MERTIE L. POTTER | MARY MOLLER

Psychiatric–Mental Health Nursing 2E

FROM SUFFERING TO HOPE

Brief Contents

Psychiatric–Mental Health Nursing 2E

FROM SUFFERING TO HOPE

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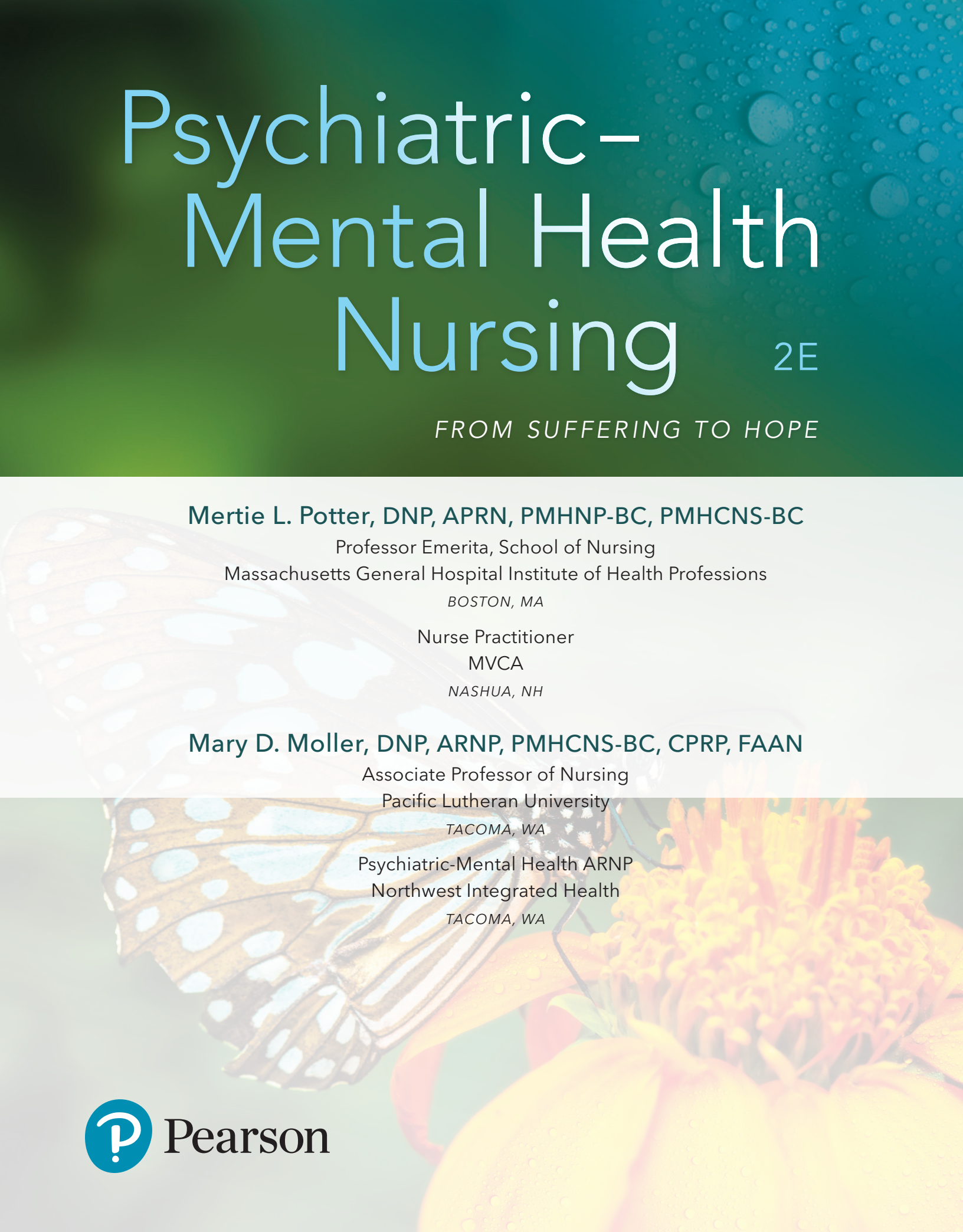

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Dear Student

You are about to launch on a journey that we trust will lead you into a deeper appreciation and understanding of the suffering experienced by individuals diagnosed with mental illness and their families. Hope and recovery in mental illness are achievable and need to be fostered and encouraged in both patients and families. This second edition includes much new and updated information.

