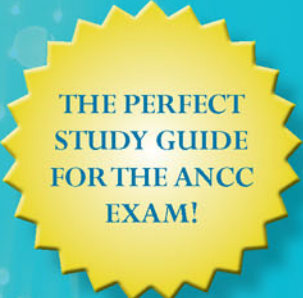


PSYCHIATRIC NURSING CERTIFICATION REVIEW GUIDE

FOR THE GENERALIST AND
ADVANCED PRACTICE PSYCHIATRIC
AND MENTAL HEALTH NURSE

Third Edition

Victoria Mosack



THE PERFECT
STUDY GUIDE
FOR THE ANCC
EXAM!

Psychiatric Nursing Certification Review Guide for the Generalist and Advanced Practice

Psychiatric and Mental Health Nurse

Third Edition

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Preface

This is the third edition of a book developed especially for nurses preparing to take certification examinations offered by the American Nurses Credentialing Center (ANCC). Major revisions were needed in a number of areas to accommodate changes in the field of psychiatric and mental health nursing and to incorporate more recent references as well as evidence-based practice guidelines that may have become available since the previous revision was published.

The book is inclusive in that it contains both basic and advanced content, and may be used by nurses seeking certification as generalists as well as nurses seeking certification in advanced practice psychiatric and mental health nursing. It is assumed that the reader of this review guide has completed a course of study in psychiatric and mental health nursing. The *Psychiatric Nursing Certification Review Guide for the Generalist and Advanced Practice Psychiatric and Mental Health (PMH) Nurse* is not intended to be a basic learning tool.

The purpose of the book is twofold. It will assist individuals engaged in self-study preparation for certification examinations, and may be used as a reference guide in the practice setting. Many nurses preparing for certification examinations find that reviewing an extensive body of scientific knowledge requires a very difficult search of many sources that must be synthesized to provide a review base for the examination. The purpose of this publication is to provide a succinct, yet comprehensive review of the core material.

The book has been organized to provide the reviewer with test taking strategies and techniques. This is followed by chapters on the Essentials of Psychiatric Nursing Care, Major Theoretical Frameworks for Psychiatric Nursing, Substance-Related Mental Disorders, Anxiety and Stress-Related Disorders, Schizophrenia and Other Psychotic Disorders, Mood Disorders, Behavioral Syndromes and Disorders of Adult Personality, Cognitive Mental Disorders and Geropsychiatric Nursing, Behavioral and Emotional Disorders of Childhood and Adolescence, and The Larger Mental Health Environment.

Following each chapter are test questions, which are intended to serve as an introduction to the testing arena. In addition, a bibliography is included for those who desire a more in-depth discussion of the subject matter in each chapter. These references can serve as additional instructional material for the reader.

Certification is a process that is gaining recognition both within and outside the profession. For the professional, it is a means of gaining special recognition as a certified psychiatric nurse, which not only demonstrates a level of competency, but may also enhance professional opportunities and advancement. For the consumer, it means that a certified nurse has met certain predetermined standards set by the profession.

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Chapter 10. Behavioral and Emotional Disorders of Childhood and Adolescence: Michele L. Zimmerman, MA, RN, CS

Chapter 11. The Larger Mental Health Environment: Janice V. R. Belcher, PhD, RN, CS

Test Taking Strategies and Techniques

We all respond to testing situations in different ways. What separates the successful test taker from the unsuccessful one is knowing how to prepare for and take a test. Preparing yourself to be a successful test taker is as important as studying for the test. Each person needs to assess and develop their own test taking strategies and skills. The primary goal of this chapter is to assist potential examinees in knowing how to study for and take a test.

▣ STRATEGY #1 KNOW YOURSELF

When faced with an examination, do you feel threatened, experience butterflies or sweaty palms, have trouble keeping your mind focused on studying or on the test questions? These common symptoms of test anxiety plague many of us, but can be used advantageously if understood and handled correctly (Divine & Kylen, 1979). Over the years of test taking, each of us has developed certain testing behaviors, some of which are beneficial, while others present obstacles to successful test taking. You can take control of the test taking situation by identifying the undesirable behaviors, maintaining the desirable ones, and developing skills to improve test performance.

▣ STRATEGY #2 DEVELOP YOUR THINKING SKILLS

Understanding Thought Processes

In order to improve your thinking skills and subsequent test performance, it is best to understand the types

of thinking as well as the techniques to enhance the thought process.

Everyone has a personal learning style, but we all must proceed through the same process to think.

Thinking occurs on two levels—the lower level of memory and comprehension and the higher level of application and analysis (ABP, 1989). Memory is the ability to recall facts. Without adequate retrieval of facts, progression through the higher levels of thinking cannot occur easily. Comprehension is the ability to understand memorized facts. To be effective, comprehension skills must allow the person to translate recalled information from one context to another. Application, or the process of using information to know why it occurs, is a higher form of learning. Effective application relies on the use of understood memorized facts to verify intended action. Analysis is the ability to use abstract or logical forms of thought to show relationships and to distinguish the cause and effect between the variables in a situation.

As applied to testing situations, the thought process from memory to analysis occurs quite quickly. Some examination items are designed to test memory and comprehension, while others test application and analysis. An example of a memory question is as follows:

Clients' initial response to learning that they have a terminal illness is generally:

- A. Depression
- B. Bargaining
- C. *Denial*
- D. Anger

To answer this question correctly, the individual has to retrieve a memorized fact. Understanding the fact, knowing why it is important, or analyzing what should be done in this situation is not needed. An example of a question that tests comprehension is as follows:

Shortly after having been informed that she is in the terminal stages of breast cancer, Mrs. Jones begins to talk about her plans to travel with her husband when he retires in two years. The nurse should know that:

- The diagnosis could be wrong and Mrs. Jones may not be dying.
- Mrs. Jones is probably responding to the news by using the defense mechanism of denial.
- Mrs. Jones is clearly delusional.
- Mrs. Jones is not responding in the way most clients would.

In order to answer this question correctly, an individual must retrieve the fact that denial is often the first response to learning about a terminal illness and that Mrs. Jones' behavior is indicative of denial.

In a higher level of thinking examination question, individuals must be able to recall a fact, understand that fact in the context of the question and apply this understanding to explaining why one answer is correct after analyzing the answer choices as they relate to the situation (Sides & Cailles, 1989). An example of an application analysis question is as follows:

Mr. Smith has just learned that he has an inoperable brain tumor. His comment when the nurse speaks to him later is "This can't possibly be true. Mistakes are made in hospitals all the time. They might have mixed up my test results." The nurse's most appropriate response would be to:

- Refer Mr. Smith for a psychiatric consultation.
- Neither agree nor disagree with Mr. Smith's comment.
- Confront Mr. Smith with his denial.
- Agree with Mr. Smith that mistakes can happen and tell him you will see about getting repeat tests.

To answer this question correctly, the individual must recall the fact that denial is often the initial response to learning about a terminal illness; understand that Mr. Smith's response in this case is evidence of the normal use of denial; apply this knowledge to each option, understanding why it may or may not be correct; and analyze each option for what action is most appropriate for this situation. Application/analysis questions require the examinee to use logical rationale, which demonstrates the ability to analyze a relationship, based on a well-defined principle or fact. Problem-solving ability becomes important as the examinee must think through each question option, deciding its relevance and importance to the situation of the question.

Building Your Thinking Skills

Effective memorization is the cornerstone to learning and building thinking skills (Olney, 1989). We have all experienced "memory power outages" at some time, due in part to trying to memorize too much, too fast, too ineffectively. Developing skills to improve memorization is important to increasing the effectiveness of your thinking and subsequent test performance.

Technique #1

Quantity is NOT quality, so concentrate on learning important content. For example, it is important to know the various pharmacologic agents appropriate for the management of chronic obstructive pulmonary disease (COPD), not the specific dosages for each medication.

Technique #2

Memory from repetition, or saying something over and over again to remember it usually fades. Developing memory skills that trigger retrieval of needed facts is more useful. Such skills are as follows:

Acronyms

These are mental crutches that facilitate recall. Some are already established such as PERRL (pupils equal, round, reactive to light), or PAT (paroxysmal atrial tachycardia). Developing your own acronyms can be particularly useful since they are your own word association arrangements in a singular word. Nonsense words or funny, unusual ones are often more useful since they attract your attention.

Acrostics

This mental tool arranges words into catchy phrases. The first letter of each word stands for something that is recalled as the phrase is said. Your own acrostics are most valuable in triggering recall of learned information since they are your individual situation associations. An example of an acrostic is as follows:

Kissing **P**atty **P**roduces **A**ffection stands for the four types of nonverbal messages: **K**inesics, **P**aralanguage, **P**roxemics and **A**pppearance.

ABCs

This technique facilitates information retrieval by using the alphabet as a crutch. Each letter stands for a symptom, which when put together creates a picture of the clinical presentation of the disease. For example, the characteristics of the disease and symptoms of osteoarthritis using the ABC technique are as follows:

- Aching or pain
- Being stiff on awakening
- Crepitus
- Deterioration of articular cartilage
- Enlargements of distal interphalangeal joints
- Formation of new bone at joint surface

- g) Granulation inflammatory tissue
- h) Heberden's nodes

One letter

Recall is enhanced by emphasizing a single letter. The major symptoms of schizophrenia are often remembered as follows:

- Affect (flat)
- Autism
- Auditory hallucinations

Imaging

This technique can be used in two ways. The first is to develop a nickname for a clinical problem that when said produces a mental picture. For example, “a wan, wheezy pursed lip” might be used to visualize a patient with pulmonary emphysema who is thin, emaciated, experiencing dyspnea, with a hyperinflated chest, who has an elongated expiratory breathing phase. A second form of imaging is to visualize a specific patient while you are trying to understand or solve a clinical problem when studying or answering a question. For example, imagine an elderly man who is experiencing an acute asthma attack. You are trying to analyze the situation and place him in a position that maximizes respiratory effort. In your mind you visualize him in various positions of side lying, angular and forward, imaging what will happen to the man in each position. A second form of imaging is to visualize a specific situation while you are trying to answer a question. For example, if you are trying to remember how to describe active listening or physical attending skills, see yourself in a comfortable environment, facing the other person, with open posture and eye contact.

Rhymes, music & links

The absurd is easier to remember than the most common. Rhymes, music or links can add absurdity and humor to learning and remembering (Olney, 1989). These retrieval tools are developed by the individual for specific content. For example, making up a rhyme about diabetes may be helpful in remembering the predominant female incidence, origin of disease, primary symptoms and management, as illustrated by:

There once was a woman
 whose beta cells failed,
 She grew quite thirsty
 and her glucose levels sailed,
 Her lack of insulin caused her to
 increase her intake
 And her increased urinary output
 was certainly not fake,
 So she learned to watch her diet
 and administer injections
 That kept her healthy, happy
 and free of complications.

Words that rhyme can also be used to jog the memory about important characteristics of phenomena. For example, the stages of group therapy can be remembered and characterized by the following, according to Tuckman (1965):

- Forming
- Storming
- Norming
- Performing

Setting content to music is sometimes useful for remembering. Melodies that are repetitious jog the memory by the ups and downs of the notes and the rhythm of the music.

Links connect key words from the content by using them in a story. An example given by Olney (1989) for remembering the parts of an eye is: IRIS watched a PUPIL through the LENS of a RED TIN telescope while eating CORN-EA on the cob.

Additional memory aids may also include the use of color or drawing for improving recall. Use different colored pens or paper to accentuate the material being learned. For example, highlight or make notes in blue for content about respiratory problems and in red for cardiovascular content. Drawing assists with visualizing content as well. This is particularly helpful for remembering the pathophysiology of the specific health problem.

The important thing to remember about remembering is to use good recall techniques.

Technique #3

Improving higher level thinking skills involves exercising the application and analysis of memorized fact. Small group review is particularly useful for enhancing these high level skills. It allows verbalization of thought processes and receipt of input about content and thought process from others (Sides & Cailles, 1989). Individuals not only hear how they think, but how others think as well. This interaction allows individuals to identify flaws in their thought process as well as to strengthen their positive points.

Taking practice tests is also helpful in developing application/analysis thinking skills. These tests permit the individual to analyze thinking patterns as well as the cause-and-effect relationships between the question and its options. The problem-solving skills needed to answer application/analysis questions are tested, giving the individual more experience through practice (Dickenson-Hazard, 1990).

■ STRATEGY #3 KNOW THE CONTENT

Your ability to study is directly influenced by organization and concentration (Dickenson-Hazard, 1990). If effort is spent on both of these aspects of exam preparation, examination success can be increased.

Preparation for Studying: Getting Organized

Study habits are developed early in our educational experiences. Some of our habits enhance learning, although others do not. To increase study effectiveness, organization of study materials and time is essential. Organization decreases frustration, allows for easy resumption of study, and increases concentrated study time.

Technique #1

Create your own study space. Select a study area that is yours alone, free from distractions, comfortable, and well lighted. The ventilation and room temperature should be comfortable since a cold room makes it difficult to concentrate and a warm room may make you sleepy (Burkle & Marshak, 1989). All your study materials should be left in your study space. The basic premise of a study space is that it facilitates a mind-set that you are there to study. When you interrupt study, it is best to leave your materials just as they are. Do not close books or put away notes as you will just have to relocate them, wasting your study time, when you do resume study.

Technique #2

Define and organize the content. From the test giver, secure an outline or the content parameters that are to be examined. If the test giver's outline is sketchy, develop a more detailed one for yourself using the recommended text as a guideline. Next, identify your available study resources: class notes, old exams, handouts, textbooks, review courses, or study groups. For national standardized exams, such as initial licensing or certification, it is best to identify one or two study resources that cover the content being tested and stick to them. Attempting to review all available resources is not only mind boggling, but increases anxiety and frustration as well. Make your selections and stay with them.

Technique #3

Conduct a content assessment. Use a simple rating scale such as the following:

- 1 = requires no review
- 2 = requires minimal review
- 3 = requires intensive review
- 4 = start from the beginning

Read through the content outline and rate each content area (Dickenson-Hazard, 1990). **Table 1-1** provides a sample exam content assessment. Be honest with your assessment. It is far better to recognize your content weaknesses when you can study and remedy them, rather than thinking during the exam how you wished you had studied more. Likewise with content strengths: if you know the material, do not waste time studying it.

■ **Table 1-1** Sample Content Assessment

Exam Content: Theories & Skills	
Category: Provided by Test Giver	Rating: Provided by Examinee
Group dynamics	2
Group process	2
Behavior modification	3
Crisis intervention	1
Reality therapy	4
Communication process	3
Interviewing skills	3
Self-care	4
Decision making	1
Legal/ethical issues	2
Cognitive techniques	2
Mental status evaluation	3
Problem solving	3
Community resources evaluation	3
Nursing process	3
Nursing theory	2
Role theory	3
Change theory	2
Communication theories	2
Organizational theory	2
Research design	2
Research evaluation	2
Research application	2
Team building	3
Conflict management	2
Teaching/learning skills	3
Supervisory skills	3
Observation skills	3
Evaluation skills	2
Nursing diagnosis	3
DSM IV	3
Grief and loss theory	3
Death and dying	2
Stress management theory	2
Stress management skills	4
Family dynamics	2
Assertiveness training skills	3
Motivation skills	4

Houseman, C. (Ed.). (1998). *Psychiatric certification review guide for the generalist and clinical specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.). Sudbury, MA: Jones and Bartlett.

■ **Table 1-2** Sample Study Plan

Goal: Achieve a passing grade on the certification exam. Time available: 2 Months		
Objective	Activity	Date Accomplished
Understand elements of milieu therapy	Read section in Chapter 2	Feb. 5 & 6, 1 hour each day
	Read notes from review class and combine with notes taken from text	Feb. 7, 1 hour
	Review combined notes and sample test questions	Feb. 8, 1 hour
Master social/cultural/ethnic factors	Read section in Chapter 2—Take notes on chapter content	Feb. 9 & 10, 1 hour each day
	Read notes from review class and combine with notes taken from text	Feb. 11, 1 hour
	Review combined notes and sample test questions	Feb. 12, 1 hour
Know material contained in Code for Nurses with Interpretive Statements	Read ANA Publication—Take notes on content	Feb. 13 & 14, 1 hour each day

Houseman, C. (Ed.). (1998). *Psychiatric certification review guide for the generalist and clinical specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.). Sudbury, MA: Jones and Bartlett.

Technique #4

Develop a study plan. Coordinate the content that needs to be studied with the time available (Sides & Cailles, 1989). Prioritize your study needs, starting with weak areas first. Allow for a general review at the end of the study plan. Lastly, establish an overall goal for yourself—something that will motivate you when it is brought to mind.

Table 1-2 illustrates a study plan developed on the basis of the exam content assessment in Table 1-1. Conducting an assessment and developing a study plan should require no more than 50 minutes. It is a wise investment of time with potential payoffs of reduced study stress and enhanced exam success.

Technique #5

Begin now and use your time wisely. The smart test taker begins the study process early (Olney, 1989). Sit down, conduct the content assessment, and develop a study plan as soon as you know about the exam. **DO NOT PROCRASTINATE!**

Getting Down to Business: The Actual Studying

There is no better way to prepare for an examination than individual study (Dickenson-Hazard, 1989). The responsibility to achieve the goal you set for this exam lies with you alone. The means you employ to achieve this goal do vary and should begin with identifying

your peak study times and using techniques to maximize them.

Technique #1

Study in short bursts. Each of us have our own biologic clock that dictates when we are at our peak during the day. If you are a morning person, you are generally active and alert early in the day, slowing down and becoming drowsy by evening. If you are an evening person, you do not completely wake up until late morning and hit your peak in the afternoon and evening. Each person generally has several peaks during the day. It is best to study during those times when your alertness is at its peak (Dickenson-Hazard, 1990).

During our concentration peaks, there are mini-peaks, or bursts of alertness (Olney, 1989). These alertness peaks of a concentration peak occur because levels of concentration are at their highest during the first part and last part of a study period. These bursts can vary from 10 minutes to 1 hour depending on the extent of concentration. If studying is sustained for 1 hour there are only two mini-peaks; one at the beginning and one at the end. There are 8 mini-peaks if that same hour is divided into 4, 10-minute intervals. Hence it is more helpful to study in short bursts (Olney, 1989). More can be learned in less time.

Technique #2

Cramming can be useful. Since concentration ability is highly variable, some individuals can sustain their mini-peaks for 15, 20, or even 30 minutes at a time.

Pushing your concentration beyond its peak is fruitless and verges on cramming, which in general is a poor study technique. There are, however, times when cramming, a short-term memory tool, is useful. Short-term memory generally is at its best in the morning. A quick review or cram of content in the morning can be useful the day of the exam (Olney, 1989). Most studying, however, is best accomplished in the afternoon or evening when long-term memory functions at its peak.

Technique #3

Give your brain breaks. Regular times during study to rest and absorb the content are needed by the brain. The best approach to breaks is to plan them and give yourself a conscious break (Dickenson-Hazard, 1990). This approach eliminates the “day dreaming” or “wandering thought” approach to breaks that many of us use. It is better to get up, leave the study area and do something nonstudy related for longer breaks. For shorter breaks of 5 minutes or so, leave your desk, gaze out the window or do some stretching exercises. When your brain says to give it a rest, accommodate it! You will learn more with less stress.

Technique #4

Study the correct content. It is easy for all of us to become bogged down in the detail of the content we are studying. However, it is best to focus on the major concepts or the “state of the art” content. Leave the details, the suppositions, and the experience at the door of your study area. Concentrate on the major textbook facts and concepts that revolve around the subject matter being tested.

Technique #5

Fit your studying to the test type. The best way to prepare for an objective test is to study facts, particularly anything printed in italics or bold. Memory enhancing techniques are particularly useful when preparing for an objective test. If preparing for an essay test, study generalities, examples, and concepts. Application techniques are helpful when studying for this type of an exam (Burkle & Marshak, 1989).

Technique #6

Use your study plan wisely. Your study plan is meant to be a guide, not a rigid schedule. You should take your time with studying. Do not rush through the content just to remain on schedule. Occasionally study plans need revision. If you take more or less time than planned, readjust the plan for the time gained or lost. The plan can guide you, but you must go at your own pace.

Technique #7

Actively study. Being an active participant in study rather than trying to absorb the printed word is also

helpful. Ways to be active include: taking notes on the content as you study; constructing questions and answering them; taking practice tests; or discussing the content with yourself. Also, using your individual study quirks is encouraged. Some people stand, others walk around, and some play background music. Whatever helps you to concentrate and study better, you should use.

Technique #8

Use study aids. Although there is no substitute for individual studying, several resources, if available, are useful in facilitating learning. Review courses are an excellent means for organizing or summarizing your individual study. They generally provide the content parameters and the major concepts of the content that you need to know. Review courses also provide an opportunity to clarify not-well-understood content, as well as to review known material (Dickenson-Hazard, 1990). Study guides are useful for organizing study. They provide detail on the content that is important to the exam. Study groups are an excellent resource for summarizing and refining content. They provide an opportunity for thinking through your knowledge base, with the advantage of hearing another person’s point of view. Each of these study aids increases understanding of content and when used correctly, increases effectiveness of knowledge application.

Technique #9

Know when to quit. It is best to stop studying when your concentration ebbs. It is unproductive and frustrating to force yourself to study. It is far better to rest or unwind, then resume at a later point in the day. Avoid studying outside your morning or afternoon concentration peaks and focus your study energy on your right time of day or evening.

■ STRATEGY #4 BECOME TEST-WISE

Most nursing examinations are composed of multiple-choice questions (MCQs). This type of question requires the examinee to select the best response(s) for a specific circumstance or condition. Successful test taking is dependent not only on content knowledge but on test taking skill as well. If you are unable to impart your knowledge through the vehicle used for its conveyance, i.e., the MCQ, your test taking success is in jeopardy.

Technique #1

Recognize the purpose of a test question. Most test questions are developed to examine knowledge at two separate levels: memory and application. A memory question requires the examinee to recall and comprehend facts from their knowledge base, while an

application question requires the examinee to use and apply the knowledge (ABP, 1989). Memory questions test recall, but application questions test synthesis and problem-solving skills. When taking a test you need to be aware of whether you are being asked a fact or to use that fact.

Technique #2

Recognize the components of a test question. Multiple-choice questions may include the basic components of a background statement, a stem, and a list of options. The background statement presents information that facilitates the examinee in answering the question. The stem asks or states the intent of the question. The options are four to five possible responses to the question. The correct option is called the *keyed response* and all other options are called *distractors* (ABP, 1989). Knowing the components of a test question helps you sift through the information presented and focus on the question's intent (see **Table 1-3**).

Technique #3

Recognize the item types. Basically two styles of MCQs are used for examinations. One requires the examinee to select the one best answer; the other requires selection of multiple correct answers. Among the one-best-answer styles there are three types. The A type requires the selection of the best response among those offered. The B type requires the examinee to match the options with the appropriate statement. The X type asks the examinee to respond either true or false to each option (ABP, 1989). **Most standardized tests, such as those used for nursing licensure and certification, are composed of four or five option-A type questions.**

Technique #4

Practice, practice, practice. Taking practice tests can improve performance. Although they can assist in evaluation of your knowledge, their primary benefit is to assist you with test taking skills. You should use them to evaluate your thinking process, your ability to read, understand and interpret questions, and your skills in completing the mechanics of the test.

