmacokinetic interactions, p. 42
plasticity, p. 34
psychoneuroimmunology, p. 48
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receptors, p. 37
reticular activating system, p. 34
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selective serotonin reuptake inhibitors, p. 43
serotonin, p. 42
soporific, p. 45
sympathetic nervous system, p. 36
synapse, p. 37
therapeutic index, p. 45
trazodone, p. 43
valproate, p. 45
valproic acid, p. 45
venlafaxine, p. 43

CONCEPT: INTRACRANIAL REGULATION: *Intracranial regulation* (ICR) includes normal and abnormal processes of intracranial function. Nurses care for individuals experiencing a wide variety of ICR issues in both community and inpatient settings.

ICR functioning depends on a consistent supply of blood delivering oxygen and nutrients, with carbohydrates as the main source of fuel for the brain (Giddens, 2017). Alterations in these basic processes can lead to mental disturbances and physical manifestations. Unfortunately, agents used to treat mental disease can cause a variety of undesired effects, such as sedation or excitement, motor disturbances, sexual dysfunction, and weight gain. There is a continuing effort to develop new drugs that are effective, safe, and well tolerated.

INTRODUCTION

One of the goals of psychiatric-mental health nursing is to understand the neurobiology of psychiatric disorders and how psychotropic medications help manage a constellation of symptoms and reduce the risk of relapse. Because all brain functions are carried out by similar mechanisms (interactions of **neurons**), often in similar locations, it is not surprising that mental disturbances are frequently associated with alterations in other brain functions. The drugs used to treat mental disturbances can provide symptom relief as well as can interfere with other activities of the brain. Box 4.1 summarizes some of the major brain functions.

BRAIN STRUCTURES AND FUNCTIONS

The basic architecture of the brain is genetically programmed; however, plasticity occurs throughout life. **Plasticity** is a process of adapting and changing as gray matter shrinks and thickens and connections are pruned or forged (Kania, Wronska, & Zieba, 2017). The connections between neurons can change with mental illness or psychotropic medications.

Cerebrum

The cerebrum or cerebral cortex is made up of the four different lobes of the brain. It is also called the human brain or higher brain and is responsible for higher cognitive skills, self-awareness, and executive functions. The four lobes are the frontal, parietal, occipital, and temporal lobes (Fig. 4.1). The frontal lobe is responsible for conscious movement, problem-solving skills, and speech production. The prefrontal cortex (PFC) is the most anterior part of the frontal cortex and is involved in moderating social behaviors, goal setting and planning, and personality. The parietal lobes are involved in tactile sensation and spatial awareness. The occipital lobe is primarily responsible for vision and visual processing. The temporal lobe is responsible for hearing, language reception, and language comprehension.

Brainstem

Basic life functions like regulation of heart rate, breathing, and sleep occur through the brainstem which is composed of the midbrain, pons, and medulla (Fig. 4.2).

Projections from the brainstem, called the **reticular activating system (RAS)** control the level of consciousness and sedation. Many psychiatric medications can alter the signals sent through the brainstem, which can impact sleep and wakefulness, heart rate, and respiration. For those medications that can be sedating, it may be recommended to take them at bedtime and to use caution or even avoid driving. Caution while driving is found on many psychotropic medications.

Cerebellum

The cerebellum is involved in both motor control and cognitive processing. It helps us maintain balance by coordinating muscles from various groups for complex tasks like riding a bike. It is also involved in the coordination of eye movement. Alterations involving the cerebellum are associated with the development of the positive symptoms (hallucinations, delusions, and altered perception) in people with schizophrenia. Drugs like benzodiazepines and alcohol can alter the function of the cerebellum, causing trouble with walking, blurred vision, and fine motor control.

There is frequently cerebellar dysfunction or a noted decrease in size of the cerebellum in people with schizophrenia. This change may explain the issues with coordination and poor cognitive performance that are part of the negative symptoms of schizophrenia (Cao & Cannon, 2019).

Limbic Brain

In addition to the gray matter forming the cortex, there are pockets of gray matter lying deep within the cerebrum: the hippocampus, the amygdala, and the basal ganglia. The **hippocampus** interacts with the PFC in making new memories. The **amygdala** plays a major role in processing fear and anxiety. The hippocampus and amygdala, along with the hypothalamus and thalamus, are a group of structures called the **limbic system** or "emotional brain." Chronic stress triggers shrinkage of the hippocampus, which may lead to higher levels of depression and cognitive impairment (Lin et al., 2018). Structural plasticity of both the hippocampus and the amygdala is induced by electroconvulsive therapy in major depressive disorder (MDD), especially in individuals with smaller hippocampal volumes at baseline (Joshi et al., 2016). Amygdala hyperactivity is common in trauma and may underlie paranoia in schizophrenia (Pinkham et al., 2015). Amygdala hypoactivity predicts a general capacity to respond to antidepressants (Williams et al., 2015).