Why did we title this book ***Psychiatric–Mental Health Nursing: From Suffering to Hope?*** During our years of nursing, we have witnessed patients and families suffer in times of emotional pain and distress as well as in times of physical illness. We also have witnessed patients make incredible recoveries as they gain hope and confidence through relationships and experiences with competent and caring nurses.

The word *patient* has been selected for use in this textbook due to its root meanings: (1) to suffer, undergo, or bear and (2) to bear or endure pain. The term *patient* reminds us that nursing care focuses on relieving human distress, as well as promoting patient health and wellness.

Caring for patients experiencing mental health challenges is rewarding for the nurse who sees patients improve, helps them learn new coping skills to meet needs, and helps them return to normal functioning. We intend for this text to assist you in providing care and compassion to patients in any clinical setting.

Throughout this text, we hope that you will learn how to:

- Promote patient empowerment using nursing interventions that alleviate patient suffering and distress and promote hope
- Find the context for patient health and recovery by recognizing how neurobiological processes, psychological factors, spiritual needs, and social networks (including family, cultural values, and beliefs) impact patient mental health
- Recognize and address needs of patients across the lifespan
- Engage patients in a therapeutic relationship to promote their safety and recovery

We have heard from nursing students how the first edition was helpful in their growth in the nursing profession. We are excited as *you* begin this journey.

Thank you for joining us.

Sincerely,

Mertie L. Potter,
DNP, APRN, PMHNP-BC, PMHCNS-BC

Mary D. Moller,
PhD, DNP, ARNP, PMHCNS-BC, CPRP, FAAN

About the Authors

Mertie L. Potter Mertie L. Potter received her bachelor's degree from Simmons College, her master's degree from the University of Michigan, her doctoral degree from Case Western Reserve University, and her Post-Master's Certificate as a Family Psychiatric and Mental Health Nurse Practitioner from Rutgers University. She acquired common sense and a hard work ethic from working alongside her parents at Maple Leaf Farm. Her lifelong passion for helping those struggling with mental health issues piqued as a result of the family's farm property being next to a state psychiatric facility. That led to summer jobs there and observations of her parents' respect and compassion for patients at that hospital.

Dr. Potter is Professor Emerita of Nursing at Massachusetts General Hospital Institute of Health Professions and a nurse practitioner at Merrimack Valley Counseling Association in Nashua, New Hampshire. She is ANCC certified as a family psychiatric–mental health nurse practitioner and as a clinical nurse specialist in adult psychiatric–mental health nursing. She is abundantly blessed by her life's calling.

Dr. Potter's professional interests include group work, crisis intervention, stress management, chronic illness, pain management, suffering, grieving, spirituality, older adults, medical missions, camp nursing, and nursing theory. She has experience in education, counseling, prescribing, group work, team building, consulting, camp nursing, medical missions, and speaking/presenting. She has spoken on a number of these topics.

Dr. Potter has authored and coauthored articles, chapters, and books, one of which received an AJN Book of the Year Award. She served on the New Hampshire Board of Nursing for 5 years and had the privilege of being elected Vice-Chairperson for a number of them. She was selected to serve as a program evaluator for the National League for Nursing Commission for Nursing Education Accreditation.

Mary D. Moller Mary D. Moller received her bachelor's degree in nursing from Mt. Marty College in Yankton, South Dakota; her master's degree in psychiatric nursing from the University of Nebraska Medical Center College of Nursing; and her doctoral degree from Case Western Reserve University Frances Payne Bolton School of Nursing. Her doctoral research in schizophrenia received the Dean's Legacy Award in 2006. However, she attributes her real education to what she has learned from her thousands of patients and their family members encountered since 1971, when she had the privilege of becoming a registered nurse. She is dually certified as an adult psychiatric–mental health clinical nurse specialist by the American Nurses Credentialing Center and as a certified psychiatric rehabilitation practitioner by the United States Psychiatric Rehabilitation Association.

Dr. Moller was drafted rather unwillingly into psychiatric nursing in the late 1970s while teaching neurological nursing at a diploma school of nursing. Although initially she was very apprehensive, she quickly saw the parallels between neurology and psychiatry and began implementing the only kind of nursing she knew, rehabilitation nursing, working with a group of patients who had never been exposed to this kind of nursing. After seeing patients who had been experiencing catatonia respond for the first time in years, she literally fell in love with psychiatric nursing and, since 1978, has dedicated her career to improving the lives of individuals with serious and persistent mental illness and their families.