Exam resources, including sample questions for the American Nurses Credentialing Center (ANCC) certification exams, are available online at: <http://www.nursecredentialing.org/Certification/ExamResources.aspx>

■ STRATEGY #5 APPLY BASIC RULES OF TEST TAKING

Technique #1

Follow your regular routine the night before a test. Eat familiar foods. Avoid the temptation to cram all night. Go to bed at your regular time (Nugent and Vitale, 1997).

Technique #2

Be prepared for exam day. It is important to familiarize yourself with the test site, the building, the parking, and travel route prior to the exam day. If you must travel, arrive early to allow time for this familiarization. It is helpful to make a list of things you need on the exam day: pencils, admission card, watch, and a few pieces of hard candy as a quick energy source. On exam day allow yourself plenty of time to arrive at the site. Wear comfortable clothes and have a good breakfast that morning.

■ **Table 1-3** Anatomy of a Test Question

Background statement	A woman brings her 65-year old mother in to see a clinical nurse specialist because she is concerned that it is now a month since her mother was widowed, and she continues to be tearful when talking about the loss and wants to visit the grave regularly.
Stem	Which of the following initial approaches would most likely result in compliance with your nursing recommendations?
Options	<ul style="list-style-type: none"> a. Three or four short questions followed by a request to a psychiatrist to prescribe an antidepressant b. Immediate reassurance only c. <i>Careful listening and open-ended questions</i> d. Referring the mother to a support group

Technique #3

Understand all the directions for the test. Know if the test has a penalty for guessing or if you should attempt every question (Nugent and Vitale, 1997).

Technique #4

Read the directions carefully. An exam may have several types of questions. Be on the lookout for changing item types and be sure you understand the directions on how you are to answer before you begin reading the question.

Technique #5

Use time wisely and effectively. Allow no more than 1 minute per question. Skip difficult questions and return to them later or make an educated guess.

Technique #6

Read and consider all options. Be systematic and use problem-solving techniques. Relate options to the question and balance them against each other.

Technique #7

Check your answers. Reconsider your answers, especially those in which you made an educated guess. You may have gained information from subsequent questions that is helpful in answering previous questions or may be less anxious and more objective by the end of the test.

Some Dos & Don'ts to Remember

- Do identify key words in the stem before looking at options.
- Do confine your thinking to the information provided.
- Do eliminate wrong answers and focus on the one or two most likely correct responses.
- Do guess; generally there is no penalty (loss of extra points) for having done so—true for ANCC exams.
- Don't spend too much time on any one question—it is a timed examination.
- Don't second-guess—your first response is likely the best response.
 - If you tend to second-guess your responses, only review questions that you could not answer on the first pass through the exam—computer-based exams allow you to mark questions that you may want to address later in the exam.
- Don't change an answer without a good reason, such as having misread the question.

Considerations for Computerized Examinations

All ANCC certification examinations are computer-based exams.

- Be sure that you have completed all information needed to register for the exam.
- Bring a photo ID—if a letter of authorization is needed, have it with you.
- If you are easily distracted by sound, consider using earplugs (these may be available at the testing center; check before using your own).
- Personal items such as books, laptop computers, iPods, cellular telephones, food, or drink are not allowed during testing; secure these items elsewhere.
- Arrive 30 minutes before the appointed testing time.
- If you are not comfortable taking exams using a computer, consider taking a practice exam usually available at the examination site.
- Use computer-based practice exams, particularly if you are unfamiliar with this testing format. Sample online questions for each ANCC certification exam are available at: <http://www.nursecredentialing.org/Certification/ExamResources.aspx>
- Know what to do if you experience any electronic or other difficulties during the examination. In addition to addressing the issue at the test site, you should also notify the certifying board (inform ANCC about problems during exam using the post-test survey).

■ STRATEGY #6 PSYCH YOURSELF UP: TAKING A TEST IS STRESSFUL

Although a little stress can be productive, too much can incapacitate you in your studying and test taking (Divine & Kyles, 1979). For persons with severe test anxiety, interventions such as Cognitive Therapy, Systematic Desensitization, Study Skills Counseling and Biofeedback have all been used with some success (Spielberger, 1995). Techniques derived from these approaches can influence the results achieved by changing attitudes and approaches to test taking and thereby reducing anxiety. Psyching yourself up can have a positive effect and make examinations a nonanxiety-laden experience (Dickenson-Hazard, 1990). The following techniques are based on the principles of successful test taking as presented by Sides & Cailles (1989). Incorporation of these techniques can improve response and performance in examination situations.

Technique #1

Adopt an “I can” attitude. Believing you can succeed is the key to success. Self-belief inspires and gives you

the power to achieve your goals. Without a success attitude, the road to your goal is much harder. We all stand an equal chance of success in this world. It is those who believe they can who achieve it. This “I can” attitude must permeate all your efforts in test taking, from studying, to improving your skills, to actually writing the test.

Technique #2

Take control. By identifying your goal, deciding how to accomplish it, and developing a plan for achieving it, you take control. Do not leave your success to chance; control it through action and attitude.

Technique #3

Think positively. Examinations are generally based on a standard that is the same for all individuals. Everyone can potentially pass. Performance is influenced not only by knowledge and skill but by attitude as well. Those individuals who regard an exam as an opportunity or challenge will be more successful.

Technique #4

Project a positive self-fulfilling prophecy. While preparing for an examination, project thoughts of the positive outcomes you will experience when you succeed. Self-talk is self-fulfilling. Expect success, not failure, for yourself.

Technique #5

Feel good about yourself. Without feeling a sense of positive self-worth, passing an examination is difficult. Recognize your professional contributions and give yourself credit for your accomplishments. Think “I will pass,” not “I suppose I can.”

Technique #6

Know yourself. Focus exam preparation and test taking on your strengths. Try to alter your weaknesses instead of becoming hung up on them. If you tend to overanalyze, study and read test questions at face value. If you are a speed demon when taking a test, slow down and read more carefully.

Technique #7

Failure is a possibility. We all have failed at something at some point in our lives. Rather than dwelling on the failure, making excuses and believing you will fail again, recognize your mistakes and remedy them. Failure is a time to begin again; use it as a motivator to do better. It

is not the end of the world unless you allow it to be. It is best to deal with the failure and move on, otherwise it interferes with your success.

Technique #8

Persevere, persevere, persevere! Endurance must underlie all your efforts. Call forth those reserve energies when you have had all you think you can take. Rely upon yourself and your support systems to help you maintain a sense of direction and keep your goal in the forefront.

Technique #9

Motivation is muscle. Most individuals are motivated by fear or desire. The fear in an exam situation may be one of failure, the unknown, or discovery of imperfection. Put your fear into perspective; realize you are not the only one with fear, and that all have an equal opportunity for success. Develop strategies to reduce fear and use fear to your advantage by improving the imperfections. Desire is a powerful motivator, and you should keep the rewards of your desire foremost in your mind. Whatever motivates you, use it to make you successful. Reward yourself during your exam preparation and once the exam has been completed. You alone hold the key to success; use what you have wisely.

■ SUMMARY

This chapter has provided concepts, strategies, and techniques for improving study and test taking skills. Your first task in improvement is to know yourself: how you study and how you take a test. You should use your strengths and remedy the weaknesses. Next you need to develop your thinking skills. Work on techniques to improve memory and reasoning. Now you need to organize your study and concentrate on using your strengths and these new and improved skills to be successful. Create a study space, develop a plan of action, then implement that plan during your periods of peak concentration. Before taking the exam, be sure you understand the components of a test question, can identify key words and phrases, and have practiced. Apply the test taking rules during the exam process. Finally, believe in yourself, your knowledge, and your talent. Believing you can accomplish your goal facilitates the fact that you will.

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Essentials of Psychiatric Nursing Care

▣ MENTAL HEALTH

- Definition—Mental health is a state of psychological and emotional well-being. The mentally healthy individual: a) strives to achieve balance in physical, emotional, social, and spiritual spheres; and b) is able to cope effectively with normal stresses in life and function productively to meet individual, family, and community needs (World Health Organization [WHO], 2005).
- Factors influencing mental health according to Videbeck (2006) include:
 1. Individual/Personal factors—including one's biological and genetic makeup, emotional resilience or hardiness, self-esteem, autonomy and independence, reality orientation, and ability to cope with stressors
 2. Interpersonal/Relationship factors—including effective communication skills and strategies, ability to socially/emotionally engage with and help/be helped by another, intimacy, and a balance of connectedness and separateness
 3. Social-cultural/Environmental factors—including positive and realistic social awareness, a sense of community, access to resources, support of diversity, and intolerance of violence
- Hardiness is viewed as a characteristic of mentally healthy people and involves the following:
 1. Control—feeling in charge of and able to influence own life
 2. Commitment—feeling deeply involved in life and work

3. Challenge—viewing change as normal and obstacles as opportunities (Johnson, 1997)

- Absence of mental health may be perceived as uncomfortable to the individual and/or significant others and result in the perception of a need for change.

▣ CHANGE

- Definition—process resulting in transformation
- Planned change—deliberate, goal-directed effort to solve problems; applicable to any system (individual, family, organization)
- Process involves the following responses (Huelskoetter and Romano, 1991):
 1. Feelings of tension, anxiety, and fear
 2. A sense of need
 3. Feelings of hope
 4. A search
 5. Decision and goal setting
 6. Commitment to goals and change
 7. Creative behavior
 8. Changes in behavior
- Success of change is dependent on the change agent's ability to facilitate a helping relationship and collaborate with the individual, group, family, or organization.
- Change involves risk and resistance. It cannot be rushed.

- Change is effected by nurses within the nursing process.

■ THE NURSING PROCESS

- Assessment—Data are collected in a continuous, comprehensive, accurate, and systematic manner. Interviews are usually conducted with clients and others to complete the nursing history. Relevant data for adult patients include:
 1. Appearance
 2. Presenting problem
 3. Personal and family history
 4. Medical and psychiatric history
 5. Physical status
 6. Mental status
 - a. Reaction to interview
 - b. Behavior (speech, ADL, etc)
 - c. Level of consciousness
 - d. Orientation
 - e. Intellect
 - f. Thought content and process
 - g. Judgment
 - h. Affect
 - i. Mood
 - j. Insight
 - k. Memory
 - l. Comprehension
 7. Sociocultural status
 - a. Socioeconomic status
 - b. Life values and goals
 - c. Social habits—including drinking and drug use
 - d. Sexual behavior
 - e. Social support network
 8. Spiritual status
 - a. Philosophy and meaning of life
 - b. Sense of oneness or spiritual integrity
 - c. Relatedness to God or higher power
 - d. Relatedness to people and nature

See Chapter 10 for information regarding assessment of children.
- Diagnoses are made according to:
 1. North American Nursing Diagnosis Association (NANDA) (See Examples in Clinical Chapters)
 2. Standard classification of mental disorders, i.e., The American Psychiatric Association's Diagnosis and Statistical Manual (DSM IV-TR) or International Classification of Disease (ICD-10-CM)
- Planning provides goals and actions that are:
 1. Specific
 2. Individualized
 3. Collaborative

- Intervention—treatment according to diagnoses and care plan should be based on scientific theory and includes:
 1. Psychotherapeutic interventions—may be talking, poetry writing, social skills training, cooking, modeling assertiveness, or expression of feelings
 2. Health teaching—about medication, nutrition, sleep hygiene
 3. Self-care activities—e.g., relaxation, exercise, spirituality
 4. Somatic therapies—e.g., nursing care of clients receiving ECT
 5. Therapeutic environment—milieu
 6. Psychotherapy (advanced practice role for Psychiatric-Mental Health Clinical Nurse Specialist [PMHCNS] or Nurse Practitioner [PMHNP])
 7. Prescriptive authority & treatment (advanced practice role for PMHNP and in some states PMH-CNS)

Interventions can be interdependent (other team members must collaborate) or independent (discussed and determined with client).

- Evaluation of client responses to nursing action is based on client changes in the following:
 1. Cognition
 - a. Giving up irrational beliefs
 - b. Making positive self-statements
 - c. Improving ability to problem solve
 2. Affect
 - a. Decreased anxiety
 - b. Decreased depression
 - c. Decreased loneliness
 3. Behavior
 - a. Adaptive responses
 - b. Improved coping skills
 - c. Improved social skills
- Revisions to plan of care are made as needed and the process continues.
- The nursing process and all nursing interventions occur within the context of the nurse–client relationship.

■ NURSE–CLIENT RELATIONSHIP

- Definition—A dynamic, collaborative, therapeutic, interactive process between the nurse and the client
- Purpose—to create a safe climate wherein clients feel free to reveal themselves and their concerns and feel comfortable to try out new ideas and behaviors

- Phases of nurse–client relationship (Peplau, 1952)
 1. Orientation—begin as strangers
 - a. Client—seeks or is brought in for help; communicates needs and expectations
 - b. Nurse—responds to client; explains parameters of relationship; gathers data; listens and clarifies areas of concern; establishes rapport; negotiates contract that establishes frequency and duration of sessions, specifies type of work to be done, clarifies fees if any, and lays groundwork for termination
 2. Identification
 - a. Client—responds to help offered by nurse; explores deeper feelings; identifies with nurse and may be dependent, active, and compliant
 - b. Nurse—structures relationship to focus on client and facilitates expression of problems and feelings; avoids fostering unnecessary dependency; encourages self-care
 3. Exploitation—working
 - a. Client—more independent in accessing services and working in partnership to interpret behaviors; begins to try out new behaviors
 - b. Nurse—supports client and explores feelings and problems at client’s pace; deals with resistances, encourages risk taking, and facilitates achievement of goals
 4. Resolution—termination
 - a. Client—engages in new problem-solving skills and coping behaviors; views self positively and plans for future; may decompensate when anticipating separation
 - b. Nurse—reviews goals and accomplishments; shares own feelings and assists client to express feelings about relationship and separation

- Phenomena that occur in nurse–client relationships
 1. Therapeutic use of self-application of nurse’s own personality characteristics within the interaction to facilitate healing.
 2. Transference—client experiences emotional reaction towards nurse based on unconscious feelings that originated in past relationships. Nursing response is to confront distortions of reality gently in order to facilitate client self-awareness.
 3. Countertransference—nurse responds to client with feelings from own earlier conflicts. Nurse must increase self-awareness and access supervision to assist in dealing with client more effectively.

- 4. Resistance—client attempts to keep anxiety-provoking thoughts and feelings out of awareness by disrupting the interactional process with avoidance, acting out, forgetting, silence, lateness, etc. Nursing response is to make observations and support client in dealing with anxiety.
- 5. Testing behaviors (McMahon, 1992)
 - a. Attempting a social relationship
 - b. Casting nurse into parental role
 - c. Assessing whether nurse trusts them
 - d. Attempting to take care of nurse
 - e. Avoiding discussion of problems
 - f. Asking for personal data
 - g. Violating personal space
 - h. Seeking attention from nurse
 - i. Assessing nurse’s commitment
 - j. Revealing information to shock nurse
 - k. Touching nurse inappropriately

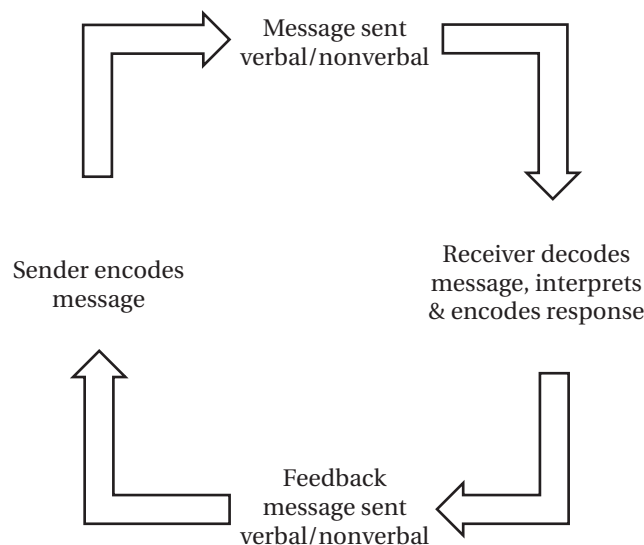
Nurse must set limits and encourage client to discuss meaning of behavior.

- Psychotherapy—use of relationship and communication to change feelings, attitudes, and behaviors
 1. Supportive—expressing feelings, exploring choices
 2. Re-educative—learning new ways of belief and behavior
 3. Reconstructive—deep emotional and cognitive restructuring

- Clinical supervision—use of more experienced practitioner or peers to “obtain feedback on interventions and analyze the emotions particular clients generated; this process allows nurses to be objective about their reactions and to decenter emotions” (Delaney & Lettieri-Marks, 1997, p. 134) that may interfere with the nurse–client relationship.

■ COMMUNICATION

- Definition—Continuous process by which information is transmitted between people and their environment
- Goal—understanding
- Process of communication (See **Figure 2-1**)
- All behavior communicates some message.
- Verbal messages include the written and spoken word.
- Nonverbal messages are observed by the receiver in four ways:



■ **Figure 2.1** Process of Communication

Houseman, C. (ed.) (1998). *Psychiatric certification review guide for the generalist and clinical specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.). Sudbury, MA: Jones and Bartlett.

1. Kinesics—body motion, i.e., facial expression, posture, position of arms and legs, eye contact, touch
 2. Paralanguage—tone of voice, inflection, emphasis, pauses, sighs, laughter
 3. Proxemics—use of personal space, territoriality, i.e., backing away or moving closer, selection of a particular seating arrangement
 4. Appearance—personal image, i.e., clothing, makeup, hair, beard
- Nonverbal messages may be congruent with verbal messages or they may conflict with them.
 - Culture and social class influence perceptions and values that influence how communication is transmitted and received.
 - Type of relationship also influences type of communication:
 1. Therapeutic communication takes place between the nurse and client and focuses on the client's thoughts, feelings, behavior, and roles with the expectation that the active listening of the nurse will help the client explore, understand, and change.
 2. Social communication is less goal oriented, more superficial, and does not necessarily involve the expectation of help.
 - Although nurse–client relationships may involve some social communication, the main component is therapeutic communication.

Therapeutic Communication includes:

- Active listening or physical attending skills
 1. Comfortable environment—privacy, low noise, soft light
 2. Facing the other person and leaning towards him/her
 3. Open, relaxed posture
 4. Eye contact
- Attitudes and behaviors that build trust and rapport
 1. Nonjudgmental, positive regard
 2. Punctuality
 3. Honesty
 4. Respect, acceptance, and confirmation
 5. Genuineness, empathy
 6. Congruence between verbal and nonverbal behaviors (Johnson, 1997)
 7. Stated purpose of interaction
 8. Being unhurried; giving undivided attention
 9. Being sensitive and responsive to nonverbal communication
 10. Listening
 11. Being professional but warm, accepting, supportive, and objective
 12. Recognizing and accepting culture-specific attitudes and behaviors
 13. Using understandable and acceptable language
 14. Being aware of own feelings and how they affect one's behavior
 15. Being clear that responsibility for action rests with client

16. Helping to develop awareness of consequences and alternatives (McMahon, 1997)
- Communication techniques
 1. Using broad openings and open-ended questions
 2. Clarifying content and feelings
 3. Reflecting content and feelings
 4. Confronting content and feelings
 5. Verifying perceptions
 6. Giving information
 7. Providing feedback
 8. Stating observations
 9. Silence
 10. Directing
 11. Focusing
 12. Questioning
 13. Connecting information
 14. Summarizing
 - Barriers to therapeutic communication
 1. Advice
 2. Reassurance
 3. Being judgmental
 4. Changing the subject
 5. Excessive questioning/closed-ended questions
 6. Challenging
 7. Stereotypical comments
 8. Self-focusing behavior
 9. Using emotionally charged words
 - Communication with children
 1. Introducing to play materials
 2. Encouraging verbalization at own pace
 3. Asking questions that are relevant to developmental age
 - Result of therapeutic communication is enhanced client self-disclosure.
 - Nurse self-disclosure can enhance or inhibit therapeutic communication depending on its use. Like all interventions, it requires timing and judgment. Its use, according to Auvil and Silver (1984) depends on:
 1. Nurse's theoretical framework—i.e., more likely to occur if working from a humanist perspective than from a psychoanalytic or behaviorist approach
 2. Stage of the relationship
 - a. Orientation—nurse self-disclosure that occurs early in the relationship more likely to meet nurses' needs
 - b. Working phase—appropriate if used by nurse to hasten therapeutic alliance to help clients learn about themselves and others, encourage their catharsis of

feelings, support their goals, and validate their reality (McMahon, 1997)

- c. Termination—expression of feelings about end of relationship to model appropriate behaviors for client

■ CULTURAL & ETHNIC FACTORS

- Definitions
 1. Culture—patterns of knowledge, belief, behavior, and custom that are learned by members of a particular society
 2. Ethnicity—membership in diverse groups according to race, birthplace, language, culture, or religion
 3. Ethnocentrism—judging others' behavior by the values of our own culture
 4. Cultural relativism—attempting to understand the behavior of others within the context of their own culture
 5. Stereotyping—overgeneralizations based on culture or ethnicity; may occur unconsciously
- Impact of culture on mental health nursing
 1. Influences client coping behaviors
 2. Defines what symptoms are labeled as illness
 3. Determines explanations for illnesses, e.g., may be personalistic or caused by purposeful intervention of others
 4. Prescribes taboo topics and behaviors
 5. Determines how mentally ill are perceived
 6. Prescribes health-seeking behaviors and attitudes to healthcare providers
 7. Determines types of acceptable treatment approaches
 8. Influences behavioral expression of mental illnesses resulting in culture-bound illnesses such as *susto*, *mal ojo* (Hispanic), falling out (African American), and voodoo
 9. Determines distribution of illness, e.g., somatic vs depressive symptoms, male vs female
- Cultural differences according to Tripp-Reimer and Lively (1993)
 1. Time—emphasis on present (predominant in African American, Native American, and Hispanic culture) vs future (predominant in US and other highly industrialized nations that also value schedules)
 2. Success—doing: people valued for accomplishments (predominant in US) vs being: people valued for being themselves (Chinese culture)
 3. Relational—collectivist: individual goals are subordinate to group goals (African American, Native American, and Hispanic) vs individual-