Linking the frontal cortex, basal ganglia, and upper brainstem, the limbic system mediates thought and feeling through complex, bidirectional connections. **Antianxiety drugs (anxiolytics)** slow the limbic

BOX 4.1 Functions of the Brain

- Monitor changes in the external world
- Monitor the composition of body fluids
- Regulate the contractions of the skeletal muscles
- Regulate the internal organs
- Initiate and regulate the basic drives: hunger, thirst, sex, aggressive self-protection
- Mediate conscious sensation
- Store and retrieve memories
- Regulate mood (affect) and emotions
- Think and perform intellectual functions
- Regulate the sleep cycle
- Produce and interpret language
- Process visual and auditory data

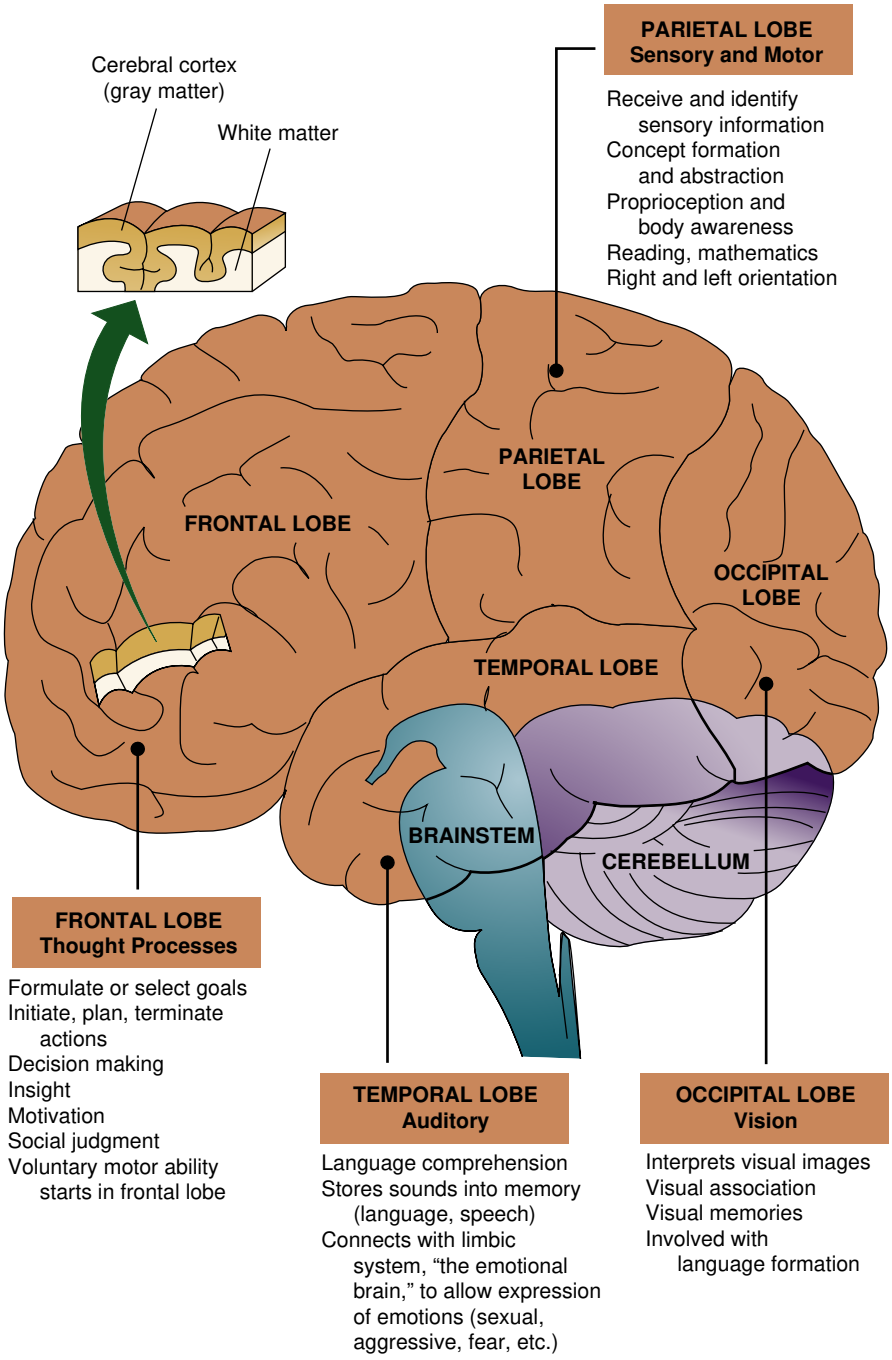

Fig. 4.1 Functions of the cerebral lobes: frontal, parietal, temporal, and occipital.

system. Subcortical **basal ganglia** play a major role in motor responses via the extrapyramidal motor system, which relies on the neurotransmitter dopamine to maintain proper muscle tone and motor stability. Neuroimaging shows that haloperidol can reduce striatal volume within hours, temporarily changing brain structure and producing abnormal involuntary motor symptoms (**extrapyramidal symptoms [EPSs]**). In the basal ganglia, two types of movement disturbances may occur: (1) acute EPS, which develops early in treatment, and (2) tardive dyskinesia (TD), which usually occurs much later. **First-generation antipsychotics (FGAs) (typical agents)** and high doses of **second-generation antipsychotics (SGAs) (atypical agents)** such as risperidone are most likely to cause EPSs.

It is important to remember that movement is regulated by the basal ganglia, including the diaphragm (essential for breathing) and the muscles of the throat, tongue, and mouth (essential for speech). Thus drugs that affect brain function can stimulate or depress respiration or affect speech patterns (e.g., slurred speech).

Thalamus

The thalamus filters sensory information before it reaches the cerebral cortex. Disrupted sensory filtering in schizophrenia is associated with altered connections between the thalamus and prefrontal cortex (PFC). Deep-brain stimulation (DBS) changes electrical impulses in the corticobasal ganglia-thalamic loops and is being investigated in treating chronic, severe depression; obsessive-compulsive disorder (OCD); anorexia nervosa; and other psychiatric disorders (Graat, Figee, & Denys, 2017).