Dr. Moller is an Associate Professor of Nursing at Pacific Lutheran University in Tacoma, Washington, where she is coordinator of the Psychiatric Mental Health Nurse Practitioner Doctor of Nursing Program. From 2009 through 2014 she was the Coordinator of the Psychiatric Mental Health Nurse Practitioner Specialty at the Yale University School of Nursing. She is in practice as an advanced registered nurse practitioner at Northwest Integrated Health in Tacoma, where she serves as Director of Psychiatric Services in a triple integration clinic that treats individuals with a substance use disorder and also provides primary care as well as mental health services. Dr. Moller has an active consulting practice with an emphasis on psychiatric wellness that has taken her to China, Australia, Hong Kong, Israel, Cuba, and several other countries. Prior to returning to education, Dr. Moller founded and served as clinical director of the first APRN-owned and managed rural outpatient psychiatric clinic in the United States—the Suncrest Wellness Center, which was located in Spokane, Washington, from 1992 to 2008. The experiences and relationships developed during this time in her life have blessed and continue to truly bless not only Dr. Moller, but also all those she encounters as she shares what she learned.

Dr. Moller's professional interests include psychiatric rehabilitation with people recovering from schizophrenia, bipolar disorder, major depression, posttraumatic stress disorder, attention-deficit disorder, and personality disorders. She is the coauthor of the Three R's Psychiatric Wellness Rehabilitation Program, which includes three training/participant psychoeducational manuals focusing on relapse, recovery, and rehabilitation. This program was a CMS model training program in 1996. She has also produced four videos in the award-winning Understanding and Communicating with a Person Who Is Experiencing series, which include hallucinations, delusions, mania, and relapse. She is also coauthor of the Be Smart trauma recovery program, which also has both training and participant manuals. Her work centers on both individual and group therapy.

Dr. Moller has presented more than 1,000 research and training workshops, seminars, and consultations in 49 states and 10 countries. She has published numerous articles and book chapters and received many awards, including an honorary PhD from Mt. Marty College and the Distinguished Alumnus Award from the University of Nebraska Medical Center College of Nursing. She is an active member of the American Psychiatric Nurses Association and served as president in 2009–2010. She has received the APNA Award for Clinical Excellence and the Distinguished Service Award, as well as the NAMI Professional of the Year Award. In 2018, she was named Psychiatric Nurse of the Year by the American Psychiatric Nurses Association.

Thank You!

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We extend heartfelt thanks to our contributors, who gave their time, effort, and expertise so tirelessly to the development and writing of chapters and resources. Together we have created a book that we hope will foster our goal of preparing all nursing students to work in a holistic manner to promote the principles of mental health for all patients and their families.

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We are grateful to all the nurses, both clinicians and educators, who reviewed the manuscript of this text. Their insights, suggestions, and eye for detail helped us prepare a more relevant and useful book, one that focuses on the essential components of learning in the field of psychiatric–mental health nursing.

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Preface

Each year, patients with mental illness enter the healthcare system not just for mental health care, but also for regular physical examinations and for treatment of acute or chronic medical illness. In addition, acute or chronic illness can provoke stress responses that bring on symptoms of anxiety, depression, and/or grief. As a result, nurses in all settings will encounter and have the privilege to care for patients on a continuum of mental health.

Psychiatric–Mental Health Nursing: From Suffering to Hope is designed to help nursing students recognize the signs of patient suffering and help promote hope and healing in patients across this continuum. Within its pages, nursing students will learn to recognize how the five domains of wellness—biological, psychological, sociological, cultural, and spiritual—affect and are affected by mental health and illness. Students will learn how neurobiological, genetic, and environmental constructs and familial, cultural, and spiritual values and practices affect individual wellness and inform nursing care. In addition, nursing students will learn interventions to help patients progress from high-acuity mental illness occurring at the initial onset or during a relapse through to recovery, during which patients begin to experience lower levels of acuity and learn how to manage their illness, to rehabilitation, when patients are able to return to a more normal level of functioning and engage fully in home, school, and work environments. This is particularly important because patients with mental illness can—and do—get well. To do this, they need to believe, to have hope that they can become well again, and to have a plan and strategies to help them on the path to wellness. Nurses in all settings need to be able to help patients navigate the healthcare system, manage their mental and physical healthcare, and believe that they can get better and reach full recovery.