- istic: individual goals are more important than group goals (predominant in US)
 - 4. Nature—people dominant to nature (middle class US) vs living in harmony with nature (Native American), vs subjugated to nature (Moslem cultures)
 - 5. Verbal communication—volume (Asians speak softly), speed and directness (Asians value indirectness); silence interpreted differently by various cultures
 - 6. Privacy—personal space (Arabic: closer vs US: further); eye contact (Native Americans prefer less than predominant US)
- Impact of ethnicity on mental health nursing
 1. Metabolism rates, clinical drug responses and side effects found in research to be significantly different among racial and ethnic populations
 2. Field of ethnic pharmacology developed (Campinha-Bacote, 1997)
 - Culturally competent nursing care—“care that is sensitive to issues related to culture, race, gender and sexual orientation; this care is provided by nurses who use cultural nursing theory, models and research principles in identifying and evaluating the care provided within the cultural context of the clients.” (AAN, 1992)
 1. Be aware of one’s own cultural beliefs and behaviors.
 2. Be culturally aware—have knowledge of cultural differences.
 3. Assess the degree to which the client has assimilated the predominant culture; do not assume.
 4. Perform a Cultural Assessment to determine from the client and the client’s reference group their emic (native) view of what is considered normal and abnormal in both problem definition and expectations for treatment and care.
 5. Intercultural communication
 - a. Adapt activity level, tone of voice, and remarks to the cultural background of the client.
 - b. Develop listening skills, observe nonverbal behavior and eliminate barriers to communication.
 - c. Show respect and acceptance to clients in ways they understand.
 6. Facilitation skills—negotiate interactions that may tend to be inconsistent with the value and belief system of an individual or family from another culture; conflict resolution.
 - 7. Flexibility—negotiate a treatment plan that reflects, respects, and incorporates both traditional treatment and folk remedies. (Campinha-Bacote, 1997)
 - 8. Design culturally responsive programs that are available, accessible, appropriate, acceptable, and adoptable to decrease underutilization of mental health services by ethnic groups.
 - 9. Show respect and acceptance to clients in ways they understand.
 - 10. In completing cultural assessments, nurses should examine the cultural influences of basic elements of care including (Keltner, Schwecke, & Bostrom, 2007):
 - a. Communication (fluency/preferred language other than English, nonverbal or culturally-related preferences related to touch, etc.)
 - b. Orientation (identification with a specific group, following traditions, beliefs, etc.)
 - c. Nutrition (preferred & “feel good” foods, and avoided foods)
 - d. Views of health—including culturally based beliefs about mental health/illness, how one develops illness, beliefs about what is needed for treatment, and how wellness is achieved and “cure” is defined
 - e. Learning style (preferred method for obtaining information)

■ INTERDISCIPLINARY TREATMENT & THE HEALTHCARE TEAM

- Components
 1. Interdisciplinary treatment utilizes members of different professions who come together to plan and evaluate the treatment of individual clients.
 2. Each member is considered to have vital input to the treatment plan based on his/her particular area of expertise.
 3. The client is also considered to be a member of the team.
- Goal—targeted interventions, consistently implemented and evaluated by everyone involved with the client
- Attributes of mental health team
 1. Strong team commitment
 2. Shared responsibility, control, and decision making
 3. Common goals and philosophy of intervention
 4. Flattened hierarchy of authority
 5. Decision making by consensus
 6. Open communication
 7. Examination of roles and relationships

8. Setting limits on own and others' behavior in a nonpunitive way
 9. Flexibility, versatility, creativity, and optimism
- Professions involved with mental health team
 1. Diet therapy—provides culturally relevant, attractive, nourishing foods with awareness of psychological importance of food, conflicts about eating (eating disorders), and drug interactions with certain foods (MAO inhibitors)
 2. Expressive therapies
 - a. Art—uses artwork of clients to express underlying feelings and conflicts.
 - b. Music—vicarious listening stimulates the expression of ideas and emotions verbally; active production of music allows for non-verbal expression.
 - c. Psychodrama—explores psychological conflicts through enactment rather than verbalization.
 3. Nursing—establishes and maintains milieu; responsible for 24-hour care, activities of daily living, and safety; advanced practice psychiatric & mental health nurses may perform individual, family, or group psychotherapy.
 4. Ministry—assists with spiritual care of client and family; may provide marital therapy or pastoral counseling.
 5. Psychiatry—diagnoses and treats conditions amenable to medical treatment; responsible for admission and discharge; may provide individual, group, or family therapy.
 6. Occupational therapy—involves clients in meaningful activities and provides vocational rehabilitation if needed.
 7. Recreational therapy—assists clients to identify appropriate leisure activities.
 8. Psychology—performs diagnostic testing, and provides plans for treatment based on causative factors; may implement individual, group, or family therapy.
 9. Social work—evaluates family, social, and environmental contributions to problem; may provide family, group, or individual psychotherapy.
 10. Voluntary agencies—recognized organizations that offer information and support (often provided by peers) to individuals with mental health problems and their families: Recovery Incorporated, Alcoholics Anonymous, National Alliance for the Mentally Ill, National Depressive and Manic Depressive Association; these agencies may vary depending on locality.
 - Nurses may be case managers for clients or client advocates at all levels within the healthcare system.

■ CLIENT ADVOCACY

- Definition—interceding on behalf of clients who are unable to speak or act for themselves or are unaware of available options
- Examples
 1. Informing clients about treatment alternatives
 2. Presenting information to the treatment team
 3. Helping clients enter and navigate the health-care system
 4. Testifying on behalf of clients in court
 5. Promoting respect for mentally ill in policy and law
- Guidelines for advocacy according to Boyd and Luetje (1991)
 1. Make sure client has need for advocacy.
 2. Check plans with clients and others regarding support system.
 3. Get support and information from others with similar goals.
 4. Present data clearly.
 5. Include all pertinent information.
 6. Do not use more power than is necessary.
 7. Be patient and persistent.

■ CASE MANAGEMENT

- Definition—assessment for, and coordination of, individualized, culturally appropriate mental-health, and other health and social services, for clients and their families or residential care groups
- Goal—improved functioning and empowerment for clients and cost containment and provider accountability for third party payers
- Types
 1. Rehabilitative—refers to time-limited services provided as part of a private benefit plan with emphasis on returning client to productivity
 2. Supportive—refers to services provided to chronically mentally ill clients for as long as necessary
- Outcomes
 1. Enhanced communication, education, and participation of clients and families
 2. Discharge planning that begins at start of treatment
 3. Early identification of client problems, possible delays in treatment and barriers to care at both individual and group levels
 4. Increased communication among providers and reduction of duplication or overlapping services (Farnsworth & Biglow, 1997)

- Tools
 1. Interdisciplinary Treatment Plans (ITPs)—integrate the care of all health care team members; directed by case manager.
 2. Critical Pathways—identify essential treatment interventions that must be performed each day to meet the expected time-specific client outcomes; usually reflects a specific DRG (Farnsworth & Biglow, 1997).
 3. Nursing Care Plans—more detailed than ITPs and more individualized than critical pathways; use NANDA nursing diagnoses and interventions derived from individual assessment of client.
 4. Research Based Practice Protocols
 - a. Agency for Health Care Policy and Research (ACHPR) guidelines for depression
 - b. Nursing Intervention Classification (NIC) (Farnsworth & Biglow, 1997)

▣ PSYCHIATRIC LIAISON NURSING

- An advanced practice psychiatric and mental health nurse (Clinical Nurse Specialist), as member of the healthcare team, provides direct care, including psychotherapy, to individuals, groups, and families as well as consultation to nursing and other hospital staff, around client, unit, or institutional issues.
- Liaison nurses use knowledge about “systems, change, organizations, problem solving, stress, crisis, interpersonal relationships, communication, and sociocultural concepts” (Walker & Price-Hoskins, 1992, p. 267). See Chapter 11 for more information.

▣ MILIEU

NOTE: Although the primary focus of psychiatric hospitalization has evolved to that of crisis stabilization, the nursing role in creating and maintaining a therapeutic environment is important. Because all treatment environments affect patient care and outcomes, information about milieu therapy is presented here and within the mental disorders chapters, as a cue to all psychiatric nurses to value the elements of a therapeutic environment regardless of setting, whether inpatient, residential, outpatient, or community.

- Definitions
 1. Therapeutic environment—physical and psychosocial surroundings as an integrated, inter-related whole acting as the treatment agent in a variety of settings (Watson, 1992)

2. Milieu therapy—scientific planning of the social and physical environment so that every interaction and activity is therapeutic
 3. Therapeutic community—a structured environment with an established philosophy of care
 4. Token community—therapeutic community drawn from behavior modification theory; uses tokens to reinforce adaptive behavioral responses; clients can then exchange tokens for privileges.
- Structured aspects of milieu
 1. Community meetings
 2. Daily schedule
 3. Physical environment
 4. Rules and regulations
 5. Classes, activities, and groups
 - Unstructured aspects of milieu
 1. Daily interactions among clients
 2. Interactions between clients and staff
 - Characteristics of successful milieu
 1. Effective interaction between and among staff and clients
 2. Norms that provide predictability and security
 3. Patient government using democratic process
 4. Patient’s active responsibility for own treatment and for treatment of others
 5. Fostering growth in direction of increased recognition of strengths and personal empowerment
 6. Encouragement of self-awareness, risk taking, and change
 7. Confrontation of misperceptions, destructive behavior, and poor judgment
 8. Links with client’s family and significant others
 9. Links with community
 - Nurses’ role in milieu
 1. Creation and maintenance of milieu
 2. Physical care and assurance of safety
 - a. Assessing, reinforcing and promoting client’s ability to perform activities of daily living (ADLs)—eating, bathing, dressing, etc.
 - b. Assessment of physical illness or reactions to medications
 - c. Assessment of detoxification reactions in chemically dependent
 - d. Assessment of self- or other-directed destructive behavior
 - (1) Providing for surveillance—observations every 15 minutes
 - (2) Ensuring safety in physical environment (Greene, 1997)

3. Medication administration and education
4. Attitude therapy—active friendliness, passive friendliness, kind firmness, no demand
5. Modeling healthy behavior as participant in community
6. Intervening to influence attitudes, behaviors, and relationships in therapeutic way as described by Greene (1993):
 - a. Clarifying and correcting perceptions of current stressors
 - b. Identifying thoughts and feelings evoked by stressors
 - c. Examining how thoughts and feelings influence behavior
 - d. Evaluating the extent to which coping behaviors are adaptive or effective
 - e. Identifying alternative adaptive coping strategies
 - f. Testing of identified alternative coping strategies in milieu

■ PRINCIPLES OF PRESCRIPTIVE AUTHORITY (for advanced practice psychiatric & mental health (PMH) nursing)

- Prescriptive authority and treatment is a function of advanced practice PMH nurses as granted by federal and state law (nurse practice act) in the jurisdiction of nursing practice (ANA, APNA, ISPN, 2007). Most state laws involve advanced practice nurses writing prescriptions through a collaborative relationship with a physician or under delegated authority from a physician (Buppert, 2008).
- Principles of pharmacotherapy (Sadock & Sadock, 2007; Stahl, 2008)
 1. Pharmacology—the study of what drugs do and how they do it
 2. Psychotropic medications—drugs used to treat psychiatric conditions (also called psychotropics)
 3. Pharmacokinetics—“what the body does to the drug”—includes absorption, distribution, metabolism, and elimination
 4. Pharmacodynamics—“what the drug does to the body” (desired effect and adverse side effects)—site of action (target organs/systems) including receptors, ion channels, enzymes, and carrier proteins
 - a. Pharmacodynamic considerations include receptor mechanisms, dose-response curve, development of tolerance, dependence and withdrawal; includes mechanism of action and therapeutic index (TI)—TI is the ratio of median toxic dose to median effective dose—a relative measure of safety/toxicity of a drug (e.g., with small differences between toxic and effective doses, lithium has a low therapeutic index).
- Examples of receptor mechanisms include:
 - (1) Agonists—drugs that activate receptors; can be full, partial or inverse
 - (2) Antagonists—drugs that block receptor sites, generally retuning the receptor conformation back to the same state that exists without an agonist present—can be competitive (with agonist for receptor) or noncompetitive
- Pharmacogenetic research goals include identification of variant alleles that alter pharmacokinetics and pharmacodynamics; and why patients differ in the way drugs are metabolized.
- Principles of prescribing
 1. General guidelines (Buppert, 2008)
 - a. Prescribe the right drug at the right time for the right indication for the right person.
 - b. Follow the practice protocols/guidelines for prescribing at the site of advanced nursing practice.
 - c. Before prescribing, obtain the following information:
 - (1) Known allergies
 - (2) Other prescribed, over-the-counter, and herbal preparations the patient is currently using
 - (3) For female patient, ascertaining the possibility of pregnancy (see **Table 2-1**) and/or breastfeeding—obtain appropriate laboratory testing as indicated
 - (4) Any liver or kidney dysfunction, other health condition that can affect absorption, distribution, metabolism, or excretion of drug
 - (5) Any cardiac condition, suicide/homicide ideation, symptoms of psychosis, mania/hypomania
 - (6) Personal or familial experiences with the medication (what worked/did not work, side effects experienced, and tolerability of adverse side effects)
 - d. Address any contraindications, cross-sensitivities, and drug interactions.
 - e. Inform patient of potential adverse effects and ask whether patient wants to accept risk of side effects (documentation advised).

■ **Table 2-1** Food & Drug Administration (FDA) Pregnancy Categories

Category	Definition
A	Controlled studies in humans have demonstrated no risk.
B	Animal trials show no risk; no evidence of risk in 2nd or 3rd trimester.
C	Human risk unknown and cannot be ruled out.
D	Positive risk to fetus; must weigh benefit to pregnant women vs fetal risk.
X	The drug is contraindicated in women who are or may become pregnant.

NOTE: FDA has proposed revision of current pregnancy labeling (eliminating A through X labeling). The proposed labeling would include: a summary of fetal risk, clinical considerations (dosing, risks of not treating, & complications), as well as data upon which the recommendations are made. A summary of the proposed rule is available at: <http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Labeling/ucm093310.htm>

- f. Inform patient when to call/return if adverse change in condition occurs.
- g. Other considerations include:
 - (1) Affordability of medication(s) prescribed
 - (2) Inclusion of drug on formulary for the agency or health maintenance organization
 - (3) Potential for abuse of the medication (e.g., methylphenidate, benzodiazepines)
- Controlled substances (see **Table 2-2**)
 1. The federal government, through the Drug Enforcement Administration (DEA) oversees prescribing of controlled substances and the granting of license to providers for the purpose of prescribing.
 2. Certain conditions must exist before the advanced practice PMH prescribes controlled substances.
 - a. State law in the jurisdiction of practice must allow prescription of controlled substance by the advanced practice nurse.

■ **Table 2-2** US Drug Enforcement Administration—Schedule of Controlled Substances

Schedule	Description	Examples
I	Substance has a high potential for abuse, has no medical use in the US, and has a lack of accepted safety for use under medical supervision.	heroin, LSD, marijuana
II	Substance has a high potential for abuse, has a currently accepted medical use in the US with severe restrictions, and abuse may lead to severe psychological or physical dependence.	amphetamine, codeine, dextroamphetamine, hydrocodone, methadone, oxycodone (OxyContin)
III	Substance has a potential for abuse less than II, has currently accepted medical use in the US, and may lead to moderate or low physical dependence or high psychological dependence.	codeine with aspirin, acetaminophen/hydrocodone (Vicodin)
IV	Substance has a low potential for abuse as compared to Schedule III, has currently accepted medical use in the US, and abuse may lead to limited physical and psychological dependence.	benzodiazepines (e.g., alprazolam, lorazepam, oxazepam), phenobarbital, zolpidem (Ambien)
V	Substance has a low potential for abuse as compared to Schedule IV, has currently accepted medical use in the US, and abuse has a narrow scope for physical and psychological dependence.	atropine, buprenorphine (Buprenex), Lomotil, codeine/guaifenesin (Robitussin A-C)

- b. The advanced practice nurse must be registered with the DEA, have applied for, and been granted license to prescribe controlled substances as evidenced by provision of a DEA number, which must be used on all prescriptions for scheduled drugs.

■ MENTAL HEALTH EDUCATION

- Definition—imparting of knowledge to clients and families
- Goals according to Walker and Price-Hoskins (1992)
 1. Offering information about the illness and interventions
 2. Helping people recognize symptoms
 3. Teaching people when and how to intervene for themselves
 4. Offering relief from blame and guilt
 5. Clarifying family expectations
 6. Instilling confidence that change can occur
 7. Developing an objective perspective and balance
- Methods of Learning
 1. Lecture
 2. Discussion
 3. Modeling
 4. Observation
 5. Experiential methods
 - a. Role playing
 - b. Behavioral rehearsal
 6. Coaching
 7. Audio or video recorded presentation
 8. Computer-aided instruction
 9. Self-instruction
 - a. Keeping a diary
 - b. Monitoring thoughts, feelings, and behaviors
- Guidelines for teaching adult learners
 1. Assess knowledge base.
 2. Increase awareness of need for learning.
 3. Encourage self-direction.
 4. Encourage learners to apply material to what they already know.
 5. Use mode of learning most useful to the learner, i.e., auditory, visual, or kinesthetic.
 6. Repeat as often as necessary, changing and combining methods and modes as required.
 7. Accommodate teaching to the client's capacity for learning and attention span, both of which may be affected by illness.

■ THEORIES AND PRACTICE OF INDIVIDUAL PSYCHOTHERAPY—SEE CHAPTER 3

■ FAMILY THERAPY

- Background
 1. Treatment modality that theorizes that the presenting problem displayed by the client with psychiatric symptoms (identified patient) is the result of pathology throughout the entire family system.
 2. This family dysfunction is due to imbalances in the system, generally caused by conflict between the marital partners. This conflict is expressed unconsciously by the following behaviors:
 - a. Triangling—another family member is brought in, in order to stabilize the emotional process.
 - b. Scapegoating—another family member is blamed.
 3. Result of these behaviors is psychiatric symptoms.
- Therapeutic goals
 1. Assisting family members to identify and express their thoughts and feelings
 2. Resolving conflict between marital partners to decrease need for triangling and scapegoating
 3. Assisting parents in working together and strengthening their parental authority
 4. Clarifying family expectations and roles
 5. Practicing different, more constructive methods of interacting
- Techniques used in family therapy according to Hogarth (1993)
 1. Joining—finding similarities and matching family's behaviors; respecting their values and hierarchies
 2. The family history
 - a. Data are gathered beginning with the parents' initial relationship and include each family member in chronological order.
 - b. Information may be recorded in a genogram that maps out significant events and relationships over three generations of the family.
 - c. History taking takes focus off identified patient and emphasizes the family as a whole.
 3. Encouraging interactions and relationships
 - a. The family, or specific family members, are instructed to discuss a pertinent issue.

- b. Therapist clarifies and interprets the family's communication.
 - c. Individuals are required to speak for themselves in expressing feelings and concerns rather than allowing others to speak for them.
 - d. Family members are asked to share responsibility for resolution of problems instead of laying blame.
4. Experiential activities
- a. Homework—tasks assigned by the therapist, which when enacted by the family members further the therapeutic process; completion or failure to complete the task is discussed at the next session.
 - b. Paradoxical prescription—instructions are given to perform the opposite of what is intended in order to produce change.
 - c. Sculpting—enactment of an experience with words omitted that when “frozen” is a symbolic representation of the family members' relationships; by asking a family member to rearrange the “sculpture,” change is modeled.
5. Results in family therapy are measured by the degree to which families are moved from dysfunctional to functional patterns. Optimal family functioning according to Hogarth (1993) includes:
- a. Open systems orientation
 - b. Clear boundaries
 - c. Positive links to society
 - d. Contextual clarity
 - e. Clear and congruent communication
 - f. Strong parental coalition
 - g. Appropriate power distribution
 - h. Autonomous persons
 - i. Warm, caring affective tone
 - j. High self-esteem of members
 - k. Efficient negotiation and task performance
 - l. Transcendent values of hope and altruism

- Therapeutic factors of groups (Yalom, 2005)
 1. Instillation of hope
 2. Universality
 3. Imparting information
 4. Altruism
 5. Corrective recapitulation of primary family group
 6. Development of socializing techniques
 7. Imitative behaviors
 8. Interpersonal learning
 9. Group cohesiveness
 10. Catharsis
 11. Existential factors
- Descriptors of groups
 1. Homogeneous—members chosen from preselected criteria, e.g., sexually abused women
 2. Heterogeneous—mix of individuals regarding diagnosis, sex, age, etc.
 3. Mixed—sharing an essential feature, i.e., same diagnosis but varying sex, age, etc.
 4. Closed—after group begins, no new members are added
 5. Open—members and leaders change
- Types of groups
 1. Task—emphasis on accomplishing what needs to be done
 2. Teaching—imparting information, i.e., orientation to unit
 3. Supportive/therapeutic—helping others who share same experience cope with stress and overcome dysfunction, e.g., bereavement, weight loss
 4. Psychotherapy—emphasis on person reducing intrapsychic stress, changing behavior, ideas, etc.; may follow a variety of theoretical frameworks, e.g., Psychoanalytic, Transactional Analysis, Rational Emotive, Rogerian, Gestalt, Interpersonal, Bion; advanced practice role
 5. Psychoeducational—structured group involving teaching, with member disclosure of related thinking and behavioral problems, and homework to put learned information and skills into practice, e.g., groups for family members of the chronically mentally ill and assertiveness training groups
 6. Peer support group—sharing stresses related to common situation, e.g., hospice nurses
 7. Multiple family—teaching about disease process and utilizing group process to understand mental health issues; may also refer to a group modality in which the therapist works with one family while other families watch and learn vicariously

■ GROUP DYNAMICS & GROUP PROCESS THEORY

- Background
 1. Groups are complex human systems whose whole is greater than the sum of their parts.
 2. Individuals can learn, grow, and change more in groups due to opportunities for feedback and consensual validation.
 3. Nurses who participate in groups or advanced practice psychiatric and mental health nurses who serve as group therapists are aware of the powerful forces harnessed by group work.

- Basic roles of therapist (Yalom, 2005)
 1. Technical expert
 2. Model setting participant
- Group dynamic issues according to Long and McMahon (1992)
 1. Rank—position member holds in relation to other members of the group; members who participate frequently and actively usually rank high in the group and thus have greater influence on group behavior
 2. Status—prestige given to certain positions or individuals in a group; members vie for status in group; may be due to member characteristics or behavior
 3. Group content—what is said in a group, i.e., information discussed
 4. Group process—activities in a group, i.e., how interactions occur among members, timing of interactions, roles of members, seating arrangements, tone of voice of members, and nonverbal behaviors
 5. Sociogram—method of recording group process
- Group process issues
 1. Style of leader
 - a. Autocratic—leader is in charge and controls.
 - b. Democratic—leader shares responsibility with members.
 - c. Laissez Faire—leader is nondirective.
 2. Roles of members
 - a. Building or maintenance roles—contribute to group process and functioning, e.g., encourager, gatekeeper, harmonizer.
 - b. Task roles—emphasize completing the task, e.g., initiator, opinion giver, evaluator, energizer, information seeker.
 - c. Individual roles—not related to group tasks or maintenance and may inhibit group, e.g., aggressor, dominator, help-seeker, playboy, special-interest pleader, blocker.
- Therapeutic group norms (Yalom, 2005)
 1. Self-monitoring—assuming responsibility for own functioning
 2. Self-disclosure
 3. Procedural norms—spontaneous, interactive
 4. Group importance to members
 5. Members as agents of help
 6. Support
 7. Working in the here and now
- Group development stages (Tuckman, 1965)
 1. Forming (orientation)—Group leader is more directive and active, members look to leader for structure and approval. Leader describes group contract (i.e., goals, confidentiality, and communication rules), encourages interaction among group, and maintains working level of anxiety. Members develop initial roles.
 2. Storming—Conflict develops regarding control, power, and authority. Anxiety increases and resistance may occur as evidenced by client absence, shared silence, excessive dependency on leader, scapegoating, excessive hostility toward leader, formation of sub-groups and acting out. Leader encourages healthy expression of anger.
 3. Norming (cohesiveness stage)—Members express positive feelings toward one another and feel strongly attracted to group. Self-disclosure occurs and new roles are adopted.
 4. Performing (working phase)—Leader's activity decreases and usually consists of keeping the group on course or dealing with resistance of group and individuals within. Responsibility for group is more equally shared. Anxiety of group is decreased, and energy is channeled to completing tasks.
 5. Mourning (termination)—Begins during first phase but is most acutely felt in closed group when it approaches end and in open group when members or leaders leave. Leaders encourage discussion of ending and expression of pain and loss experienced in grieving process. Members may try to avoid, experience anxiety, anger, or regression; they should also be encouraged to reminisce, evaluate, and experience sense of accomplishment and give feedback to one another (Lasalle & Lasalle, 1991).
- Transference and countertransference also occur in groups and may be dealt with by group members as well as leaders.

■ ETHICAL CONSIDERATIONS

- Ethics—branch of philosophy that deals with morality
- Ethical theories or perspectives according to Sellin (1991)
 1. Egoism—the right act is the one best for oneself.
 2. Utilitarianism—the right act promotes the greatest good for the greatest number.
 3. Deontology or formalism—the right act is established by use of ethical principles as follows:
 - a. Autonomy—individuals are respected for themselves and should have control over their own choices whether or not these

are in their best interest or agree with our opinions. If someone decides what is best for another it is termed paternalism. Children, the mentally retarded, and the mentally ill are often thought not to be competent enough to be autonomous.

- b. Beneficence—promoting the good of others and preventing them from harm
- c. Nonmaleficence—responsibility to do no harm; many suggest that it is more important to avoid harm than to do good. Some interpret it as a person's duty to prevent someone else from harming a third person.
- d. Justice—distribution of resources, benefits and burdens fairly among members of a society

Ethical principles may conflict with one another so that it is difficult to determine which act produces the most good.

From ethical principles client rights have been specified.

- Right—a just claim that is due an individual or group: rights may be established by policies and/or protected by laws. Important patient rights in psychiatric nursing include:
 1. Right to privacy
 - a. Confidentiality—no information can be shared about client, including fact of hospitalization or whether in therapy.
 - b. Privileged communication—in five states court may not legally mandate nurses to give information obtained in a professional capacity (Stuart & Sundeen, 1991); does not apply to patient records.
 - c. Exceptions:
 - (1) Tarasoff—if therapist is reasonably certain that a client is going to harm someone, must breach confidentiality and inform potential victim.
 - (2) Possible child abuse—many states mandate that cases be reported to authorities.
 - (3) Guardianship or involuntary commitment hearings—clinical information must be shared.
 2. Right to treatment—patients cannot be held against their will without an individualized treatment plan and certain other standards of care specified by law.
 3. Right to treatment in least restrictive setting
 - a. Clients who are not dangerous cannot be hospitalized against their will.
 - b. Clients capable of functioning on an open ward should not be held in a locked ward.

- c. Clients can wear their own clothes and keep their own personal effects excluding dangerous objects and valuables that cannot be protected.
 - d. Clients, who with support can live in the community, should be discharged to outpatient care.
 - e. Seclusion and restraint can only be utilized when therapeutically necessary, and where all other methods have failed to control violent behavior toward self or others.
4. Right to informed consent
 - a. Voluntary permission can be given by a competent client after procedures to be performed have been explained and are understood.
 - b. Clients often sign forms on admission that cover psychiatric treatment.
 - c. Commitment procedure gives hospital the right to treat involuntary patients.
 - d. Written consent must be obtained for ECT and experimental drugs.
 5. Right to refuse treatment
 - a. Clients, including committed patients in nonemergencies, may not be forcibly medicated.
 - b. Guardians can give permission or a court order can be sought for incompetent clients.
 - c. If patient is violent toward self or others and all less restrictive methods have failed, patients (including those who have been voluntarily admitted) may be forcibly medicated.
 - d. Nurses must know the laws in their state and assure adequate written documentation.
 6. Right to habeas corpus—committed clients may at any time petition the court for release on the grounds that they are sane.
 7. Right to independent psychiatric examination—clients may demand evaluation by physician of own choice and must be released if determined to be not mentally ill.
 8. Right to outside communication
 - a. Clients may have visitors, write and receive letters, make and receive phone calls, including those to judges and lawyers.
 - b. The hospital can limit times for phone calls and visitors and deny access when visitors could cause harm to clients or staff.
 9. Right to be employed if possible—clients cannot be forced to work, and if they choose to as part of therapy, must be paid minimum wage.

■ QUESTIONS

Select the best answer

1. According to traditional definitions of mental health, which of the following would the nurse be most likely to describe as mentally healthy?
 - a. Jerry Jones, a Viet Nam veteran with no family ties, who has been unemployed for 10 years
 - b. Tom Sarris, a CEO, who spends 14 hours at work each day and is too tired to do anything with his family on weekends
 - c. George Connors, a shoe salesman who delights in playing affectionately with his children but has been unable to hold a steady job since they were born
 - d. Sam Thomas, a restaurateur who loves his work, but sets limits on the hours he spends there in order to enjoy his family and friends
2. Which of the following would be described as a component of mental health according to Johnson?
 - a. Refusing to be involved in any relationship that limits independence
 - b. Absence of anxiety under any circumstances
 - c. Dependence on friends and family to assist with crises
 - d. Ignoring cues from the environment when deciding what to do
3. In helping a client change, the nurse should:
 - a. Encourage the client to move rapidly to avoid delay
 - b. Realize that the problems the client is facing will make him or her eager to change
 - c. Encourage feelings of hope
 - d. Understand that change is a natural process that never involves anxiety and fear
4. In facilitating change the nurse should:
 - a. Avoid deliberate goal-directed activity since this will inhibit the process
 - b. Restrict clients to few choices to avoid overwhelming them
 - c. Give up if resistance is encountered
 - d. Form a helping relationship and collaborate with clients
5. John Korman is a 36-year-old male recently admitted to a psychiatric unit. The nurse taking his history observes that his speech is slurred, and he states that he cannot remember where he has been for the past 12 hours, but the police who brought him in stated that he was arrested driving the wrong way on a one-way street. Which of the following items on the mental status exam would the nurse NOT mark "impaired"?
 - a. Behavior
 - b. Judgment
 - c. Memory
 - d. Affect
6. Which of the following is NOT necessary for the nurse to make a spiritual assessment?
 - a. Assure that the client has a religious affiliation.
 - b. Determine if client believes in a higher power.
 - c. Evaluate the client's relationship to others.
 - d. Determine the client's philosophy of life.
7. Which of the following interventions would be labeled as an independent nursing intervention on a psychiatric unit?
 - a. Giving medications
 - b. Making discharge plans
 - c. Deciding privileges
 - d. Assuring safety
8. The staff of a day treatment program have determined that all clients must participate in a group outing to a local museum because all of the staff want to see the exhibit. Two women clients in the group voice their opposition to visiting the museum because they do not wish to risk being identified as psychiatric clients by others in the community. The staff refuse to listen to their concerns and insist that they go on the trip, but do not describe any particular reason. Which adjective describes the type of goal planning evident in this situation?
 - a. Specific
 - b. Individualized
 - c. Collaborative
 - d. Authoritarian
9. Which of the following behaviors would indicate a good client response to a nursing action?
 - a. The client's body is noticeably less tense and he or she has stopped pacing.
 - b. The client stops interacting with others on the unit.
 - c. The client states "If I don't do what people want they won't like me."
 - d. The client refuses to listen to feedback from other members of the community.
10. A nurse brings a client the Clozapine medication that she has been taking. The client does not look well and complains of a sore throat. The nurse notes that her temperature is elevated

and concludes that the client has an upper respiratory infection. After giving the client the medication, she states that she will ask the doctor for a PRN aspirin order. The doctor orders a CBC and determines that the client has agranulocytosis. At which step of the nursing process did this nurse's problem begin?

- a. Diagnosis
 - b. Planning
 - c. Intervention
 - d. Revision of plan
11. Which of the following is NOT true of the Resolution or Termination phase of the nurse–client relationship?
 - a. Preliminaries for this phase are introduced in the Orientation phase.
 - b. Talk about the impending separation should be avoided so that the client does not decompensate.
 - c. The client should be encouraged to review his progress and goals.
 - d. The nurse should model appropriate expression of feelings.
 12. Which of the following statements would the nurse NOT make in negotiating a contract with the client within the nurse–client relationship?
 - a. "I would like to meet with you on a once a week basis while we are trying to resolve this crisis."
 - b. "We need about 10 sessions to work on this problem."
 - c. "I have malpractice insurance in case there is any problem."
 - d. "We will not be exploring your past, but only looking at things that are going on now."
 13. In a session with the nurse, the client begins to whine about his inability to complete his assigned task from the previous session. The nurse responds by scolding him for his failure. This is an example of:
 - a. Transference
 - b. Countertransference
 - c. Transference and Countertransference
 - d. Goal setting
 14. Sarah has been at least 10 minutes late for each of her previous sessions. Today she arrives 20 minutes late. The nurse should:
 - a. Express anger towards Sarah.
 - b. Confront Sarah firmly and set limits on her behavior.
 - c. Discuss terminating their sessions if she continues this pattern.
 - d. Comment on her observations and assist Sarah to understand her behavior.
 15. Jim, a 14-year-old client, is discussing his drug abuse problem with his nurse. When she asks him to clarify the types of substances he routinely uses, he responds by saying "How about you, have you ever used marijuana?" How should the nurse respond?
 - a. "That's none of your business, Jim, now let's get back to your problem."
 - b. "Why, yes I have, but I was older and more responsible."
 - c. "As you recall, Jim, we agreed to work on your problems with drugs in our sessions. I wonder what concerns you about whether I have used drugs."
 - d. "That's an inappropriate question. I don't have to answer that and wonder why you'd even ask it."
 16. According to the Communication Process, at the end of the feedback loop, the sender becomes the receiver.
 - a. True
 - a. False
 17. Which of the following statements is true concerning communication?
 - a. Some behavior is random and does not communicate a message.
 - b. The message sent by the sender is obvious and does not have to be interpreted by the receiver.
 - c. The main goal of communication is understanding.
 - d. The only real form of communication is the verbal message, either written or spoken.
 18. Sobbing and grunting would be forms of what kind of nonverbal messages?
 - a. Kinesics
 - b. Paralanguage
 - c. Proxemics
 - d. Appearance
 19. Terry Barr is describing to the nurse that he sees himself as extremely patient and laid back. As he speaks, he drums his fingers on the arm of the chair. What can the nurse infer from this communication?
 - a. Terry is obviously lying and trying to fool the nurse.
 - b. Terry's verbal and nonverbal communications are not congruent.
 - c. Terry is in touch with his feelings and expressing them openly and honestly.

- d. Terry's culture is interfering with his ability to communicate.
20. As they are walking down the hall, the nurse and client are discussing their favorite movies. This is an example of:
- Social communication
 - Therapeutic communication
 - Inappropriate communication
 - Lack of communication
21. Which of the following would be the best example of an open-ended question?
- How did you come to be in the hospital?
 - Did your husband bring you over to the hospital?
 - Who brought you to the hospital?
 - When did you come into the hospital?
22. Adrienne has just finished describing how devastated she was at the recent loss of her mother. Which of the following responses by the nurse would NOT be a barrier to therapeutic communication?
- "I know how you feel. I lost my mother recently, too."
 - "Well, it's better to have loved and lost, if you know what I mean."
 - "When did she die? Of what? Does anyone else in your family have that problem?"
 - "It sounds like it's been a really tough period for you."
23. Timmy, a 6-year-old, is accompanying his parents to a family therapy session to deal with his school phobia. Which of the following behaviors by the nurse would NOT constitute therapeutic communication skills with a child?
- "Let's pick out some toys from the closet to play with while I talk to your Mom and Dad."
 - "What do you like best about school, Timmy? What do you like least?"
 - "Tell me about the picture you drew of your family."
 - "Is there something that makes you anxious about going to school, Timmy?"
24. In a peer supervision group a nurse is discussing a recent self-disclosure to a client. The group is most likely to question the appropriateness of the behavior if:
- The nurse has been using a humanistic theoretical approach.
 - The nurse-client relationship was in the termination phase.
 - The nurse-client relationship was in the working phase.
 - The nurse-client relationship was in the orientation phase.
25. Susan, a new graduate, has recently joined the staff of an inner-city mental health clinic. She is shocked at some of the parenting behaviors of her initial client and tells other clinicians that she thinks her client should know better. How could her attitude be labeled?
- Stereotyping
 - Culturally relativistic
 - Ethnocentric
 - Culturally deprived
26. Susan finds herself frustrated when her client uses some money she receives to buy winter coats for her nephews instead of saving it to buy a car so she could commute to a better job. Susan's client is demonstrating which cultural values?
- Present oriented, individualistic
 - Future oriented, individualistic
 - Present oriented, collectivist
 - Future oriented, collectivist
27. A Middle Eastern client comes to the nurses' station and stands face to face less than a foot away from the nurse. The nurse should be aware that:
- The client is becoming aggressive and trying to intimidate the nurse.
 - The client has a different sense of personal space than the predominant American culture.
 - The client is testing the nurse and needs to be confronted.
 - The client is being seductive with the nurse.
28. An Asian American client arrives for her first session with the nurse. She speaks softly and avoids discussion of her problem directly. The nurse should:
- Understand that she has low self-esteem and suggest that they work on this problem.
 - Realize that this behavior is due to extreme guilt and shame and indicates a secret that needs disclosing.
 - Be aware that this is defensive behavior and probably foreshadows a great deal of resistance.
 - Understand that this is culturally appropriate behavior and should be respected and mirrored.

29. In a well-functioning mental health team who is the most important member?
- The doctor
 - The nurse
 - The psychologist
 - The client
30. Which of the following characteristics is most indicative of success in a mental health team?
- A team leader with a decisive authoritarian approach
 - A set of firm rules and regulations to cover most situations that could arise
 - Many diverse philosophies of treatment
 - Open communication
31. The goal of Art therapy and Music therapy is:
- To assist clients in passing time in the hospital productively.
 - To teach clients a new skill or hobby.
 - To evaluate clients for possible job training.
 - To stimulate the expression of feelings.
32. Which of the following is not a responsibility of the generalist nurse?
- Psychotherapy
 - 24-hour care
 - Milieu management
 - Safety
33. Which of the following is most true about a psychiatric and mental health advanced practice nurse who testifies in court on behalf of a child who has been sexually abused?
- The nurse is functioning as an advocate for the child.
 - The nurse is functioning as a case manager for the child.
 - The nurse is exceeding her capabilities as a psychiatric and mental health advanced practice nurse.
 - The nurse is functioning as a Psychiatric Liaison Nurse.
34. Of the following advocacy guidelines, which is true?
- All clients are in need of advocacy as provided by the nurse.
 - Joining forces with other groups with similar goals should be avoided since this leads to a large group that is difficult to handle.
 - The maximum power possible should be brought to the task to ensure the maximum benefit.
 - Patience and persistence are important characteristics of successful client advocates.
35. Jerry Coleman is a 46-year-old client with Bipolar Disorder who has recently had an exacerbation of his manic symptoms. He has been referred for appropriate services to a psychiatric and mental health advanced practice nurse by his disability insurance company. What kind of services might he expect to receive from his case manager?
- A thorough evaluation of his case and coordination of all services
 - Referral for medication evaluation and maintenance
 - Referral for vocational rehabilitation if necessary
 - Weekly reports to his boss concerning the details of his disability
36. Sharon Getty has been admitted to a neurological unit with a complaint of chronic pain. She has been referred to the psychiatric and mental health advanced practice nurse who functions as the Psychiatric Liaison Nurse for that unit. Which might be a response of the liaison nurse?
- Discussion with R.N.s on the unit about the need for them not to talk with the client about the emotional components of her pain
 - Avoiding talking with the client's family because they will probably be upset to learn that they might be contributing to the client's problems with pain
 - Realizing that individual psychotherapy with the client is the role of the psychiatrist
 - Referring the client to occupational therapy if appropriate
37. Which of the following is NOT true?
- Milieu therapy implies that all activity is therapeutic.
 - A therapeutic environment cannot exist without community meetings.
 - Token communities use privileges to reward appropriate behavior.
 - The physical environment is an important part of the milieu.
38. To which of the following values would the nurse working within the therapeutic milieu probably NOT subscribe?
- The need for accessible team members and cooperative working relationships
 - Empowerment of clients and staff to make decisions that affect the group
 - Emphasis on the individual at the expense of the group
 - Encouragement of risk taking and growth
39. Carmine d'Angelo is a 29-year-old client with a diagnosis of Schizophrenia, Paranoid Type. When

- he is denied off-unit privileges at a community meeting, he becomes hostile and accuses certain community members of "having it in for me." What would be the most appropriate response of the nurse?
- Ignore the behavior because it is inappropriate.
 - Confront Mr. D'Angelo with his inappropriate behavior and put him in seclusion.
 - Meet with him at their usual time and clarify his misperceptions.
 - Ask the community members that he accused to have nothing more to do with him.
40. What types of things would the nurse NOT work on with Mr. D'Angelo over the next few sessions?
- How his thoughts and feelings influence his behavior
 - Whether or not his behavior at the previous community meeting achieved his purpose
 - What other coping strategies might be more effective
 - Who seems to be "most out to get" him
41. In a therapy group, a client makes inappropriate demands of the psychiatric and mental health advanced practice nurse who is the group therapist. The psychiatric and mental health advanced practice nurse responds assertively and effectively resolves the problem to the satisfaction of all concerned. What curative factor, according to Yalom does this situation exemplify?
- Altruism
 - Catharsis
 - Interpersonal Learning
 - Universality
42. Mrs. C. S. is an extremely shy individual who was admitted to the hospital with a depressive disorder. What characteristics of therapy groups will best serve her needs?
- The realization that no one else in the group has anything like the problem she has
 - The fact that two members of the group are talking constantly without interruption will protect her from feeling like she must participate.
 - The experience of being left alone by other group members will protect her autonomy and decrease her performance anxiety.
 - The fact that others support one another in learning to change will encourage her to take the risks needed to grow.
43. A psychiatric and mental health advanced practice nurse is called in as a consultant to a nursing home seeking to enhance the morale of its residents. The psychiatric and mental health advanced practice nurse decides to begin an ongoing Resocialization Group since many of the clients have been pretty much isolated from others in their previous living situations. How would such a group be classified?
- Homogeneous, closed ended
 - Heterogeneous, open ended
 - Open ended, task
 - Closed ended, psychotherapy
44. Ann and John lose their first child to Sudden Infant Death Syndrome. They decide to attend a hospital-sponsored group for people who have had this experience. What type of group will they be attending?
- Teaching group
 - Psychotherapy group
 - Task group
 - Supportive/Therapeutic group
45. A psychiatric and mental health advanced practice nurse working as a group psychotherapist makes observations about the effective way members handled a participant who was acting out in the group. What type of leadership style does this nurse exhibit?
- Autocratic
 - Democratic
 - Laissez faire
 - Materialistic
46. After a particularly difficult community meeting, the staff of a unit sit down and begin to talk about which clients were seated in close proximity and who agreed with whom on the issues that came up. What is the staff discussing?
- Gossip
 - Rank and Status
 - Group Content
 - Group Process
47. A nursing group has convened to make decisions about renovation plans for a psychiatric unit. One of the members is discussing how little the hospital ever pays attention to input from nursing staff. Which member role is this participant exhibiting?
- Maintenance role
 - Task role
 - Individual role
 - Gatekeeper role
48. A psychiatric and mental health advanced practice nurse has had several meetings with a therapy group. On this particular occasion it is noted that members seem angry with the nurse

and each other. They seem to be competing with each other to see who can refrain from breaking the silence longest. Which stage of group development do these behaviors signify?