To help nursing students understand patients with mental illness and options for interventions and treatments available, *Psychiatric–Mental Health Nursing: From Suffering to Hope* is designed to:

- Provide examples of nursing interventions that will help relieve patient suffering and promote hope for recovery.
- Provide strategies nurses can use as they care for patients with mental illness, regardless of setting. These include everything from steps nurses can use to teach patients how to relax their breathing to examples of nursing interventions for patients experiencing severe anxiety, psychosis, symptoms of dementia, sleep disturbance, and suicidal ideation.
- Facilitate understanding and application of the therapeutic nurse–patient relationship and gain skill in communicating with patients with psychiatric disorders through a deeper understanding of patient and nurse perceptions, thoughts, and feelings.
- Outline both the neurobiology and psychology of mental health to help students understand that patients with mental illness are not lying, making it up, or able to change their behavior simply because they want to.
- Present information on specific psychiatric disorders identified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), published in 2013 by the American Psychiatric Association.
- Provide contexts for psychiatric illness and recovery—discussing how family members, cultural values and beliefs, and sociologic constructs affect mental illness and patient care.
- Provide information relevant to nurses in the workplace: discussions of the legal and ethical issues surrounding patient care, as well as an overview of leadership and management skills that nurses need in professional healthcare environments.
- Address the needs of patients across the lifespan.

Organization

We received a number of suggestions for how to achieve the appropriate order of the chapters. Bearing in mind that faculty can assign chapters in any order they prefer, we have provided an organizational structure that we think will be accessible to a wide variety of nursing programs.

The first unit, Foundations of Psychiatric–Mental Health Nursing, presents six chapters that provide students with the scientific, theoretical, sociological, and cultural constructs that inform psychiatric nursing practice today.

The second unit, Psychiatric Nursing Role Development, provides nursing students with strategies and interventions they will need to provide care for patients with mental illness. This begins with a new chapter that introduces students to the concepts of stress, anxiety, and coping and that provides nursing interventions for each level of anxiety. The unit continues with information on the importance of self-reflection and self-awareness in nursing practice; guidance for building the nurse–patient relationship and using therapeutic communication; and an overview of the nursing process, particularly its application in psychiatric nursing. The last chapters in this unit provide an overview of care settings and contexts in which patients access and receive mental health care, applicable ethical and legal concepts, and information on management and leadership skills and activities that promote successful nursing practice.

In the third unit, students will find information about the specific psychiatric disorders. The unit begins at the start of the lifespan with a chapter addressing neurodevelopmental disorders and other mental health issues prominent in the care of children and adolescents. New for this edition is a separate chapter on trauma- and stressor-related disorders and two chapters covering depressive and bipolar disorders rather than the combined chapter that appeared in the first edition. Each chapter in this unit provides an overview of etiology and impact of the disorders through the lens of the domains of patient functioning—biological, psychological, sociological, cultural, and spiritual—as well as outlining options for the collaborative care of patients through the variety of pharmacologic and nonpharmacologic treatments shown to have a positive impact on patients with those disorders. A detailed nursing management section outlines assessment, diagnosis and planning, implementation, and evaluation of nursing care for patients diagnosed with disorders in that category. A combination of features provides nurses with meaningful strategies they can use in caring for patients. For instance, the feature "Perceptions, Thoughts, and Feelings: Validating Patient Care" gives examples of how nurses can validate their understanding of patients' concerns and help patients clarify their understanding of their mental illness and its effects on themselves and others. Evidence-Based Practice features provide examples of the implications of research on nursing practice. Nursing Care Plans assist nursing students with understanding how to develop a care plan to address a specific care priority.

The fourth and final unit, Specialized Treatments and Interventions, explores options patients have for treatment as well as nursing interventions specific to incidents critical to patient health and safety, including crisis intervention, suicide, and loss and grief. A separate chapter on pharmacotherapy provides a basis of understanding of the role of and classes of psychotropic drugs. A chapter on integrative and complementary therapies provides an overview of both natural products and mind–body practices and their use in patients with mental illness. A chapter on group and family therapy provides an overview of working in group settings and with families experiencing mental health challenges. Finally, the unit looks at interventions for individuals in crises of different kinds, as well as interventions specific to caring for patients exhibiting suicidal ideation or behaviors, strategies for working with patients experiencing loss and grief, and issues related to aging and mental health.