- a. Storming
 - b. Norming
 - c. Performing
 - d. Mourning
49. A psychiatric and mental health advanced practice nurse notes that members of her therapy group have become most supportive of one another and very attached to the group. Which stage of group development do these behaviors signify?
- a. Forming
 - b. Storming
 - c. Norming
 - d. Performing
50. Whose responsibility is it to deal with transference issues in group therapy?
- a. The nurse
 - b. The group members
 - c. The nurse and the group members
 - d. The group member who is involved in the transference
51. How should a member terminating be handled in groups?
- a. Little attention should be paid to it since this person is now ready to leave and other members are more in need of assistance.
 - b. Members may discuss it if they wish, but should be allowed to avoid it if it causes anxiety.
 - c. Members should be encouraged to focus only on the positive aspects of the leaving so that negative feelings do not arise.
 - d. Members should be encouraged to express whatever feelings arise in the process of leaving.
52. Which of the following best summarizes the family therapist's position on how mental illness occurs?
- a. The symptomatic person is the innocent victim of other members of the family.
 - b. If other family members are given education and support, they can help the symptomatic person.
 - c. The symptomatic person is the result of pathology throughout the entire family system.
 - d. If other family members set limits and confront the symptomatic person with reality, they can help him or her.
53. A psychiatric and mental health advanced practice nurse is the family therapist for a family whose youngest child is the identified patient. The child has been brought in for therapy because he has been doing poorly and acting out at school. How will the nurse begin the initial session with the family?
- a. By asking the child why he is doing poorly in school
 - b. By asking the parents why they think he is doing poorly at school
 - c. By asking each family member how they did in school
 - d. By asking questions about the family in general
54. In working with the family, the nurse finds that the child is waking many times during the night and climbing into the parents' bed. Which of the following would the nurse probably NOT use as an intervention in this situation?
- a. Suggesting that one of the parents sleep in the child's room so everyone can get a good night's sleep
 - b. Encouraging the parents to work together to set limits on the child's sleeping in their bed
 - c. Asking the parents to talk together about how they will handle the situation when the child wakes up in the night
 - d. Encouraging each member of the family to talk about his/her feelings in the matter
55. The nurse suggests that if the child cannot sleep, that he play a cassette tape on his recorder and try to listen to as many cassettes as he can, making sure that he gets out of bed, so that he does not fall asleep in the process. This intervention is known as:
- a. Homework
 - b. Paradoxical prescription
 - c. Sculpting
 - d. Triangling
56. The nurse also asks the parents to keep a record of the number of nights the child stays in his own room and to reward him with a treat if he can do it three nights in a row. This intervention is known as:
- a. Homework
 - b. Paradoxical prescription
 - c. Sculpting
 - d. Triangling
57. A family with extremely rigid boundaries will probably NOT have:
- a. Positive links to society
 - b. Clear boundaries

- c. Strong parental coalition
d. Efficient negotiation and task performance
58. Members of a therapeutic community decide at a community meeting that it is not right for two extremely demanding clients to determine the activities for the entire group. This decision can best be classified under which ethical perspective?
- a. Egoism
b. Utilitarianism
c. Deontology
d. Formalism
59. When the nurse asks potentially suicidal clients to relinquish any sharp objects they have in their possession, which ethical principle is being utilized?
- a. Autonomy
b. Beneficence
c. Nonmaleficence
d. Justice
60. A government agency doing a security check on an individual calls a psychiatric and mental health advanced practice nurse seeking information about any mental health problems that the individual might have. What initial response is the best for the psychiatric and mental health advanced practice nurse?
- a. Turn all written records over to the investigators.
b. Submit a treatment summary describing the client's problems.
c. Write a report that describes the client's problems in the least damaging way possible.
d. Refuse to acknowledge that the client is in therapy until a release of information form is signed by the client.
61. A psychiatric and mental health advanced practice nurse has been treating a client for several months. Recently the client has become increasingly agitated and expressed a great deal of hostility towards his ex-wife. At their last session, the client described a detailed plan to kill her and kidnap his children. What is the psychiatric and mental health advanced practice nurse's response?
- a. Call the client's ex-wife and inform her that she may be in danger.
b. Call the police and discuss the case with them.
c. Consult a lawyer about the case.
d. Preserve the client's right to confidentiality.
62. A mother brings her adolescent son in to be seen by a psychiatric and mental health advanced practice nurse. The mother wishes to hospitalize the boy. She indicates that she can no longer control his behavior and that he is dating girls of whom she does not approve and staying out past his curfew. Based on the boy's right to treatment in the least restrictive setting, what is the psychiatric and mental health advanced practice nurse's best response?
- a. Determine the most secure facility to hospitalize the child because he is probably a "run risk."
b. Seek a Day Treatment Program since the child's behavior is not dangerous.
c. Offer to work with the mother and son in regard to appropriate expectations and discipline.
d. Tell the mother that all adolescents act that way and that she is wrong to be upset about this normal behavior.
63. Leroy Jones was committed to an inpatient psychiatric unit because of hallucinations that have not been controlled by oral medications prescribed on an outpatient basis. In the hospital, Mr. Jones has been prescribed I.M. Prolixin. When the nurse brings the first injection, Mr. Jones refuses the medication. What is the nurse's best immediate response in this situation?
- a. Talk with Mr. Jones about his objections to the medication.
b. Tell Mr. Jones that he cannot refuse the medication since it is necessary for his treatment.
c. Call his doctor and tell him/her that Mr. Jones has refused the medication.
d. Call an emergency team to restrain Mr. Jones while the medication is being given.
64. Which of the following is NOT an accurate statement regarding client rights?
- a. Committed clients may petition the courts for release.
b. Committed clients may demand an evaluation by any physician.
c. Committed clients may not have letters restricted.
d. Committed clients may not be hospitalized involuntarily.
65. A nurse who is unaware of standards of care and fails to provide care that results in harm to the client is not subject to being charged with malpractice.
- a. True
b. False

66. The parents of an autistic child consult a psychiatric and mental health advanced practice nurse about their failure to relate to their child. The nurse decides that some education would be helpful to this family in dealing with the problem. What could the family NOT expect to receive as a result of the nurse's teaching intervention?
- An objective perspective
 - Decreased blame and guilt
 - Clarification of expectations
 - A solution to their problems
67. In an assertiveness group, a nurse encourages a client to role play a distressing interaction she has had repeatedly with her mother-in-law. The nurse has the client play herself while the nurse plays the mother-in-law. Which methods of learning are exemplified in this situation?
- Lecture
 - Experiential
 - Self-instruction
 - Audio presentation
68. Alice Walsh is a 46-year-old admitted to a psychiatric unit with Major Depression. Her doctor prescribes an MAO inhibitor that she will be taking when she leaves the hospital in four days. Her nurse wants to teach her about the side effects of her medication, particularly the dietary restrictions. She prepares a 45-minute presentation that covers everything about the medication. Afterwards Mrs. Walsh seems confused and still cannot relate several essential facts about the medication. What is the best nursing response to the situation?
- Phone the doctor and suggest that Mrs. Walsh be placed on another medication with fewer restrictions.
 - Realize that Mrs. Walsh will probably not be able to understand the essentials regarding her medication and teach a relative instead.
 - Realize that Mrs. Walsh's depression is probably inhibiting her ability to learn and repeat the presentation in a few days when she is a little better.
 - Break down the essential facts into a few brief sessions that can be repeated over the next several days and assess Mrs. Walsh's knowledge of the previous session before proceeding.
69. Prescription writing is:
- A standard of practice granted to nurses by the American Medical Association
 - A standard of practice granted to all nurses by the American Nurses Association
 - A standard of practice granted to advanced practice nurses by federal and state law
 - The singular function of advanced practice psychiatric nurse practitioners
70. In the mental health setting, the best prescribing practice includes:
- Assessing thoughts of harm to self or other
 - Writing patient's height and weight on all prescriptions
 - Selecting the appropriate medication for the identified patient
 - Both a and c are correct

ANSWERS

- | | |
|-------|-------|
| 1. d | 36. d |
| 2. c | 37. b |
| 3. c | 38. c |
| 4. d | 39. c |
| 5. d | 40. d |
| 6. a | 41. c |
| 7. d | 42. d |
| 8. d | 43. b |
| 9. a | 44. d |
| 10. b | 45. b |
| 11. b | 46. d |
| 12. c | 47. c |
| 13. c | 48. a |
| 14. d | 49. c |
| 15. c | 50. c |
| 16. a | 51. d |
| 17. c | 52. c |
| 18. b | 53. d |
| 19. b | 54. a |
| 20. a | 55. b |
| 21. a | 56. a |
| 22. d | 57. a |
| 23. d | 58. b |
| 24. d | 59. b |
| 25. c | 60. d |
| 26. c | 61. a |
| 27. b | 62. c |
| 28. d | 63. a |
| 29. d | 64. d |
| 30. d | 65. b |
| 31. d | 66. d |
| 32. a | 67. b |
| 33. a | 68. d |
| 34. d | 69. c |
| 35. d | 70. d |

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Major Theoretical Frameworks for Psychiatric Nursing

■ THEORY

- Definition—a set of concepts, definitions, and propositions, used to describe, explain, predict, or control a phenomenon
- Characteristics
 1. Can interrelate concepts in such a way as to create a different way of looking at a phenomenon
 2. Must be logical in nature
 3. Should be relatively simple, yet generalizable
 4. Can be the basis for hypotheses that can be tested
 5. Contributes to and assists in increasing the general body of knowledge within the discipline through the research implemented to validate it
 6. Can be utilized by the practitioners to guide and improve their practice
 7. Must be consistent with other validated theories, laws, and principles, but will leave open unanswered questions that need to be investigated (George, 1990)
- Theory and research
 1. Theory is constructed through deductive or inductive approaches
 - a. Deductive theory construction proceeds from the general to the specific. The theorist or investigator borrows concepts from other bodies of knowledge and tests the concepts and relationships in nursing

practice. An example is Rogers' Theory of Nursing.

- b. Inductive theory construction proceeds from the specific to the general. The theorist or investigator immerses himself/herself in the data and attempts to generate theoretical statements. An example is Orem's Theory of Self-Care (Riehl & Roy, 1980).
2. Theory serves to:
 - a. Guide research—the theory sets limits on questions to ask and methods to pursue in research.
 - b. Guide practice—after validation from research, theory can give direction to practice.
 - c. Provide a common language between practitioners and researchers.
 - d. Enhance professional autonomy and accountability—theory, supported by research, allows the nurse to predict consequences of care, contributing to autonomous nursing practice (Meleis, 1985).

■ EVIDENCE-BASED PRACTICE (EBP)

EBP involves clinical decision making based on the best practice evidence, emphasizing disciplined research. A nurse engaged in EBP is adept at accessing, evaluating, synthesizing, and using new research evidence (Polit & Beck, 2010). Evidence hierarchies are used to rank the strength of evidence from the lower level (expert opinion) to the

highest level (systematic reviews of randomized control trials that include meta-analyses).

- Systematic reviews can be accessed through the following:
 1. Cochrane Database of Systematic Reviews (CDSR) – www.cochrane.org/reviews/
 2. Agency for Healthcare Research and Quality (AHRQ) – www.ahrq.gov
- Other pre-appraised evidence
 1. Clinical Practice Guidelines – available at: www.guideline.gov
- Models of EBP include the following:
 1. Iowa Model
 2. Ottawa Model
 3. Stetler Model

■ RESEARCH

- Definition—Systematic method of gathering data that provides means of developing and testing theories as well as measuring outcomes of nursing interventions in the clinical area. Participation in research is a Psychiatric Mental Health Nursing Standard of Practice recognized by the American Nurses Association (ANA), American Psychiatric Nurses Association (APNA), and International Society of Psychiatric-Mental Health Nurses (ISPN) (ANA, APNA, ISPN, 2007).
- Researcher roles for nurses
 1. Principal investigator
 2. Coinvestigator
 3. Member of research team
 4. Data collector
 5. Client advocate
 6. Evaluator of research findings
 7. User of research outcomes in evidence-based practice
 8. Problem-area identifier
- Research process
 1. Determine problem.
 2. Review relevant literature.
 3. Identify a theoretical framework.
 4. Determine the research variables.
 5. Formulate hypothesi(e)s.
 6. Select research instruments.
 7. Collect data.
 8. Analyze data.
 9. Determine results and conclusions.
- Types of research
 1. Experimental—experimenter uses random sampling, manipulates the independent variable, and uses control and experimental groups.
 2. Quasi-experimental—variable may be manipulated but subjects not assigned randomly to control and treatment groups.
 3. Nonexperimental—researcher measures variables as they occur naturally; uses correlations to determine nature and extent of relationship between and among variables; includes prospective and retrospective.
 4. Qualitative—researcher makes observations or interviews participants. Data used to describe process or phenomenon—most common forms are phenomenological and ethnographic.
 5. Case study—researcher describes and analyzes one or a small number of cases.
- Research instruments—may measure physical or psychological characteristics. Often questionnaires are used that must be evaluated for the following:
 1. Reliability—ability to measure the same trait repeatedly
 2. Validity—ability to measure what it is supposed to be measuring
- Statistical data analysis (McCrum-Gardner, 2007; Polit & Beck, 2008, 2010; Polit & Hungler, 1991)
 1. Descriptive—means, medians, modes, standard deviation
 2. Inferential statistics—to test hypotheses and decide if relationship between variables is supported
 - a. Testing differences between two group means
 - (1) t-Tests for independent samples
 - (2) Paired t-Tests
 - b. Testing differences between three or more groups
 - (1) ANOVA
 - (2) Kruskal-Wallace test
 - (3) Mann Whitney U
 - (4) Friedman test
 - c. Comparing differences between cases that fall into categories—Chi Square (χ^2) test
 - d. Testing the relationship between two variables
 - (1) Pearson product moment correlation (r)
 - (2) Spearman's rho
 - (3) Kendall's tau
 - e. Multivariate statistics
 - (1) Multiple regression analysis—to understand the effects of two or more independent variables on a dependent measure

- (2) Stepwise multiple regression—all potential predictors considered simultaneously to determine the combination of variables providing the most predictive power
 - (3) Analysis of covariance—used statistically to control one or more extraneous variables; useful to adjust for initial differences in situations where random assignment is impossible
 - (4) Factor analysis—reducing a large set of variables into a smaller set of related variables
3. Level of significance—the probability of a particular result occurring by chance
- Protection of human subjects
 1. Right to informed consent—may be more complicated with psychiatric clients due to nature of illness
 2. Right to confidentiality (privacy of data) and anonymity (privacy of source of information)
 3. Right to refuse to participate or withdraw at anytime

■ NURSING THEORETICAL MODELS

Developed around four core concepts (metaparadigm):

- Individual—the person or client in need of nursing care
- Environment—the combination of all forces that affect an individual
- Health—a state of well-being
- Nursing—the discipline and practice of assisting others to maintain or recover health (George, 1990; Fawcett, 1984)

■ NURSING THEORIES

- Theory of Self-Care (Dorothea Orem)
 1. Self-care—an individual's activities to maintain life, health, and well-being. Self-care requisites are actions directed toward the provision of self-care. The three categories of self-care requisites are:
 - a. Universal—activities of daily living
 - b. Developmental—specialized activities related to a developmental task or an event
 - c. Health deviation—activities required by illness, injury, or disease

2. Self-care deficit—the inability to provide complete self-care; the need for nursing care. Nursing care includes the following:
 - a. Entering into and maintaining nurse-patient relationships
 - b. Assessing how patients can be helped
 - c. Responding to patients' requests and needs
 - d. Prescribing, providing, and regulating direct help
 - e. Coordinating and integrating nursing with other services
3. Nursing systems refer to the amount of nursing care a patient requires. Categories are as follows:
 - a. Wholly compensatory—the nurse provides all care.
 - b. Partly compensatory—the nurse and patient provide care.
 - c. Supportive-educative—the patient provides care. The nurse promotes the patient as a self-care agent (Foster & Janssens, 1990).

- Theory of Goal Attainment (Imogene King)

King describes her theory of goal attainment within an open systems framework.

 1. The three systems in the framework are as follows:
 - a. Personal systems—each individual is a personal system.
 - b. Interpersonal systems—the interaction among human beings
 - c. Social systems—an organized boundary system of roles, behaviors, and practices
 2. The theory of goal attainment states that people come together to help and be helped to maintain health. Concepts of the theory are as follows:
 - a. Interaction—goal-directed communication
 - b. Perception—organizing, processing, storing, and exporting information
 - c. Communication—information given from one person to another
 - d. Transaction—observable behaviors of people interacting with their environment
 - e. Role—set of behaviors expected of a person occupying a certain position
 - f. Stress—an energy response to a stressor
 - g. Growth and development—continuous changes that take place in life
 - h. Time—a sequence of events moving to the future
 - i. Space—physical area; territory (George, 1990)

- Theory of Nursing (Martha Rogers)
 1. The phenomenon central to nursing is the life process of human beings.
 2. Assumptions of Rogers' theory:
 - a. The human being is a unified whole possessing his/her own integrity and manifesting characteristics that are more than and different from the sum of his/her parts.
 - b. The person and environment are continually exchanging matter and energy with each other.
 - c. The life process revolves irreversibly and unidirectionally along the space-time continuum.
 - d. Pattern and organization identify individuals and reflect their wholeness.
 - e. The human being is characterized by the capacity for abstraction and imagery, language and thought, sensation, and emotion.
 3. Building blocks of Rogers' theory:
 - a. Energy field—an electrical field in a continuous state of flux
 - b. Openness—energy fields are open to exchange with other energy fields.
 - c. Pattern—energy fields have patterns that change as required.
 - d. Four dimensionality—energy fields are embedded in a four-dimensional space-time matrix.
 4. Principles of homeodynamics are built upon the five assumptions and four building blocks:
 - a. Integrality—the continuous, mutual, simultaneous interaction between human and environmental fields
 - b. Resonancy—the identification of human and environmental fields by changing wave patterns
 - c. Helicy—the evolving innovative repatterning growing out of the mutual interaction of man and environment (Rogers, 1983; Falco & Lobo, 1990)
- The Adaptation Model (Sister Callista Roy)

There are five essential elements of the model:

 1. Each person is an adaptive system with input, internal processes, adaptive modes, and output.
 - a. Input—internal or external stimuli
 - b. Internal processes—coping mechanisms
 - (1) Regulator subsystem—chemical, neural, and endocrine transmitters
 - (2) Cognator subsystem—perception, information processing, judgment, emotion
 - c. Adaptive modes or system effectors
 - (1) Physiological function mode—identifies patterns of physical functioning.
 - (2) Self-concept mode—identifies patterns of values, beliefs, and emotions.
 - (3) Role function mode—identifies patterns of social interactions.
 - (4) Interdependence mode—identifies patterns of human value, affection, love, and affirmation.
 - d. Output:
 - (1) Adaptive response, or
 - (2) Ineffective response
 2. The goal of nursing—the promotion of adaptive responses in relation to the adaptive modes
 3. Health—a process of being and becoming an integrated person
 4. Environment—conditions, circumstances, and influences affecting the growth and behavior of a person
 5. The Nursing Process:
 - a. First-level assessment—behavioral assessment; assessment of four adaptive modes
 - b. Second-level assessment
 - (1) Identification of focal, contextual, and residual stimuli
 - (2) Identification of ineffective responses
 - c. Identification of nursing diagnosis
 - d. Goal setting with the client
 - e. Implementation—manipulating focal, contextual, or residual stimuli
 - f. Evaluation—assessment of goal behaviors and possible readjustment of goals and interventions (Galbreath, 1990)
- Theory of Culture Care Diversity and Universality (Madeleine Leininger)
 1. The main tenet of the theory is that “care is the essence of nursing and the central, dominant, and unifying focus” (Leininger, 1991, p. 35).
 2. Other concepts include:
 - a. Culture—the learned, shared, and transmitted values, beliefs, norms, and lifeways of a group that guide their actions and decisions
 - b. Cultural care diversity—differences in meanings, patterns, values, or symbols of care, within or between collectivities related to human care expressions
 - c. Cultural care universality—uniform meanings, patterns, or symbols that are manifest in many cultures and reflect ways to help people
 - d. Cultural and social structure dimensions—patterns of structural and organizational factors of a particular culture, including:

- (1) Religious factors
 - (2) Social and kinship factors
 - (3) Political and legal factors
 - (4) Economic factors
 - (5) Educational factors
 - (6) Technological factors
 - (7) Cultural values
 - (8) Ethnohistorical factors
 - e. Ethnohistory—past facts, events, and experiences of individuals, groups, cultures, or institutions that are people-centered and that describe, explain, and interpret human lifeways within a certain culture
 - f. Cultural care preservation or maintenance—actions and decisions that help people retain relevant cultural care values to maintain well-being, recover from illness, and face handicaps or death
 - g. Cultural care accommodation or negotiation—actions and decisions to help people of a designated culture negotiate for a beneficial outcome with health caregivers
 - h. Cultural care repatterning or restructuring—actions and decisions to help clients modify their lifeways for beneficial health care, while respecting their cultural values and beliefs
 - i. Cultural congruent nursing care—actions and decisions tailored to fit cultural values and beliefs (Leininger, 1991)
- Health Promotion Model (Nola Pender)
 1. The Health Promotion Model (HPM) builds on theories of social learning (Bandura) and of reasoned action and planned behavior (Fishbein; Ajzen). The HPM describes the multidimensional interactions between the environment and persons in the pursuit of health. A main focus of the model is promotion of preventative health behaviors—to optimize health and prevent/limit the infirmities of disease (Pender, Murdaugh, & Parsons, 2005).
 2. The HPM focuses on the following three areas:
 - a. Individual characteristics and experiences that involve:
 - (1) Previous health-related behavior
 - (2) Personal factors (biological, psychological, and sociocultural)
 - b. Behavior-specific cognitions and affect that involve:
 - (1) Perceived benefits of action—positive outcomes that will occur with health-related behavior
 - (2) Perceived barriers to action—anticipated, imagined, or actual blocks that inhibit execution of behavior
- (3) Perceived self-efficacy—the personal evaluation of capacity/ability to organize and execute healthy behavior
 - (4) Activity-related affect—a subjective assessment of the positive or negative emotional consequence of the behavior
 - (5) Interpersonal influences—health behavior cognitions related to the beliefs and attitudes of others—including norms (expectations of others), social support (encouragement), and vicarious models (watch what others do)
 - (6) Situational influences—circumstances that can facilitate or impede health behavior
 - (7) Commitment to a plan of action—intention to implement health behavior
 - (8) Immediate competing demands and preferences that can affect health behavior
 - (a) Competing demands—alternative behaviors over which the person has little control, such as work and child-care responsibilities
 - (b) Competing preferences—alternative behaviors over which the person has high control, such as having a chocolate bar rather than a carrot for a snack.
 - c. Behavioral outcomes that involve:
 - (1) Health promoting behavior—outcome measure of behavior; directed toward attaining positive health outcome such as optimal well-being, personal fulfillment, and productive living.
- Interpersonal Relations/Psychodynamic Nursing (Peplau)—See Chapter 2 - Nurse-Client Relationship

■ PERSONALITY THEORIES

(Corsini & Wedding, 2008; Seligman, 2006)

- Psychoanalytic/Psychodynamic (Sigmund Freud) concepts in the theory of Freud include the following:
 1. Levels of awareness
 - a. Conscious—thoughts, feelings, and desires a person is aware of and able to control
 - b. Preconscious—thoughts, feelings, and desires that are not in immediate awareness but can be recalled to consciousness

- c. Unconscious—thoughts, feelings, and desires that are not available to the conscious mind
 2. Stages of development—according to Freud, each person passes through the following stages of psychosexual development. A person can get stuck in any stage:
 - a. Oral—the focus is on sucking and swallowing, gratification of oral needs
 - b. Anal—focus on spontaneous bowel movements, control over impulses
 - c. Phallic—focus on genital region, identification with parent of the same gender
 - d. Latency—focus on coping with the environment; sexual impulses dormant
 - e. Genital—focus on erotic and genital behavior, developing mature sexual and emotional relationships
 3. Personality structure—the personality has three main components:
 - a. Id—the pleasure principle; unconscious; desire for immediate and complete satisfaction; disregard for others
 - b. Ego—the reality principle; rational and conscious; weighing of actions and consequences
 - c. Superego—the censoring force of the personality; conscious and unconscious; evaluating and judging behavior (Scroggs, 1985)
 4. Several terms common to psychiatric nursing originated with Freud, including:
 - a. Oedipus complex or Electra conflict—at the age of 4 or 5, the child falls in love with the parent of the opposite sex and feels hostility toward the parent of the same sex.
 - b. Defense mechanisms—conscious or unconscious actions or thoughts to protect the ego from anxiety (See **Table 3-1**).
 - c. Freudian slips—also known as parapraxes—overt actions with unconscious meanings
 - d. Free association—a method for discovering the contents of the unconscious by associating words with other words or emotions
 - e. Transference—feelings, attitudes, and wishes linked with a significant figure in one's early life projected onto others in one's current life
 - f. Countertransference—feelings and attitudes of the therapist projected onto the patient inappropriately
 - g. Resistance—anything that prohibits a person from producing material from the unconscious
 - h. Fixation—getting stuck in one stage of development (Scroggs, 1985; Drapela, 1987)
 5. Treatment—psychoanalysis:
 - a. Daily therapy sessions are conducted for several years.
 - b. The patient reveals thoughts, feelings, dreams, etc.
 - c. The therapist reveals no personal information, functioning primarily as a shadow figure. The therapist interprets the patient's behavior for him or her.
- Psychoanalysis (Carl Jung)
The major concepts of Jung's theory are as follows:
 1. Archetype—unconscious, intangible collective idea, image, or concept; Scroggs (1985) defines the main archetypes identified by Jung as follows:
 - a. The Way—the image of a journey or voyage through life
 - b. The Self—the aspect of mind that unifies and orders experience
 - c. Animus and Anima—the image of gender
 - d. Rebirth—the concept of being reborn, resurrected, or reincarnated
 - e. Persona—the role or mask one shows to others
 - f. Shadow—the dark side of one's personality
 - g. Stock characters—dramatic roles that appear over and over in folktales
 - (1) Hero—the character who vanquishes evil and rescues the downtrodden
 - (2) Trickster—the character who plays pranks or works magic spells
 - (3) Sage—the wise old person
 - h. Power—symbol, such as the eagle or the sword
 - i. Number—certain numbers that reappear throughout history and across cultures
 2. Psychological types—Jung described two attitudinal and four functional types of personalities:
 - a. Attitudinal types
 - (1) Introvert—oriented toward the inner, subjective world
 - (2) Extrovert—oriented toward the outer, external world
 - b. Functional types
 - (1) Thinking—intellectual process involving ideas
 - (2) Feeling—evaluative function involving value or worth
 - (3) Sensing—function involving recognition that something exists, without categorizing or evaluating it
 - (4) Intuiting—function involving creative inspiration, knowing without having the facts (Scroggs, 1985)
 3. Collective unconscious

■ Table 3-1 Defense Mechanisms

Type	Defense Mechanism	Definition
Primitive	Denial	Avoiding the reality of a painful/anxiety-producing situation by refusing to acknowledge it
	Projection	False attribution of the person's own undesirable feelings, thoughts, and impulses onto others (splitting is a form of projection)
Immature	Fantasy	Symbolic fulfillment of wish or impulse with irrational thought
	Identification	Conscious/unconscious modeling of characteristics of an idealized/respected person
	Introjection	Unconsciously taking on another person's values/traits and becoming like that person
	Regression	Unconsciously returning to an earlier, more comfortable level of development to avoid emotional discomfort
	Somatization	Transferring emotional distress to bodily symptoms (pains and other ailments)
	Undoing	Conscious behavior to cancel out an unacceptable action that has already been done (heightened superstitiousness)
Neurotic	Displacement	Shifting of feelings from an emotionally charged person or object to a substitute, less threatening, person or object
	Dissociation	Unconscious separation from emotional pain through temporary but drastic modification of character or sense of personal identity
	Intellectualization	Reasoning or logic used in attempt to avoid intimacy and confrontation with objectionable impulse or affect
	Isolation	Splitting or separating of affect from the rest of a person's thinking
	Rationalization	Using logical or acceptable, but incorrect, reasons or excuses for behavior that is unacceptable to one's self-image—can be conscious or unconscious
	Reaction formation	Substitution of behavior, thoughts, and feelings diametrically opposed to unacceptable ones
	Repression	Considered to be the basis for all defense mechanisms—unconscious exclusion of ideas, feelings, and situations that are unacceptable to the self
Mature	Compensation	An individual consciously making up for a perceived lack in one area by emphasizing strengths in another
	Sublimation	Conscious/unconscious channeling of unacceptable impulses to a primary goal that is socially acceptable
	Suppression	Conscious exclusion of thoughts, feelings, and situations that produce discomfort and some anxiety (active forgetting)
	Altruism	Conscious use of service to others; doing good for others to reduce or avoid negative feelings about self
	Humor	Using comedy to assuage emotions without producing discomfort for self or others—wit is a form of displacement that deflects emotion onto others

(Fitch & O'Brien-Pallas, 1991; Keltner, Schwecke, & Bostrom, 2007; Sadock & Sadock, 2007; Wheeler, 2008)

- Theory of Individual Psychology (Alfred Adler)

Adler saw individuals in a social context; he is considered a social-interpersonal theorist by some. Key ideas include:

 1. Inferiority feelings as the source of all human strivings
 2. Personal growth as resulting from the attempts to compensate for inferiority
 3. Complexes:
 - a. Inferiority complex—an inability to solve life's problems
 - b. Superiority complex—an exaggerated opinion of one's abilities and accomplishments, a result of the attempt to overcompensate for an inferiority complex
 4. The goal of life—to strive for superiority

5. Lifestyle—the unique set of behaviors created by each individual to compensate for inferiority and achieve superiority
 6. The influence of birth order
 - a. First-born—happy and secure, the center of attention, until dethroned by the second child; develops interest in authority and organization
 - b. Second-born—born into a more relaxed atmosphere; has the first-born as a model, or a threat to compete with; develops interest in competition
 - c. Youngest child—pet of the family; may retain dependency (Schultz, 1987; Adler, 1983)
- Theory of Basic Anxiety (Karen Horney)
Because of her focus on family, some consider Horney a social–interpersonal theorist. Concepts include:
 1. A child has two basic needs—safety and satisfaction.
 2. When those needs are not met, the child feels hostility.
 3. The child represses the hostility, and this leads to basic anxiety.
 4. Basic anxiety is a pervasive feeling of being lonely or helpless in a hostile world
 5. Protective mechanisms against basic anxiety in relationships include:
 - a. Moving toward people
 - b. Moving against people
 - c. Moving away from people
 6. Neurosis—compulsive and unconscious extension of maladaptive childhood mechanisms (Scroggs, 1985; Wilson & Kneisl, 1992)
- c. Preschooler (3–6 years)
Initiative—focus on genital needs, purpose, task-orientation vs
Guilt—denial, inhibition, showing off, self-righteous psychosomatic disease
 - d. School-age (6–12 years)
Industry—focus on socialization, competence, perseverance vs
Inferiority—inadequacy, self-restriction, conformity
 - e. Adolescent (13+ years)
Identity—focus on search for self, idealism, confidence vs
Identity diffusion—delinquency, psychosis, overidentification with heroes, cliques
 - f. Young Adult
Intimacy—focus on human closeness, sexual fulfillment, love vs
Isolation—distancing behaviors, self-absorption, character problems
 - g. Middle Aged Adult
Generativity—focus on productivity, creativity, guiding next generation vs
Stagnation—lack of faith, obsessive need for pseudointimacy, early invalidism
 - h. Older Adult
Integrity—emotional and spiritual integration, fellowship with others, leadership vs
Despair—disgust, fear of death (Erikson, 1963; Whiting, 1997)
- Theory of Cognitive Development (Jean Piaget)
Piaget's stages of development are:
 1. Sensory-Motor Period—0 to 2 years
 - a. Stage I—0 to 1 month—no distinction between self and outer reality; characterized by reflexive, uncoordinated body movements.
 - b. Stage II—1 to 4 months—response patterns begin to be formed; the baby's fist finds its way into his or her mouth.
 - c. Stage III—4 to 8 months—response patterns are coordinated and repeated intentionally.
 - d. Stage IV—8 to 12 months—more coordinated responses ensue; child pushes obstacles aside, searches for vanished objects.
 - e. Stage V—12 to 18 months—behavior patterns are deliberately varied, as if to observe different results; groping toward a goal emerges.
 - f. Stage VI—18 months to 2 years—behavior patterns are internalized; symbolic representation emerges.

■ THEORIES OF GROWTH AND DEVELOPMENT

- Theory of Psychosocial Development (Erik Homburger Erikson)
 1. The term used in naming each stage identifies the conflict to be resolved during that stage.
 2. In each stage, the individual has a particular focus and a task, which results in adaptive or maladaptive characteristics:
 - a. Infant (0–2 years)
Trust—focus on oral needs, acquisition of hope vs
Mistrust—withdrawal (schizoid or depressive)
 - b. Toddler (1.5–3 years)
Autonomy—focus on anal needs, acquisition of skill vs
Shame and doubt—low self-esteem, secretiveness, persecution

2. Pre-operational Period—2 to 7 years—characterized by egocentric thinking expressed in artificialism, realism, and magic omnipotence
 - a. Pre-conceptual Stage—2 to 4 years—conceptualization begins to emerge, represented in language, drawings, dreams, and play.
 - b. Perceptual or Intuitive Stage—4 to 7 years—prelogical reasoning appears, based on appearances; trial and error may lead to discovery of correct relationships.
 3. Concrete Operations Period—7 to 11 years—characterized by thought that is logical and reversible; the child understands classes, relationships, and part-whole relationships dealing with concrete things.
 4. Formal Operations Period—11 years to adulthood—characterized by the development of logic and reasoning and second-order thoughts, that is, thinking about thoughts (Pulaski, 1971).
- Theory of Moral Development (Lawrence Kohlberg)
The stages of moral development are:
 1. Level I—external standards
 - a. Stage 1—avoidance of punishment; the punishment or power of others determines what is right and wrong.
 - b. Stage 2—desire for reward or benefit; action is based on getting something in return, in satisfying gratification. There is a sense of fairness and reciprocity, but not a sense of loyalty, gratitude, or justice.
 2. Level II—conventional order
 - a. Stage 3—anticipation of disapproval of others, or “good boy–nice girl” orientation; there is conformity to expectations of appropriate behavior, seeking approval.
 - b. Stage 4—anticipation of dishonor; behavior is oriented toward respecting authority, maintaining social order, and obeying social rules for their own goodness.
 3. Level III—principled morality
 - a. Stage 5—social contract, legalistic orientation; behavior is oriented toward the belief that justice flows from a social contract that assures equality for all. Behavior is geared toward rules and legalities.
 - b. Stage 6—universal ethical principles orientation; behavior is oriented toward universal, ethical abstract principles (Kohlberg, 1984).
 - Theory of Moral Development (Carol Gilligan)
Moral development of women is based more upon an ethic of caring and attachment (Gilligan,

1982). Gilligan has not yet described stages of development in females.

■ SOCIAL/INTERPERSONAL THEORY

- Theory of Interpersonal Development (Harry Stack Sullivan—the basis of H. Peplau’s work)
Sullivan focuses on behavior as interpersonal. Major concepts include:
 1. Self-system—a construct built from the child’s experience, made up of reflected appraisals from the approval or disapproval of significant others
 2. Two basic drives that underlie behavior:
 - a. The drive for satisfaction—basic physiological drives, e.g., hunger
 - b. The drive for security—a sense of well-being and belonging
 3. Anxiety—any painful feeling or emotion that arises from social insecurity or blocks to satisfaction; characteristics of anxiety are:
 - a. Interpersonal
 - b. Can be described; can be observed in behavior
 - c. Attempts to reduce anxiety
 4. Security operations—measures are taken by individuals to reduce anxiety, e.g., selective inattention.
 5. Mental illness—self-system interferes with ability to attend to basic drives.
 6. Therapy is based upon the belief that by experiencing a healthy relationship with the therapist, the patient can learn to build better relationships. Therapy is an active partnership based on trust (Sullivan, 1953).

■ EXISTENTIAL/HUMANISTIC THEORIES

The theorists focus on experience in the here and now, with little attention to the past.

- Client Centered Therapy (Carl Rogers)
The key concept is that people can become fully functioning persons when they are unconditionally valued.
 1. The attributes of the therapist:
 - a. Congruence—inner feelings match outer actions.
 - b. Unconditional positive regard—the therapist sees the client as a person of intrinsic worth, likes the client, and treats the client nonjudgmentally.
 - c. Empathic understanding—the therapist is an empathetic, sensitive listener.

2. The goal of therapy is to help the client become a fully functioning person. The client reaches this goal by:
 - a. Relinquishing facades.
 - b. Banishing “oughts.”
 - c. Moving away from cultural expectations and becoming nonconformist.
 - d. Pleasing oneself, as opposed to pleasing others; being self-directed.
 - e. Opening up and dropping defenses.
 - f. Trusting his or her inner self, his or her intuition.
 - g. Becoming willing to be a complex process.
 - h. Accepting others (Rogers, 1961; Scroggs, 1985).
- Gestalt (Frederick (Fritz) Perls)
 1. Here-and-now therapy of immediate experiencing, attained by removing masks and facades
 2. Involves a creative interaction between therapist and client to gain ongoing awareness of what is being felt, sensed, and thought
 3. Describes boundary disturbance—lack of awareness of the immediate environment, which takes the following forms:
 - a. Projection—fantasy about what another person is experiencing
 - b. Introjection—accepting the beliefs and opinions of others without question
 - c. Retroreflection—turning back on oneself that which is meant for someone else
 - d. Confluence—merging with the environment
 - e. Deflection—a method of interfering with contact, used by receivers and senders of messages
 4. Goal of therapy—integration of self and world awareness
 5. Techniques of therapy include:
 - a. Playing the projection—taking and experiencing the role of another
 - b. Making the rounds—speaking or doing something to other group members to experiment with new behavior
 - c. Sentence completion—e.g., “I take responsibility for. . . .”
 - d. Exaggeration of a feeling or action
 - e. Empty chair dialogue—having an interaction with an imaginary provocateur
 - f. Dream work—describing and playing parts of a dream (Hardy, 1991)
 - Humanistic/Holistic (Abraham Maslow)
 1. When basic needs are met, health and growth will naturally follow.
 2. Best known for his description of a hierarchy of basic needs:
 - a. Physiological needs
 - b. Safety needs
 - c. Love and belongingness needs
 - d. Self-esteem needs
 - e. Self-actualization needs (Drapela, 1987; Scroggs, 1985)
 - Rational Emotive Behavior Therapy (Albert Ellis)
 Some consider this an existential theory while others refer to it as a “cognitive” theory, because the focus is on changing thinking, rather than on feeling or experiencing. Assumptions and key concepts include:
 1. People largely control their own destinies.
 2. People act on their basic values and beliefs.
 3. People interpret events according to their basic values or beliefs and the interpretation can change.
 4. A-B-C-D-E-F of therapy (Seligman, 2006):
 - a. Activating event
 - b. Belief
 - c. Consequences—emotional and/or behavioral
 - d. Dispute (debate)
 - e. Effective rational beliefs (interventions are used to promote change)
 - f. Feelings and behavior change as a result of effective rational beliefs.
 5. Irrational beliefs have four basic forms:
 - a. Something should, ought, or must be different.
 - b. Something is awful, terrible, or horrible.
 - c. One cannot bear, stand, or tolerate something.
 - d. Something or someone is damned, as a louse, rotten person, etc.
 6. “Musturbatory” ideologies have three forms:
 - a. I must do well and win approval or I am a rotten person.
 - b. You must act kindly and justly toward me or you are a rotten person.
 - c. My life must remain comfortable and easy or the world is damnable and life hardly seems worth living.
 7. Therapy consists of detecting and eradicating irrational beliefs and musturbatory ideologies by:
 - a. Disputing—detecting irrationalities, debating against them, discriminating between logical and illogical thinking, and defining what helps to create new beliefs
 - b. Debating—questioning and disputing the irrational beliefs

- c. Discriminating—distinguishing between wants and needs, desires and demands, and rational and irrational ideas
- d. Defining—defining words and redefining beliefs

■ BEHAVIORAL THEORIES

The behavioral theories are generally not concerned with thoughts, feelings, or unconscious phenomena, except to view them as “behaviors.” The focus of behavioral therapy is on replacing maladaptive behaviors with more effective behaviors.

- Behavior Therapy (Burrhas Frederic Skinner)
All behavior is determined by contingencies of reinforcement (Scroggs, 1985). Important concepts include:
 1. Operant conditioning (also called instrumental learning)—the individual performs a behavior that leads to a positive or negative reinforcement, making it either more or less likely that the behavior will be repeated.
 2. Schedules of reinforcement—Skinner found that different schedules of reinforcement had different effects on supporting or extinguishing particular behaviors:
 - a. Fixed ratio schedule—behaviors are rewarded or reinforced every time they are repeated.
 - b. Variable ratio schedule—behaviors are rewarded randomly.
 - c. Fixed interval schedule—behaviors are rewarded at specific time intervals.
 - e. Random interval schedule—behaviors are rewarded at random time intervals (Skinner, 1974; Scroggs, 1985).
- Reciprocal Inhibition (Joseph Wolpe)
A “process of relearning whereby in the presence of a stimulus a non anxiety producing response is continually repeated until it extinguishes the old, undesirable response” (Wolpe, 1969, p. 91). Types of reciprocal inhibition include:
 1. Systematic desensitization—used primarily in the treatment of phobias—the following steps comprise the most common mode of systematic desensitization:
 - a. Training in deep muscle relaxation
 - b. Listing examples of phobic reactions; arranging them in descending order of intensity
 - c. Desensitization:
 - (1) Fantasy desensitization—while the client relaxes as deeply as possible, the examples are presented to his or

her imagination. They are repeated until the anxiety is eliminated.

- (2) In vivo desensitization—in addition to fantasy desensitization, the client actually faces the feared object or situation.
2. Avoidance (aversive) conditioning is the application of the reciprocal inhibition principle to overcome undesirable responses. An example of avoidance conditioning is the use of the drug antabuse to overcome an alcoholic’s undesirable response of drinking (Wolpe, 1968).
- Reality Therapy (William Glasser)
Focuses on changing present behavior—the basic premise is that everyone who seeks psychiatric treatment is unable to fulfill his or her basic needs and is denying the reality of the world around him or her. Major concepts include:
 1. Each person has two basic needs:
 - a. The need to love and be loved—each person needs to be involved with at least one other person who is in touch with reality and able to fulfill his/her own basic needs.
 - b. The need to feel worthwhile to himself and others—to be worthwhile, one must maintain a satisfactory standard of behavior.
 2. Responsibility—the ability to fulfill one’s needs in a way that does not deprive others of the ability to fulfill their needs; the cause of all psychiatric problems is irresponsibility.
 3. Role of the therapist:
 - a. Become so involved with the patient that the patient can face reality.
 - b. Reject the behavior that is unrealistic while accepting the patient and maintaining involvement.
 - c. Teach the patient better ways to fulfill his/her needs.
 - d. Emphasize behavior, not attitude or emotions.
 - e. Emphasize responsibility and planning to change inappropriate behavior.

■ COGNITIVE THEORIES

- Cognitive Therapy (Aaron Beck)
While practicing psychoanalysis, Beck discovered that, in addition to the thoughts verbalized during “free association,” his patients had a concurrent, second set of thoughts. He called these “automatic thoughts.” Automatic thoughts were those that labeled, interpreted, and evaluated, according to a personal set of rules. Beck called dysfunctional automatic thoughts “cognitive distortions.” Concepts in cognitive therapy include:

1. Elements of the relationship between therapist and client:
 - a. The relationship is a collaborative partnership.
 - b. Therapist and client determine the goal of therapy together.
 - c. The therapist encourages the client to verbalize disagreement with the therapist when appropriate.
 2. The process of therapy:
 - a. The therapist explains to the client that:
 - (1) Perception of reality is not reality.
 - (2) Interpretation of sensory input depends on cognitive processes.
 - b. Recognition of maladaptive ideation—the client is trained to observe his/her cognitive and emotional reactions to events, identifying:
 - (1) The observable behavior
 - (2) The underlying motivation
 - (3) His/her thoughts and beliefs
 - c. Distancing and decentering—the client practices distancing the maladaptive thoughts.
 - d. Authentication of conclusions—the client explores his/her conclusions and tests them against reality.
 - e. Changing the rules
 - (1) The client makes the rules less absolute and extreme.
 - (2) The client drops false rules from the repertoire and substitutes adaptive rules.
- Cognitive Behavior Modification (Meichenbaum)
Meichenbaum's theory combines the goals of cognitive and behavior therapies to focus on improving thoughts and behaviors. A broad range of change strategies are used by CBT therapists including (Seligman, 2006):
 1. Strategies to improve thinking (e.g., positive self-talk, reframing, problem solving, Ellis's ABCDEF model)
 2. Strategies to improve coping (e.g., visual and guided imagery, bibliotherapy, role playing, cognitive modeling, homework)
 3. Strategies to stop rumination and self-defeating behaviors (e.g., flooding, thought stopping, letter writing)
 4. Strategies to reinforce positive change (e.g., affirmations, focusing on the positive)
 - Social Learning Theory (Albert Bandura)
Bandura's theory combines cognitive and behavioral theories—the key concept of the theory

is modeling, also called imitating or learning by observation. Other concepts include:

1. Retention process—verbally encoding an observed behavior
 2. Motor reproduction process—practicing the motor skills of the observed behavior
 3. Reinforcement and motivational process—receiving reward or reinforcement for the behavior (Scroggs, 1985)
- Dialectic Behavior Therapy (Linehan)
Dialectic Behavior Therapy (DBT) is a form of CBT that also incorporates insight-oriented therapy and is used primarily to treat persons with borderline personality disorder. DBT sessions include weekly 1-hour individual and 2-hour group sessions lasting 1 year. Emphasis in therapy sessions is on skill building and problem solving (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999; Sadock & Sadock, 2007; Seligman, 2006). Basic assumptions of DBT:
 1. There is a desire for improvement and with support, improvement can be achieved.
 2. Any effort is progress, thus failure is not possible.
 3. While clients may not have caused all of their problems, they are responsible for the solutions; they must try harder or be more motivated to change.

■ THEORIES OF COMMUNICATION

Theories of communication focus on the process of verbal and nonverbal communication between and among people.

- Neurolinguistic Programming (NLP) (Richard Bandler & John Grinder)
The assumption behind NLP is that we all create personal models or maps of the world and use language to represent our models. People “get stuck,” not by their situation, but by the choices they perceive are available to them because of their maps. Concepts include:
 1. Representational systems—sensory modalities through which people access information, to include:
 - a. Auditory
 - b. Visual
 - c. Kinesthetic
 2. Cues to representational systems—patterns that are associated with representational systems and can be heard or observed

- a. Preferred predicates—e.g., the word “view” suggests a visual system.
 - b. Eye-accessing cues—e.g., looking upward suggests a visual system.
 - c. Gross hand movements—e.g., pointing toward the ear suggests an auditory system.
 - d. Breathing patterns—e.g., deep abdominal breathing suggests a kinesthetic system.
 - e. Speech pattern and voice tone—e.g., quick bursts of high pitched words suggest a visual system.
3. Language structure
 - a. Surface structure—the sentences that native speakers of a language speak and write
 - b. Deep structure—the full linguistic representation from which the surface structures of a language are derived
 - c. Ambiguity—the idea that a surface structure may represent more than one deep structure
 4. Human modeling—the process of representing something, e.g., the world of experience as represented in language. Modeling involves the following processes:
 - a. Generalization—a specific experience comes to represent the entire category of which it is a member.
 - b. Deletion—selected portions of the world are excluded from the representation created by an individual.
 - c. Distortion—the relationships among the parts of the model differ from the relationships they are supposed to represent (Bandler & Grinder, 1975, 1976; Wilson & Kneisl, 1992).
- Transactional Analysis (TA) (Eric Berne)
The focus is on the interaction between persons. Concepts include:
 1. Ego state—frame of mind
 - a. Parent—exhibits feelings and behaviors learned from parents and authorities; the parent may be nurturing or critical.
 - b. Adult—exhibits feelings and behaviors of a mature adult, e.g., analysis, perception, and sociability.
 - c. Child—exhibits feelings and behaviors natural to children under 7 years old; the child may be natural or adapted. The adapted child is acting under parental influence.
 2. Transaction—verbal and nonverbal communication between two people
 - a. Complementary transactions
 - (1) A message sent *from* the ego state of Person A is responded to in that ego state.
 - (2) A message sent *to* an ego state in Person B is responded to from that ego state.
 - b. Crossed transactions
 - (1) A message sent *from* the ego state of Person A is responded to in another ego.
 - (2) A message sent *to* an ego state in Person B is responded to from another ego state.
 - c. Ulterior transactions—messages that occur on two levels
 - (1) The social or overt level
 - (2) The hidden or psychological level
 - 3. Games—recurring sets of ulterior transactions with a concealed motive, e.g., “Why don’t you . . . Yes, but.”
 - 4. Script—an unconscious life plan
 - 5. Therapy using TA may be done in conjunction with other modes of therapy, e.g., psychoanalysis. Therapy process consists of:
 - a. Explanation of TA to the client
 - b. Structural analysis of the client’s ego states
 - c. Transactional analysis of the client’s interactions
 - d. Game analysis
 - e. Script analysis (Berne, 1961, 1964; Wilson & Kneisl, 1992)

■ THEORIES OF GROUP BEHAVIOR AND THERAPY

Many theories already described in this chapter have been applied to group behavior and group therapy, including theories of psychoanalysis, personality, and communication. The theory considered basic to all groups is systems theory.