Application of the Nursing Process

The nursing process is outlined in detail in Chapter 9 and throughout the chapters on the different mental disorders recognized by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5). The heading "Nursing Management" highlights nursing assessment, diagnosis and planning, implementation, and evaluation. In addition, we feature nursing care plans throughout the text. The nursing care plans address nursing care for patients with care needs that are frequently seen in patients who present with the disorder that is outlined in the chapter. In most cases, the nursing care plan is built on the critical thinking feature, a multi-part case study that describes a representative patient seeking treatment for the disorder.

Nurses today face many new challenges, among them the growing number of patients in the community who are experiencing mental illness. Changes in the workplace in response to quality improvement efforts, an ongoing nursing shortage, dramatic advances in healthcare knowledge, a growing population of veterans with mental health needs, and a variety of environmental disasters require skilled nurses in every setting to be prepared to work with patients with mental illness and their families. We believe that nurses are in a unique position to have a tremendous impact on their patients, families, and communities; to reduce burden levels; and to bring hope to those in need. Our goal in writing this text is to help prepare nurses with the skills and knowledge to make a positive difference for patients with mental illness and their families who are striving to maintain or regain their mental health in any and every setting in which nurses work.

NEW TO THIS EDITION

Based on the feedback of users and reviewers, we have made a number of changes to this edition with both students and faculty in mind:

- Updated references complement seminal research wherever possible
- A short list of helpful websites at the conclusion of each chapter
- New unfolding case studies in a number of chapters highlight current issues in nursing
- Separate chapters for anxiety-related disorders and trauma- and stressor-related disorders
- Separate chapters on depressive and bipolar disorders
- A new chapter on sociological influences on mental health

This edition also reveals a new signature image, the butterfly. The lighthouse in the first edition emphasized guiding someone to a safe harbor. The butterfly represents transformation to recovery, which takes place in a complex environment that depends on interprofessional collaboration. This transformation often occurs across one or more domains impacted by mental illness: biological, psychological, sociological,

cultural, and spiritual. These domains align with the four dimensions identified by the Substance Abuse and Mental Health Services Administration to support recovery: home, health, purpose, and community.

We hope that you find the second edition of *Psychiatric–Mental Health Nursing: From Suffering to Hope* assists you in further understanding mental illness and interventions nurses can provide to move patients and families to recovery of health and wellness, and that you will discover the many different ways nurses can provide comfort and hope to those in need, regardless of the setting or nursing specialty in which you choose to practice.

Mertie L. Potter
Mary D. Moller

Visual Guide

The Visual Guide walks you through the structure and features of the text. Note that the features are color coded for ease of use.

1

Framework of Psychiatric–Mental Health Nursing

Mertie L. Potter
Mary D. Moller

LEARNING OUTCOMES

1. Discuss the epidemiology of psychiatric and mental health disorders.
2. Distinguish the unique contributions of psychiatric–mental health nursing to other areas of nursing.
3. Evaluate a recovery-focused, wellness approach to patient care based on five domains: biological, psychological, sociological, cultural, and spiritual.
4. Identify patient care needs within three levels of wellness: initial onset/relapse, recovery, and rehabilitation.
5. Examine factors that affect patient health and recovery.
6. Examine significant concepts related to providing psychiatric and mental health nursing care to all patients.

KEY TERMS

actualization, 13
domains, 10
hope, 19
kinship, 12
mental health, 2
mental illness, 3

Each chapter begins with **learning outcomes** and **key terms**.

CRITICAL THINKING Kara *Initial Onset*

Kara is a 15-year-old patient who presents for hospital admission due to bradycardia and orthostatic hypotension secondary to restricted nutritional intake, purging, and weight loss of 30 pounds in the past 6 months. Her body mass index (BMI) is 15.0. When Liz, a registered nurse, enters her room to complete the admission assessment, Kara is lying in bed under several blankets and appears pale, tired, and sad. Her mother sits anxiously at her bedside. While taking a history of Kara's symptoms, Liz learns that Kara's problems started around age 11, when she first experienced symptoms of anxiety. Her mother reports that Kara was subjected to peer teasing in middle school. Her mother states, "From middle school on, Kara has been self-conscious and uncomfortable in her body." Kara's father changed jobs when Kara was 13, resulting in a family move that required Kara to attend eighth grade in a new school. The school transition was difficult for Kara; she struggled to fit in and make new friends. She started "trying to eat healthy" to lose weight and began running and exercising daily. Kara's parents and primary care provider (PCP) were initially pleased by her focus on fitness, but when she fainted in gym class and returned to her PCP, her weight loss was alarming and she required hospitalization for bradycardia that dropped below 40 bpm overnight. During her hospitalization at age 13, Kara was given a diagnosis of anorexia nervosa. She participated in an adolescent eating disorder program following discharge and continued on a supervised meal plan for several months. Her mother says, "Everything seemed to be going well, so we got lax. We thought things were back to normal."