- Systems Theory (Von Bertalanffy)
According to Von Bertalanffy (1934) the world consists of entities called “systems.” The theory has frequently been used to explain group behavior. Selected concepts include:
 1. All systems are hierarchically arrayed and fall into the following categories:
 - a. Suprasystem
 - b. System
 - c. Subsystem
 2. A system has three functions:
 - a. Meeting its purpose
 - b. Self maintenance
 - c. Adaptation

3. The whole is more than the sum of the parts.
 4. A change in one part affects other parts and/or the whole system.
 5. There is feedback or input and output:
 - a. Within the system.
 - b. Between the system and the environment (Von Bertalanffy, 1934; Van Servellen, 1984).
- Group Theories—See Chapter 2 - Group Dynamics & Group Process Theory: Curative factors of groups (Yalom, 2005)
 - Psychodrama (J. L. Moreno)
Psychodrama is a here-and-now action psychotherapy, a therapeutic drama, used primarily in group settings. The therapist functions as the “Director” of the drama chosen by the client. Psychodrama consists of a three-part process:
 1. Warm up—the protagonist chooses the time, place, scene, and auxiliary egos for his/her production.
 2. Action—the issue or conflict is acted out or relived.
 3. Post-action sharing—group members discuss their identification with the subject (Moreno, 1964).
4. Multigenerational transmission process—relationship patterns and anxiety about specific issues that have been transmitted through the generations
 5. Family projection process—assignment of characteristics to certain family members
 6. Sibling position—birth order and gender
 7. Emotional cutoff—distancing to deal with intense unresolved emotional issues
 8. Therapy—consists of role modeling and guiding family members to:
 - a. Increase differentiation of self from a “pseudoself” consisting of beliefs and values acquired in the family to a highly differentiated self.
 - b. Detriangle—observe one’s own effect and control one’s participation in the triangle, while maintaining emotional contact (Bowen, 1978; Stuart & Sundeen, 1991; Kerr & Bowen, 1988).
- Structural Family Therapy (Salvador Minuchin)
In this theory, the therapist joins the family and works to modify the family structure. Concepts in Structural Family Therapy include:
 1. The family in transition—the family is considered a social system in transformation that must maintain its continuity and adapt to internal and external stressors.
 2. Stages of family development—each stage requires restructuring. The stages include:
 - a. Courtship period—when the young person reaches adulthood and seeks a mate
 - b. Marriage—when one member moves from the family of origin to create a new family
 - c. Middle years of marriage—when parents must wean themselves from their children
 - d. Retirement and old age—when one spouse may die; adult children may assume care provider role.
 3. Family structure, which consists of:
 - a. Power and influence—the hierarchy of power and authority; parental authority is advocated.
 - b. Subsystems—sets of relationships or dyads formed by generation, gender, interest, or function
 - c. Boundaries—rules of who participates with whom. Boundary problems include:
 - (1) Enmeshment—weak or absent boundaries between individuals and/or subsystems; perceptions of self and others are poorly differentiated.

■ FAMILY THEORIES

Family therapies focus on the family as a whole. The family member who has a problem to be dealt with in therapy is known as the “identified patient.”

- Family Systems Theory (Murray Bowen)
Bowen applied systems theory to the treatment of dysfunctional families, developing a “transgenerational” therapy. The main concepts of the theory are:
 1. Differentiation of self—in the lower the level of self-differentiation, the less adaptive one is under stress. There are two types of differentiation of self:
 - a. Differentiating thought from emotion
 - b. Differentiating oneself from one’s “family ego mass”
 2. Triangles—when a two-member alliance, or dyad, becomes emotionally stressed, the members pull in a third member to reduce anxiety. Bowen considers a triangle the basic building block of any emotional system.
 3. Nuclear family emotional system—patterns of emotional interaction among family members

- (2) Disengagement—rigid boundaries between individuals and/or subsystems; communication and contact is minimal.
- 4. Tasks of the therapist include:
 - a. Joining and accommodation
 - (1) Maintenance—e.g., joining the family and maintaining family strengths by pointing them out
 - (2) Assessment—e.g., assessing the family structure and transaction patterns
 - b. Restructuring
 - (1) Actualizing family transactional patterns—e.g., re-creating communication channels
 - (2) Marking boundaries—delineating individual and subsystem boundaries
 - (3) Escalating stress—e.g., blocking transactional patterns
 - (4) Assigning tasks within and between sessions
 - (5) Utilizing symptoms—e.g., exaggerating, de-emphasizing or relabeling symptoms; moving to new symptoms
 - (6) Supporting, educating, and guiding (Minuchin and Nichols, 1993; Helm, 1991)
- Strategic Family Therapy (Madanes and Haley)

Strategic Family Therapy, also known as Problem Solving Therapy, is brief therapy that focuses on solving the presenting problem(s) (Haley, 1987; Madanes, 1981). Concepts include:

 1. Symptom—a behavior that analogically or metaphorically expresses a family problem
 2. Problem—part of a sequence of acts between people; the way one person communicates with another
 3. Focus of therapy—changing analogies and metaphors
 4. Goal—preventing repetition of problem sequences; introducing more complexity and alternatives
 5. Hierarchy—parents are considered responsible for and in charge of children.
 6. Interventions:
 - a. Decide which family members are involved.
 - b. Design and implement a strategy to shift the family organization so the present problems are not necessary.
 - c. Directives—the therapist tells the family members to do something. Directives may be:

- (1) Straightforward—e.g., the mother is directed to assume a parental role.
- (2) Paradoxical, e.g.—a spouse is directed to encourage the other spouse to have the “symptom” more frequently.
- d. Changes are planned in stages so that changes in one situation or relationship will lead to changes in another. The therapist may even create another problem and shift to another abnormal hierarchy before shifting to a normal hierarchy.
- e. If the strategy does not work within a few weeks, the therapist plans and implements another strategy (Madanes, 1981; Haley, 1987).

■ NEUROBIOLOGICAL THEORIES

The 1990s were termed “The Decade of the Brain” by the National Institutes of Mental Health in order to promote the development of theoretical and practical interventions. Neurobiological theories are based on the following general statements:

1. Cognitive and emotional dysfunctions result from multiple causes, such as genetic influences, nutrition, infectious processes, and other pathological conditions that contribute to neurotransmitter imbalances in the brain (Sanford, 1995).
2. Neurotransmitters are chemical substances, found at the synapses between neurons in the central nervous system that influence cognitive, emotional, and behavioral functioning by carrying messages from the axon of one neuron to the receptor sites on the postsynaptic neuron (See **Table 3-2**).
3. At the end of the process, neurotransmitters are either inactivated by enzymatic degradation or taken back into the presynaptic neuron (reuptake).
4. There are thought to be more than a 100 different transmitters and many neurons that release more than 1 neurotransmitter (Harris & McMahan, 1997, p. 224).
5. “Psychotherapeutic drugs are prescribed to manipulate the processes of neurotransmitter production and absorption to reestablish ‘normal’ neurochemical balance.” (Sanford, 1995, p. 31)
6. Neuroendocrinology—brain biochemicals, by way of the hypothalamus, stimulate the pituitary gland, which affects the endocrine glands along three brain endocrine axes (cascades) (Harris & McMahan, 1997) (See **Table 3-3**).

■ **Table 3-2** Selected Neurotransmitters & Effects on Mental Health

Neurotransmitter	Related State	Effect of Psychotropic
Acetylcholine—Involved in attention, memory, thirst, mood regulation, REM sleep, muscle tone, & sexual behavior	Decreased activity implicated in Alzheimer's disease	Cholinesterase inhibitors increase levels of acetylcholine Antipsychotic action can create imbalance between acetylcholine & dopamine leading to EPS
Dopamine—Involved in fine motor actions, thinking, decision making and integrated cognition, & pleasure/reward seeking behavior	Increased activity implicated in schizophrenia and mania	Antipsychotic medications block dopamine receptors & reduce dopamine activity
Norepinephrine (NE)—Involved in alertness, focused attention, orientation, learning, memory—derivative (epinephrine) controls “fight or flight” response	Decreased activity implicated in depression Depleted in dementia of the Alzheimer's type (DAT) and Korsakoff's syndrome Transmission & uptake impaired in anxiety/addiction	Some antidepressants block reuptake of NE and others inhibit MAO from metabolizing NE
Serotonin (5-HT)—involved in mood states; libido; regulation of temperature, aggression and sleep; perception of pain	Decreased activity implicated in depression and obsessive-compulsive disorder (OCD) Dysregulation implicated in anxiety, violence and schizoaffective disorder and personality disorders	SSRIs & some TCAs increase functional activity by blocking serotonin reuptake
Gamma-aminobutyric acid (GABA)—involved in modulation of aggression, anxiety, arousal, and excitation	Decreased levels implicated in anxiety disorders	Anxiolytics (benzodiazepines) aim to increase GABA function
Glutamate (amino acids)—involved in cognition/memory; sustained autonomic functions	Excitotoxicity—neurotoxic at high levels Decreased levels can lead to psychosis	PCP & ketamine (NMDA antagonists) trigger psychosis

(Hams & McMahon, 1997; Harris & McMahon, 1997; Sadock & Sadock, 2007; Sanford, 1995; Videbeck, 2006)

■ **Table 3-3** Neuroendocrinology—Endocrine Cascades

Axis	Response
Hypothalamic-pituitary thyroid axis (HPTA)	Blunted TSH response to thyrotropin releasing hormone (TRH) in depression
Hypothalamic-pituitary adrenal axis (HPA)	Hyperactive in depression and some anxiety Nonsuppression of cortisol by dexamethasone suppression test in depression Elevated cortisol levels in depression Elevated corticotropin-releasing hormone (CRH) levels in depression
Hypothalamic-pituitary gonadal axis (HPGA)	Blunted prolactin response in exogenous obesity Reduces testosterone levels in depression

(Harris & McMahon, 1997)

■ MISCELLANEOUS THEORIES

- Solution Focused Therapy (de Shazer & O'Hanlon, 1985)
 1. Theory assumes that complaints are maintained by client belief that their response to the original difficulty was the only right thing to do (de Shazer, 1985).
 2. Therapist reframes the beliefs and puts them in a different perspective that allows symptoms to be transformed into part of a mutually developed solution.
 3. Focus is on the present and future rather than the past.
 - a. Only information about past success is sought.
 - b. Emphasizes strengths of client; "Tell me how you dealt with a similar situation in the past" (Cline & Davidson, 1997).
 4. Emphasis is on outcomes with expectations of rapid change:
 - a. "When you are not feeling depressed what will you be feeling instead?" (Cline & Davidson, 1997)
 - b. "How will you know when the problem is solved?"
 5. Therapist helps clients reformulate goals to a reachable level, i.e. "having a more calm approach" instead of "stop yelling" (de Shazer, 1985).
 6. Therapist compliments clients on what they are doing right.
 7. Therapist uses exceptions: "What do you do when you overcome the urge to yell?" (de Shazer, 1985).
 8. Solution is formulated around reframed belief and way clients describe life after "problem" no longer occurs:
 - a. Have client leave with beginning step toward solution.
 - b. Goals or tasks may be assigned: "Between now and the next time we meet I would like you to notice what happens in your relationship that you would like to continue to have happen." (de Shazer, 1997).
 9. Evaluation occurs at next session.
 - a. If "problem" is better, therapist warns of relapse: "These things rarely resolve without some recurrences. You will probably have a big fight in the next few weeks."
 - b. If problem is the same: "You must be doing something right or it would be worse."
 - c. If worse: "May have to go from bad to worse before it gets better." "Is this the bottom or do things need to go from worse to worst before getting better?" (de Shazer, 1985).
- 10. Average number of sessions is usually five or six, with clients choosing time between sessions to allow for a comfortable rate of change as determined by the client.
- Crisis Intervention (Donna Aguilera)
 1. Types of crises:
 - a. Situational—external events that cause unusual stresses, e.g., hospitalization or divorce
 - b. Maturation—normal processes of growth and development in which there is difficulty with maturation, e.g., adolescence and adulthood
 - c. Adventitious—accidental, uncommon, and unexpected events, e.g., fire, earthquake, or flood (Aguilera, 1990)
 2. Phases of crisis intervention:
 - a. Assessment—assessing the precipitating event and the client's perceptions of the event
 - b. Planning of the intervention—evaluating strengths, coping skills, support systems, and alternative methods of coping
 - c. Intervention—treatment lasting 1 to 6 weeks, with the goal of returning the individual to his/her previous level of functioning by:
 - (1) Helping the person gain an intellectual understanding of the crisis.
 - (2) Helping the person express feelings.
 - (3) Exploring coping mechanisms.
 - (4) Reopening the social world.
 - d. Resolution and anticipatory planning—reinforcing adaptive mechanisms, summarizing the process of intervention, and planning for future coping (Aguilera, 1990)
- Theory of Self-Concept (John Hattie)
The attributes of self-concept include:
 1. A cognitive appraisal consisting of beliefs about self
 2. Three aspects:
 - a. Expectations from self and others—high expectations in a dimension or a task can lead to low self-concept and vice-versa. For example, if an average high school athlete expects to become a professional basketball star, his or her high expectation may lead to low self-concept.
 - b. Descriptions of oneself that are:
 - (1) Hierarchical—from a description of a simple, isolated characteristic to a general, all-inclusive description of self
 - (2) Multi-faceted—having numerous dimensions

- c. Prescriptions—standards of correctness
 - 3. Integration across various dimensions by means of:
 - a. Self-verification—soliciting feedback to confirm the view of self
 - b. Self-consistency—internal harmony among opinions, attitudes, and values
 - c. Self-complexity—viewing self as complex and multi-faceted
 - d. Self-enhancement—viewing self’s positive qualities as more important than self’s negative qualities
 - 4. Subjecting self-concept to confirmation from self and others
 - 5. That self-concept is implicit and culturally bound (Hattie, 1991).
- Theory of Self-Disclosure (Richard L. Archer)
Summarizing the research on and definitions of self-disclosure, Archer (1987) focused on its orientations and functions as follows:
 1. Self-orientation—disclosures are concerned with exploring the nature and contents of oneself, for oneself.
 2. Self-to-other orientation—disclosures are concerned with locating oneself in relation to others by getting feedback.
 3. Other-to-self orientation—disclosures are used as a means of social control or of obtaining benefits from others.
 4. Other orientation—disclosure is geared toward obtaining reciprocal disclosure.
 5. Self-and-other orientation—disclosure is concerned with interdependence of participants in a relationship (Archer, 1987).
 - Stress Theory (Hans Selye)
Selye developed a theory of the physical response to stress called the General Adaptation Syndrome (GAS). The stages of the GAS are as follows:
 1. Alarm stage—a threat is perceived, and the endocrine system and the immune system respond, creating physical and mental alertness.
 2. Resistance stage—the threat continues, and attempts are made to adapt.
 3. Exhaustion stage—if the threat continues beyond a certain point, the adaptive hormones are depleted and the body succumbs to illness (Selye, 1976; Wilson & Kneisl, 1992).
 - Coping (Monat & Lazarus, 1991)
According to Monat and Lazarus (1991) Coping “refers to a person’s efforts to master demands (conditions of harm, threat, or challenge) that are appraised (or perceived) as exceeding or taxing a person’s resources.”
 1. Problem-Focused Coping
 - a. Defining the problem
 - b. Generating alternative solutions
 - c. Weighing alternatives re cost and benefits
 - d. Choosing alternatives
 - e. Implementation
 2. Emotion-Focused Coping
 - a. Cognitive reappraisal to alter the meaning of situation without changing objective facts
 - b. Behavioral strategies such as physical exercise, meditation, or talking to friends
 3. Defense mechanisms (See Chapter 2) can be viewed as unconscious coping methods.
 - Role Theory (Hardy & Conway)
Role Theory “represents a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behavior can be expected” (Hardy & Conway, 1988, p. 63). Concepts include:
 1. Approach to studying roles:
 - a. Structural approach—roles are fixed positions with certain expectations and demands, enforced by societal sanctions.
 - b. Symbolic Interactionist approach—behavior is a response to the symbolic acts (primarily gestures and speech) of others.
 2. Role making—a process of modifying a role; phases of role making include:
 - a. Initiator behavior
 - b. Other response
 - c. Interpretation
 - d. Altered response
 - e. Role validation
 3. Role taking—the process of imagining oneself in the place of another
 4. Socialization—the process of learning the social roles, skills, and knowledge that prepare one for role performance
 5. Role stress—a condition in which role obligations are unclear, conflicting or impossible to meet
 6. Role strain—a subjective state of frustration or distress in meeting role expectations
 7. Stratification—a hierarchical ranking of people according to wealth, status, power, or occupation (Hardy & Conway, 1988)

■ QUESTIONS

Select the best answer

1. The purpose of a theory is to:
 - a. Describe, explain, predict or control a phenomenon

- b. Encourage the development of more research
 - c. Prove that there can be one way to describe a phenomenon
 - d. Prove that a phenomenon exists
2. Characteristics of theories include:
- a. They provide laws by which to govern practice.
 - b. They have little in common with practice.
 - c. They can guide and improve practice.
 - d. They need not be logical.
3. Inductive theory construction:
- a. Consists largely of concepts borrowed from other disciplines
 - b. Validates deductive theory construction
 - c. Proceeds from the general to the specific
 - d. Proceeds from the specific to the general
4. Which of the following do theories *NOT* do?
- a. Guide practice
 - b. Guide research
 - c. Provide a common language for practitioners and researchers
 - d. Limit autonomy of practice
5. The concepts central to nursing theoretical models are:
- a. Self-care, self-care deficit, and nursing systems
 - b. Caring and curing
 - c. Assessment, diagnosis, intervention, and evaluation
 - d. Person, environment, health, and nursing
6. Dorothea Orem's theory of nursing is also called the theory of:
- a. Behavioral Systems
 - b. Self-care
 - c. The environment
 - d. Adaptation
7. In Orem's theory, Nursing Systems are described as:
- a. Descriptions of a variety of ideal hospital staffing models
 - b. The theories that she drew from
 - c. Simple, complex, and combined
 - d. Wholly compensatory, partly compensatory, and supportive-educative
8. Nurse A, who utilizes Orem's theory, is caring for Patient B. Patient B requires a complete bed bath. When charting, Nurse A will describe Patient B's inability to provide complete self-care as:
- a. A health deviation
 - b. Illness
 - c. A self-care deficit
 - d. A diagnostic indication
9. Imogene King's theory of nursing is:
- a. A theory of personal systems
 - b. A theory of goal attainment
 - c. A theory of adaptation
 - d. A behavioral systems theory
10. In King's theory, a set of behaviors expected of a person occupying a certain position is called a:
- a. Role
 - b. Perception
 - c. Transaction
 - d. Developmental position
11. One of the basic assumptions in the theory of Martha Rogers is that:
- a. People come together to help and be helped to maintain health.
 - b. The universe is a continuously expanding, evolving, growing field of energy.
 - c. The person and environment are continually exchanging matter and energy with each other.
 - d. Energy fields are four dimensional, unidirectional, expanding sources of knowledge.
12. According to Rogers, which of the following does *NOT* describe the human being?
- a. Characterized by the capacity for abstraction and imagery
 - b. Characterized by the capacity for reversibility and multidirectionality
 - c. Characterized by the capacity for language and thought
 - d. Characterized by the capacity for sensation and emotion
13. The building blocks of Rogers' theory are:
- a. Energy, openness, pattern and four-dimensionality
 - b. Person, life process, pattern and organization, energy
 - c. Person, environment, health, nursing
 - d. Openness, environment, pattern and energy
14. Sister Callista Roy's theory of nursing is:
- a. The Interpersonal Relations Model
 - b. The Problem Solving Model
 - c. The Communication Model
 - d. The Adaptation Model

15. Roy's adaptive modes are:
 - a. Physiological function, self-concept, role function, and interdependence
 - b. Regulator, cognator, external, and informational
 - c. Value, belief, thought, and emotion
 - d. Adaptive response, ineffective response, output
16. The nurse who utilizes Roy's model in providing nursing care would first:
 - a. Identify focal stimuli
 - b. Manipulate focal stimuli
 - c. Identify input and internal processes
 - d. Conduct a first-level assessment
17. The nurse who utilizes Roy's model in providing nursing care will include in the second-level assessment:
 - a. Identification of ineffective responses
 - b. Identification of nursing diagnosis
 - c. Identification of goals
 - d. Patterns of physical functioning
18. The main concept in Leininger's Theory of Culture Care Diversity and Universality is that:
 - a. Culture is the learned, shared, and transmitted values, beliefs, norms, and lifeways of a group.
 - b. Care is the essence of nursing.
 - c. There is diversity and universality in every culture.
 - d. Nurses should seek to know the universality of Transcultural nursing.
19. According to Leininger, the important factors to study in cultural care include:
 - a. Religious factors
 - b. Nutritional factors
 - c. Rest patterns
 - d. Prenatal care
20. Cultural care accommodation refers to:
 - a. Actions and decisions to help people of a given culture negotiate for a beneficial outcome with health caregivers
 - b. Actions and decisions to help a client modify their lifeways for beneficial health care, while respecting their cultural values and beliefs
 - c. Actions and decisions that help people retain relevant cultural care values
 - d. Actions and decisions that are based on universal cultural care
21. The two most famous psychoanalytic theorists are:
 - a. Homey and Adler
 - b. Freud and Jung
 - c. Kohlberg and Gilligan
 - d. Adler and Sullivan
22. According to Freudian theory, unconscious actions or thoughts to protect the ego from anxiety are called:
 - a. Freudian slips
 - b. Unconscious motivation
 - c. Defense mechanisms
 - d. Transference
23. According to Freudian theory, thoughts, feelings, and desires that are not in immediate awareness, but can be recalled to consciousness, are considered:
 - a. Conscious
 - b. Preconscious
 - c. Subconscious
 - d. Unconscious
24. According to Freudian theory, the personality has three main components. The component characterized by the desire for immediate and complete satisfaction is the:
 - a. Reality principle
 - b. Id
 - c. Ego
 - d. Superego
25. Freud suggests that children of 4 or 5 fall in love with the parent of the opposite sex. This is known as:
 - a. Projection
 - b. Transference
 - c. The pleasure principle
 - d. The Oedipus complex
26. According to Freud, whatever inhibits a person from producing material from the unconscious is considered:
 - a. Resistance
 - b. Transference
 - c. Countertransference
 - d. Fixation
27. In Jungian theory, the unconscious collective intangible idea, image, or concept is the:
 - a. Persona
 - b. Shadow
 - c. Archetype
 - d. Rebirth