Kara reports that recent conflicts with friends have contributed to her increased feelings of self-dislike. She states, "I hate the way I look; I'm too fat and no one wants to hang out with me." She says, "I just wanted to lose a few pounds, so I started skipping breakfast and eating a piece of fruit for lunch. By evening, I was so hungry that I ate too much and felt disgusting. I started making myself throw up to stop from gaining weight." In addition to her recurrent eating disorder symptoms, Kara acknowledges often feeling anxious and depressed. She constantly has negative thoughts about herself. She feels anxious most days and worries that she is falling behind in school because of feeling tired and being unable to concentrate on her schoolwork. Her mother says that Kara has been more irritable at home and isn't sleeping well. She has been isolating herself in her room and shows little interest in activities she previously enjoyed.

When they returned to her PCP yesterday and discovered Kara's weight loss and low blood pressure, it was determined that hospitalization was necessary. However, since her admission, Kara has been pleading to be discharged. Liz explains to Kara that she will need to stay in the hospital until she is medically stable. Laboratory tests have been ordered to evaluate her electrolyte levels, and Kara will be placed on a cardiac monitor while her calorie intake is gradually increased. Kara becomes tearful and sobs, "You just want to make me fat!"

APPLICATION

1. Address the five domains for Kara:
   a. Biological
   b. Psychological
   c. Sociological
   d. Cultural
   e. Spiritual
2. In what ways may Kara and her mother be suffering? Why?
3. How should the nurse prioritize Kara's needs at this time? Why?
4. In what way does Liz convey hope to Kara? What might Liz have done differently to offer hope?

Unfolding case studies portray a representative patient at the different points of wellness, from initial onset or relapse, to recovery, to rehabilitation.

The section on **wellness domains** provides information related to current knowledge of the pathophysiology and etiology of psychiatric disorders, as well as context related to the five domains of wellness: biological, psychological, sociological, cultural, and spiritual.

PERCEPTIONS, THOUGHTS, AND FEELINGS
Validating the Needs of a Patient with an Eating Disorder

PATIENT'S BEHAVIOR	NURSE'S PERCEPTIONS, THOUGHTS, AND FEELINGS	EXPLORATION WITH PATIENT
Kara has been staring at her meal for 30 minutes. She has moved the food on her plate around with her fork and repeatedly reorganized utensils, condiments, and her drink, but she has not eaten anything. The nurse walks by. **KARA:** *I can't eat this.*	**PERCEPTIONS:** Kara is still eating hardly anything on her tray. **THOUGHTS:** How can I encourage her to eat? I don't want to put her on the defensive. Maybe I should offer her a meal-replacement shake instead. I know her refusal to eat is part of the core symptoms of her eating disorder diagnosis. If she continues to refuse food, it will affect her health. **FEELINGS:** I'm afraid I'm going to say something that will interfere with building a therapeutic relationship, but I am also afraid of what we would have to do if she continues to not eat.	**NURSE:** *Kara, I notice you've been reading during your free time. Tell me about the book you're reading.*

VALIDATION The nurse chooses a topic of interest to Kara in an attempt to alleviate Kara's anxiety by using distraction.

The **Perceptions, Thoughts, and Feelings** feature provides a sample interaction between a nurse and patient to help students build a foundation for therapeutic communication with their patients. These interactions also show how the nurse can provide validation and support to patients, even at times when the nurse is unsure of how to proceed.

EVIDENCE-BASED PRACTICE *Refeeding*

Clinical Question

If an adolescent with BMI of 14 agrees to eat to avoid hospitalization, and her parents agree to make certain she eats 1,800 calories per day, should the nurse at the pediatric clinic support this plan?

PATHOPHYSIOLOGY OF REFEEDING

To discern the answer to this clinical question, the nurse must understand the pathophysiology of starvation and what happens when the body is suddenly given access to nutrients. The healthy body relies on glucose as an energy supply. In states of starvation, stores of glucose are depleted and the body shifts to catabolism of fats and proteins for energy. Insulin levels drop when the body shifts from glucose metabolism to catabolism of protein and fat. In this state, a pathological condition can develop rapidly with a sudden reintroduction of nutrient-rich foods or formulas. In response to the sudden availability of carbohydrates, the pancreas increases insulin production to help transport the available glucose into cells. The cellular uptake of glucose also carries electrolytes such as phosphorus, magnesium, and potassium into the cells. This shift can cause a life-threatening depletion of circulating electrolytes. Hypophosphatemia can cause respiratory failure, edema, mental confusion, and delirium. Hypokalemia and hypomagnesemia can result in serious cardiac arrhythmias, muscle weakness, seizures, and metabolic acidosis. These life-threatening complications are collectively referred to as refeeding syndrome (RFS) (Yantis & Velander, 2009).

EVIDENCE

The current standard of care for refeeding malnourished individuals with AN advocates for medical supervision and a "start low [kcal/kg/day] and go slow" approach to refeeding. In the United States, the standard is to start at 1,200 or fewer calories per day and increase at a slow rate of 200 calories per day while monitoring the patient closely for signs of RFS (Garber et al., 2016). Research is focusing on refeeding strategies to avert the risk of RFS (Garber, Michihata, Hetnal, Shafer, & Moscicki, 2012; Garber et al., 2016; Giles, Hagman, Pan, MacLean, & Higgins, 2016; O'Connor, Nicholls, Hudson, & Singhal, 2016). The rate at which calories are reintroduced is being examined to determine if beginning at a lower caloric intake (e.g., 500–800 calories per day) and progressing more slowly in adding calories will prevent RFS (Garber et al., 2016; O'Connor et al., 2016). Other research is looking at the composition of refeeding formulas to determine if a lower percentage of carbohydrates and higher percentage of fats can avoid over-stimulating pancreatic insulin, thereby averting the dramatic shift of electrolytes from extracellular to intracellular spaces (Giles et al., 2016). Findings from these studies suggest that more research is needed to determine the safest approach to refeeding.

There is consensus about individuals who are at the highest risk for RFS. The risk for RFS is highest during the first week of reintroducing nutrients and greatest for individuals with BMI less than 15 who are severely and chronically malnourished. Other conditions such as dehydration and low white blood cell counts may further increase the risk for RFS (Garber et al., 2016; O'Connor et al., 2016).

IMPLICATIONS FOR NURSING PRACTICE

The nurse's role in safeguarding patients at risk for RFS includes recognizing risk factors and advocating for medical supervision of refeeding in those individuals at risk of this complication; supervising prescribed refeeding protocols in hospitalized patients; closely monitoring serum electrolyte levels, intake and output, and vital signs, and reporting changes immediately; and administering prescribed electrolyte supplements as ordered while monitoring for side effects. Patients and families may be unaware of the risk for RFS and assume that anything that gets the individual with AN to eat promotes better health. Thus, the nurse's role includes recognizing the risks of rapid refeeding in severely malnourished individuals and providing patient and family education about the importance of a medically supervised refeeding process that assures patient safety (Yantis & Velander, 2009).

CRITICAL THINKING QUESTIONS

1. *How might the nurse respond to the parents of an adolescent with a BMI of 14 who promise to assure their daughter eats 1,800 calories per day if she is allowed to go home rather than receive treatment in the hospital?*
2. *What actions should the nurse take if a patient on a refeeding protocol develops a rapid pulse and changes in mental status?*

Evidence-Based Practice features demonstrate how research informs nursing practice.

Interprofessional Care sections cover pharmacologic and nonpharmacologic therapies used in the treatment of patients with psychiatric disorders.

MEDICATIONS COMMONLY USED TO TREAT DEPRESSIVE DISORDERS

COMMONLY USED ANTIDEPRESSANTS

MEDICATION	INITIAL DAILY DOSE*	THERAPEUTIC DAILY DOSE RANGE*	KEY NURSING CONSIDERATIONS FOR MEDICATION CLASS
Selective serotonin reuptake inhibitors (SSRIs)			
citalopram (Celexa)	20 mg	20–40 mg	Instruct regarding onset of action; side effects may be minimized by starting at low doses and titrating slowly, but this may delay therapeutic effect. Side effects lessen with continued use.
escitalopram (Lexapro)	5–10 mg	10–20 mg	
fluoxetine (Prozac)	10–20 mg	10–80 mg	
fluvoxamine (Luvox)	25–50 mg	50–300 mg	Discourage abrupt withdrawal or discontinuation of medication.
paroxetine (Paxil)	10 mg	10–80 mg	
sertraline (Zoloft)	25–50 mg	50–200 mg	Grapefruit juice may increase the plasma levels of some SSRIs.
vortioxetine (Trintellix)	10 mg	20 mg	Advise/monitor for common side effects of insomnia, early agitation or restlessness, sweating, GI disturbance, weight gain, sexual side effects.
			Monitor for and report worsening of depression or onset of suicidal ideation.
Monoamine oxidase inhibitors (MAOIs)			
isocarboxazid	10 mg	10–30 mg	Teach dietary restrictions on tyramine-rich foods and drug-to-drug interactions; report severe headache, palpitations, chest pain, or shortness of breath.
phenelzine (Nardil)	15 mg	60–90 mg	
tranylcypromine (Parnate)	30 mg	30–60 mg	Discourage the use of caffeine.
selegiline (Eldepryl, Emsam)	6 mg/24 hr patch	6–12 mg/24 hr patch	Advise/monitor for common side effects of insomnia, headache, sedation, increased stimulation, dry mouth, constipation. Monitor for and report worsening symptoms or onset of suicidal ideation.

Medications features provide an overview of medications commonly used in the treatment of different disorders.

Nursing Management sections within each disorder chapter cover assessment, diagnosis, planning, implementation, and evaluation of patients with the disorder.

NURSING CARE PLAN Kara–*A Patient with Anorexia Nervosa, Binge-Purge Subtype*

NURSING CARE PRIORITY: Promote patient safety to reduce suicide risk and high-risk eating and purging behaviors.

Patient will: *(include date for short-term goal to be met)*	INTERVENTION Nurse will:	RATIONALE
SHORT-TERM GOALS		
Remain free from self-directed harm.	Assess for suicidal thoughts and other self-directed harm and implement suicide precautions as needed. Collaborate with the patient, parents, and treatment team to establish an individualized safety plan.	Priority is given to the continuous monitoring of suicidal thinking and self-directed harm behavior; both are crucial to maintaining safe treatment. A safety plan helps the patient, parents, and team develop strategies to assess level of safety, initiate check-ins to encourage verbalization of feelings, identify actions to reduce risk of engaging in unsafe behaviors, and prepare a list of resources and contact numbers to access if safety is at risk.
Be able to identify physical complications of binge-eating and purging by day 3 of treatment.	Teach the patient about harmful effects of purging, including dental erosion, cardiac problems, and electrolyte disturbances.	Patient education and health teaching are imperative to treatment and an integral part of the patient's understanding of the positive outcomes of healthy eating behaviors.
Identify distorted thoughts that precede episodes of binge-eating and purging by day 5 of treatment.	Provide emotional support before, during, and after meals and explore dysfunctional thought patterns.	Emotional support from the nurse helps to build a therapeutic relationship. Nonjudgmental reframing of distorted thinking engenders improved communication.
Refrain from binge-eating and purging by day 7 of treatment.	Monitor for signs and symptoms of binge-eating and purging. Sit with the patient for one hour after meals. Assess lab values such as increased serum amylase, and monitor for signs such as swollen parotid glands.	Frequent monitoring is essential in the treatment of eating disorders. Patients are often resistant to treatment due to their intense fears about gaining weight and, therefore, may not accurately report binge-eating or purging behavior.
LONG-TERM GOAL		
Kara will identify and use new coping skills to manage triggers associated with the urge to binge-eat or purge.	Collaborate with the patient to independently implement identified alternative stress-reduction techniques that will contribute to healthier coping and avoid eating disorder behaviors.	Promoting patient autonomy and independence in managing life stressors is essential in the treatment of eating disorders.

CLINICAL REASONING

1. What other nursing interventions might be appropriate for Kara?
2. What strategies or techniques might help Kara to challenge and reframe distorted thinking?

Nursing Care Plans extend the unfolding case studies to illustrate appropriate short- and long-term goals for a representative patient.

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