28. Jung's archetypes do NOT include:
- The animus
 - The shadow
 - Stock characters
 - The id
29. The functional types described by Jung include:
- Extrovert and introvert
 - The hero, the trickster, and the sage
 - Thinking, feeling, sensing, intuiting
 - Animus and anima
30. Adler developed the Theory of Individual Psychology. The main concern of Adler's theory is:
- The individual going through the stages of development
 - Personal growth through compensating for inferiority
 - Providing client-centered therapy
 - The effect of relationships on unconscious behaviors
31. Adler identified effects of the birth order of siblings. According to his theory, the child most likely to be interested in authority and organization is:
- The first-born
 - The second-born
 - The middle child in a large family
 - The youngest child
32. The key concept in the personality theory of Horney is:
- Neurosis
 - Hostility
 - Basic anxiety
 - Satisfaction of needs
33. According to Horney, which of the following is NOT a way by which people protect themselves?
- Moving toward other people
 - Moving against other people
 - Moving away from other people
 - Moving in accord with other people
34. Erikson identified eight stages of growth and development. The stage characterized by a focus on genital needs and the acquisition of a purpose is:
- Trust vs mistrust
 - Autonomy vs shame
 - Initiative vs guilt
 - Industry vs inferiority
35. If a child's activities are primarily social interaction, doing homework and practicing basketball, then according to Erikson, he is in the following stage of development:
- Trust vs mistrust
 - Autonomy vs shame
 - Initiative vs guilt
 - Industry vs inferiority
36. According to Erikson, the stage of development characterized by the acquisition of wisdom is:
- Identity vs identity diffusion
 - Intimacy vs isolation
 - Generativity vs stagnation
 - Integrity vs despair
37. Jean Piaget developed a theory of:
- Psychosexual development
 - Cognitive development
 - Moral development
 - Social development
38. In the developmental theory of Piaget, the period characterized by egocentric thinking, expressed in artificialism, realism, and magical thinking is the:
- Sensory motor period
 - Pre-operational period
 - Concrete operations period
 - Formal operations period
39. In the developmental theory of Piaget, the period characterized by the development of logic and reasoning, and second-order thoughts, that is, "thinking about thoughts," is the:
- Sensory motor period
 - Preoperational period
 - Concrete operations period
 - Formal operations period
40. The nurse is working with Mrs. L., who has been sexually promiscuous and manipulative with her family. While developing a treatment plan for Mrs. L., the nurse recognizes that her behavior is consistent with the behavior in Stage 2 of Kohlberg's theory of moral development. Mrs. L. will be motivated by:
- Avoidance of punishment
 - Desire for reward or benefit
 - Anticipation of disapproval of others
 - Anticipation of dishonor
41. If Mrs. L.'s behavior was consistent with the behavior of Stage 4 of Kohlberg's theory of moral development, she would be motivated by:

- a. Anticipation of disapproval of others
 - b. Anticipation of dishonor
 - c. A legalistic orientation
 - d. Belief in universal ethical principles
42. In Kohlberg's theory of moral development, behavior in Stage 6 is motivated by:
- a. Anticipation of disapproval of others
 - b. Anticipation of dishonor
 - c. A legalistic orientation
 - d. Belief in universal ethical principles
43. According to the work of Gilligan on moral development:
- a. In applying Kohlberg's theory, women are generally more moral than men.
 - b. Most women achieve the moral reasoning in Stage 6 of Kohlberg's theory.
 - c. Women and men have the same moral reasoning.
 - d. The moral development of women is based on different motivations than that of men.
44. The main focus of social-interpersonal theories of personality is:
- a. Neurosis
 - b. Anxiety about relationships
 - c. The effects of interactions with others
 - d. Inferiority and superiority feelings
45. In the interpersonal theory of Harry Stack Sullivan, the "self-system" is:
- a. The part of the personality that satisfies the drive for security
 - b. A construct to describe the narcissism inherent in all interpersonal relationships
 - c. A construct built from the child's experience, made up of reflected appraisals by significant others
 - d. The part of the personality that satisfies the drive for satisfaction
46. According to Sullivan, the basic drives that underlie human behavior are:
- a. The drive to reduce anxiety and the drive to avoid fear
 - b. The drive for satisfaction and the drive for security
 - c. The drive to fulfill basic physical needs and the drive to fulfill sexual needs
 - d. The drive for love and work
47. The existential theories of personality focus on:
- a. The meaning of life for the individual
 - b. Present experience, with little attention to the past
 - c. One's philosophy of life
 - d. Conforming to societal demands
48. According to Carl Rogers, the important attributes of the therapist are:
- a. Congruence, unconditional positive regard, and empathetic understanding
 - b. Knowledge of Rogers' theory, patience, and ability to interpret dreams
 - c. Knowledge of Rogers' theory, congruence, and interest in human development
 - d. Willingness to drop facades, openness to individual meanings, and compassion
49. According to Monat and Lazarus which of the following would be considered as part of emotion-focused coping?
- a. Defining the problem
 - b. Physical exercise
 - c. Generating alternative solutions
 - d. Weighing alternatives re cost and benefits
50. The therapist utilizing Gestalt therapy recognizes that introjection is:
- a. A fantasy about what another person is experiencing
 - b. Accepting the beliefs and opinions of others without question
 - c. Turning back on oneself that which is meant for someone else
 - d. Merging with the environment
51. The main goal of Gestalt therapy is:
- a. Dropping facades
 - b. Differentiating between self and others
 - c. Integration of self and world awareness
 - d. Resolving conflicts from the past
52. Techniques in Gestalt therapy do NOT include:
- a. Playing the projection
 - b. Making the rounds
 - c. Exaggeration of a feeling or action
 - d. Paradoxical prescription
53. Maslow's hierarchy of basic needs includes:
- a. Safety and satisfaction, health and growth
 - b. Physiological needs, safety, love and belongingness, self-esteem, and self-actualization
 - c. Physical, biological, psychological, sociological, and spiritual needs
 - d. Food, fluid, activity, meaning and purpose, and self-actualization
54. The A-B-Cs of Ellis's Rational Emotive Therapy are:

- a. Action, behavior, congruence
 b. Anticipation, belief, consequence
 c. Acceptance, behavior, caring
 d. Activating behavior, belief, consequence
55. According to Ellis's Rational Emotive Therapy, a basic form of irrational beliefs is that:
- a. One cannot meet one's goals.
 b. Life is difficult.
 c. Something is awful, terrible, or horrible.
 d. Behavior has meaning.
56. For the nurse who uses Rational Emotive Therapy in practice, the focus of treatment is on:
- a. Behavior rather than beliefs
 b. Accepting the beliefs of others
 c. Disputing, debating, discriminating, and defining
 d. Anticipating, acting, and accepting
57. Behavioral theories of personality are concerned with:
- a. Unconscious phenomena
 b. Cognition
 c. Emotions
 d. Reinforcement
58. One concept of Skinner's theory is that an individual performs a behavior that leads to a positive or negative reinforcement, making it either more or less likely that the behavior will be repeated. This is called:
- a. A schedule of reinforcement
 b. A fixed ratio
 c. A variable interval
 d. Operant conditioning
59. In a variable ratio schedule of reinforcement, behaviors are rewarded:
- a. Each time they are performed
 b. Every time they are repeated
 c. At specific times of performance
 d. At random times of performance
60. Mrs. J. seeks treatment for her fear of automobiles. After the initial assessment, the nurse decides to use systematic desensitization. The first step in systematic desensitization is to:
- a. Help Mrs. J. get a prescription for valium and take her for an automobile ride
 b. Explore other means of transportation
 c. Train Mrs. J. in deep muscle relaxation
 d. Show Mrs. J. a picture of an automobile and ask how she feels
61. The two types of systematic desensitization are:
- a. Automatic desensitization and standard desensitization
 b. Fantasy desensitization and in vivo desensitization
 c. Desensitization with medication and desensitization without medication
 d. Reciprocal inhibition and aversive conditioning
62. According to the Reality Therapy of William Glasser, each person has the following two basic needs:
- a. Psychological needs and spiritual needs
 b. Physiological needs and psychological needs
 c. The need to love and be loved, and the need to be productive
 d. The need to love and be loved, and the need to feel worthwhile
63. According to Glasser, the cause of all psychiatric problems is:
- a. Neurosis
 b. Irresponsibility
 c. Childhood training
 d. Irrational beliefs
64. The therapist who is utilizing Glasser's therapy will emphasize:
- a. Unconscious motivation
 b. Dream interpretation
 c. Changing behavior
 d. Re-experiencing traumatic childhood events
65. Aaron Beck developed a theory of cognitive therapy after he discovered that his clients had "automatic thoughts." The automatic thoughts:
- a. Came from too much free association
 b. Labeled, interpreted, and evaluated situations according to a personal set of rules
 c. Indicated to the client that he should not trust the therapist
 d. Warned clients of any physiological needs
66. The therapist who utilizes Beck's therapy will warn the client:
- a. To try to ignore or suppress his automatic thoughts
 b. That emotionally healthy individuals do not have automatic thoughts
 c. That automatic thoughts are deeply imbedded and cannot be changed
 d. That a perception of reality is not necessarily reality

67. The therapist utilizing Beck's therapy will help the client to:
- Recognize and change his/her automatic thoughts
 - See reality as the therapist sees it
 - Change his/her reality by changing his/her environment
 - Recognize and accept that automatic thoughts suggest delusional thinking
68. In the Social Learning Theory of Alfred Bandura, the key concept is:
- Modeling
 - Encoding a behavior
 - Rewarding behavior appropriately
 - Rewarding behavior on a ratio interval scale
69. In the Neurolinguistic Programming (NLP) of Bandler and Grinder, the "representational systems" are:
- Auditory, visual, and kinesthetic
 - Methods of analyzing communication
 - Right brain and left brain
 - Parent, adult, and child
70. An assumption behind NLP is that:
- We all have irrational beliefs.
 - We all create models of the world, and use language to represent them.
 - We are all philosophers.
 - Verbal and nonverbal communication is important in nursing.
71. In NLP, the sentences that native speakers of a language speak and write are called:
- Deep structure
 - Surface structure
 - Multimodel sentences
 - Cues to beliefs
72. In NLP, human modeling does NOT involve:
- Generalization
 - Deletion
 - Distortion
 - Disintegration
73. In Transactional Analysis (TA), the theory by Eric Berne, ego states include:
- Sane, neurotic, and psychotic
 - Rational and irrational
 - Parent, adult, and child
 - Manic, depressive, and schizophrenic
74. In TA, when a message is sent from an ego state of Person A and is responded to in that ego state, there is a:
- Crossed transaction
 - Ulterior transaction
 - Complementary transaction
 - Confused transaction
75. In TA, a message that occurs on two levels is:
- A crossed transaction
 - An ulterior transaction
 - A complementary transaction
 - A game
76. Concepts in Systems Theory include:
- Systems are designed to serve people.
 - Systems are by nature complex.
 - All systems are hierarchically arrayed.
 - All systems have five functions.
77. According to Systems Theory, the functions of a system include:
- Cooperation
 - Conflict
 - Adaptation
 - Accommodation
78. The originator of Psychodrama was:
- Moreno
 - Minuchin
 - Beck
 - Adler
79. In Psychodrama, the therapist functions as a:
- Protagonist
 - Auxiliary ego
 - Director
 - Partner
80. The nurse utilizing Bowen's theory in family therapy will observe the patterns of emotional interaction within a family. Bowen calls these patterns:
- Triangles
 - The family projection process
 - The nuclear family emotional system
 - The family differentiation process
81. In Bowen's Family Systems Therapy, the multi-generational family transmission process refers to:
- Genetic traits
 - Relationship patterns and anxiety about specific issues that have been transmitted through the generations
 - Relationships between grandparents and grandchildren
 - Hereditary disorders

82. The nurse practicing Bowen's Family Systems Therapy will guide family members to:
- Use their sibling position to their advantage
 - Periodically cut off other family members emotionally
 - Create specific triangles
 - Increase differentiation of self
83. When the nurse using Minuchin's Structural Family Therapy observes that a mother holds a 7-year-old child in her lap, answers questions for the child, and describes protecting the child from siblings and neighbors, the nurse will suspect:
- Accommodation
 - Enmeshment
 - Disengagement
 - An unusual transaction
84. In Minuchin's Structural Family Therapy, the main tasks of the therapist are:
- Joining and restructuring
 - Clarifying the family structure and explaining it
 - Identifying family communication patterns and maintaining family strengths
 - Enacting the family structure and delineating boundaries
85. A therapist who utilizes Minuchin's Structural Family Therapy will probably:
- Point out family strengths
 - Identify multigenerational transactions
 - Maintain his/her position of authority
 - Decrease stress
86. In the Structural Family Therapy of Minuchin, when the therapist blocks the usual transactional patterns or emphasizes differences among family members, he is probably trying to:
- Accommodate the family
 - Identify the true patient
 - Escalate stress
 - Identify the executive subsystem
87. A therapist who utilizes the Structural Family Therapy of Minuchin would NOT utilize symptoms by:
- Moving to new symptoms
 - De-emphasizing symptoms
 - Exaggerating symptoms
 - Rewarding symptoms
88. The focus of Strategic Family Therapy is to:
- Emphasize symptoms
 - Change analogies and metaphors in the family
 - Help the family to be more democratic
 - Identify and solve all family problems
89. After identifying the symptom and the problem, the nurse who is practicing Strategic Family Therapy will:
- Identify the family structure
 - Work to detriangle all family members
 - Design a strategy to shift the family organization
 - Mark subsystem boundaries
90. In a depressed client, which of the following neurobiological explanations can the nurse expect?
- Overactivity of serotonin (5-HT)
 - Underactivity of norepinephrine/epinephrine
 - Overactivity of dopamine
 - Underactivity of acetylcholine
91. A client seeks treatment from a Solution-Focused therapist for somatic complaints. What would the therapist's question to her most likely be?
- Can you tell me what happened in your childhood?
 - Tell me about the surgeries you have had?
 - When you aren't in terrible pain, or visiting your doctor, what will you be doing instead?
 - What was going on in your life when the pain started?
92. According to the Crisis Intervention Theory of Aquilera, types of crises are:
- Familial, academic, and social
 - Major disasters and daily events
 - Situational, maturational, and adventitious
 - Growth inducing and growth hindering
93. Crisis Intervention Therapy usually lasts:
- From 1 to 6 weeks
 - From 1 to 6 months
 - From 3 months to 1 year
 - More than 1 year
94. The main goal of Crisis Intervention is to:
- Assist the client in identifying his strengths
 - Assist the client to gain insight as to why he reacted as he did
 - Help the client to return to his previous level of functioning
 - Help the client to prevent another crisis
95. According to the Self-Concept Theory of Hattie, the first attribute of self-concept is:

- a. A cognitive appraisal of oneself
 b. A feeling of wholeness
 c. Determined completely by one's environment
 d. Undefined
96. In the Self-Concept Theory of Hattie, internal harmony among opinions, values, and attitudes is called:
- a. Self-complexity
 b. Self-verification
 c. Self-consistency
 d. Self-regulation
97. Self-concept is:
- a. Subject to confirmation from others
 b. Culturally bound
 c. Multifaceted
 d. Fixed at birth
98. Purposes of self-disclosure include:
- a. Exploring oneself
 b. Locating oneself in relation to others
 c. Social control
 d. Cutting off feedback
99. The General Adaptation Syndrome, as identified by Hans Selye, has the following stages:
- a. Surprise, alertness, reaction
 b. Inflexibility, adaptation, engulfment
 c. Alarm, resistance, exhaustion
 d. Openness, closedness, paranoia
100. In the structural approach to Role Theory, roles are considered:
- a. Subject to change depending on immediate circumstances
 b. Fixed positions with certain expectations and demands
 c. Responses to a number of things in the environment
 d. Synonymous with job descriptions
101. Role taking refers to:
- a. Socialization into a role
 b. The process of moving into a role that was previously held by another person
 c. The process of imagining oneself in the place of another
 d. Being taken by surprise by the expectations of a certain role
102. The defense mechanism considered to be the basis for all defense mechanisms is:
- a. Suppression
 b. Repression
 c. Denial
 d. Projection

ANSWERS

- | | | | |
|-----|----------|------|----------|
| 1. | a | 52. | d |
| 2. | c | 53. | b |
| 3. | d | 54. | d |
| 4. | d | 55. | c |
| 5. | d | 56. | c |
| 6. | b | 57. | d |
| 7. | d | 58. | d |
| 8. | c | 59. | d |
| 9. | b | 60. | c |
| 10. | a | 61. | b |
| 11. | c | 62. | d |
| 12. | b | 63. | b |
| 13. | a | 64. | c |
| 14. | d | 65. | b |
| 15. | a | 66. | d |
| 16. | d | 67. | a |
| 17. | a | 68. | a |
| 18. | b | 69. | a |
| 19. | a | 70. | b |
| 20. | a | 71. | b |
| 21. | b | 72. | d |
| 22. | c | 73. | c |
| 23. | b | 74. | c |
| 24. | b | 75. | b |
| 25. | d | 76. | c |
| 26. | a | 77. | c |
| 27. | c | 78. | a |
| 28. | d | 79. | c |
| 29. | c | 80. | c |
| 30. | b | 81. | b |
| 31. | a | 82. | d |
| 32. | c | 83. | b |
| 33. | d | 84. | a |
| 34. | c | 85. | a |
| 35. | d | 86. | c |
| 36. | d | 87. | d |
| 37. | b | 88. | b |
| 38. | b | 89. | c |
| 39. | d | 90. | b |
| 40. | b | 91. | c |
| 41. | b | 92. | c |
| 42. | d | 93. | a |
| 43. | d | 94. | c |
| 44. | c | 95. | a |
| 45. | c | 96. | c |
| 46. | b | 97. | d |
| 47. | b | 98. | d |
| 48. | a | 99. | c |
| 49. | b | 100. | b |
| 50. | b | 101. | c |
| 51. | c | 102. | b |

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Substance-Related Mental Disorders

■ SUBSTANCE-RELATED DISORDERS

- **Definition**—a cluster of mental disorders associated with exposure to or excessive use of psychoactive substances, medications, or toxins. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000), substance-related disorders are divided into two groups: (1) substance use disorders (abuse and dependence) and (2) substance-induced disorders (intoxication, withdrawal, and specific substance-induced (S-I) conditions including S-I delirium, S-I mood disorder, S-I psychotic disorder, etc.).
- **Epidemiology**
Results from the 2006–2007 National Surveys on Drug Use and Health (Hughes, Sathe & Spagnola, 2009) found that 8.1% of the population 12 years or older reported past month illicit drug use. About 23.2% of the population 12 years and older engaged in past month binge drinking (5 or more drinks on one occasion), and 3.4% of the population were estimated to be alcohol dependent. Following alcohol, tobacco is the second most commonly used substance in the United States with 24.6% of the population 12 years and older smoking cigarettes in the past month. Marijuana is the most commonly used illicit drug with 10.2% of persons age 12 and older reporting use in the past year. Illicit drug use other than marijuana (cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives) was 3.8% for persons 12 years and older.
- 1. Males, rather than females, responding to the 2007 National Survey on Drug Use and Health reported higher rates for current use of alcohol (56.6% vs 46.0%), tobacco (35.2% vs 22.4%), and illicit drugs (10.4% vs 5.8%).
- 2. Young adults aged 18 to 25 and youth aged 12 to 17 years were more likely than older persons to engage in binge drinking and illicit drug use, and to consume alcohol concurrently with an illicit drug (Substance Abuse and Mental Health Services Administration, 2008, 2009).
- 3. Co-occurring substance-related and other psychiatric disorders (also known as dual diagnosis) are common.
 - a. Persons diagnosed with anxiety or mood disorders are twice as likely to also abuse one or more substances. This is also true for individuals diagnosed with conduct disorder or antisocial personality disorder.
 - b. Higher rates of alcohol, tobacco, and other drug abuse have been reported in persons with schizophrenia than in the general population.
 - c. Cigarette smoking is higher among persons with comorbid schizophrenia (up to 90%), bipolar disorder (70%), and other psychiatric diagnoses than among those without a comorbid condition (National Institute on Drug Abuse, 2008).
- **Signs and symptoms**
 1. **Dependence**—Criteria established by the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR) for substance dependence

include the occurrence of at least three of the following within the same 12-month period (American Psychiatric Association [APA], 2000):

- a. Use of amounts greater than intended
 - b. Attempts at control
 - c. Excessive time spent in obtaining, using, recovering
 - d. Use despite social obligations or hazards
 - e. Use despite recurrent problems
 - f. Presence of *tolerance*—needing increasing amounts of substance to produce desired effect or markedly diminished effect with continued use of same amount of substance
 - g. Presence of *withdrawal* or use to avoid or relieve withdrawal symptoms—a substance-specific syndrome producing a state of disequilibrium with clinically significant distress or impairment of functioning produced by an abrupt discontinuation, or rapid decrease in dosage, of a substance
 - h. Specifiers including notation of the presence of physiological dependence (evidence of tolerance or withdrawal), or lack thereof
2. **Abuse**—Criteria for substance abuse include:
 - a. Recurrent use resulting in a failure to fulfill major role obligations
 - b. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
 - c. Recurrent use in hazardous situations (driving while under the influence of a substance of abuse)
 - d. Recurrent substance-related legal problems
 - e. Criteria for substance dependence (for the specific substance) have never been met.
 3. Substances with abuse potential include: alcohol, sedatives/hypnotics, amphetamines, cocaine, cannabis, hallucinogens, opioids, phencyclidine, inhalants, caffeine, nicotine, and anabolic steroids.
- Differential diagnosis
 1. DSM-IV-TR (APA, 2000) Disorders with similar symptoms/presentations
 - a. Mood/Depressive Disorders
 - b. Anxiety
 - c. Psychotic Disorders
 - d. Personality Disorders
 - e. Impulse Control Disorders
 - f. Adjustment Disorders
 - g. Sleep Disorders
 - h. Sexual Dysfunction Disorders
 - i. Amnesia, Dementia, and Delirium Disorders
 2. Evidence that symptoms are better accounted for by a disorder that is not substance induced include:
 - a. Symptoms precede onset of the substance abuse/dependence.
 - b. Symptoms persist for a substantial period of time after the cessation of acute withdrawal or severe intoxication.
 - c. Symptoms are substantially in excess of what would be expected given the character, duration, or amount of the substance used.
 - d. Other evidence is presented suggesting the existence of an independent nonsubstance induced disorder (history of recurrent nonsubstance-related episodes).
 - Diagnostic studies/tests (APA, 2006)
 1. Common laboratory values associated with Substance Use Disorders (SUD):
 - a. Liver function tests (LFTs)—liver enzymes increased in alcohol dependence—gamma-glutamyltransferase (GGT), aspartate aminotransferase (AST), and alanine aminotransferase (ALT). Other increased values include mean corpuscular volume (MCV), high density lipoprotein cholesterol and carbohydrate deficient transferrin (CDT).
 - b. Urine drug screening (UDS) detects presence of drug in the urine—diagnostic limitations include:
 - (1) Short “window” of detection of metabolites
 - (2) Intermittent use patterns of abusers
 - (3) Issues of civil liberties
 - c. Blood alcohol level (BAL)—greater than 150 mg/dl = evidence of intoxication; and greater than 300 mg/dl at any time suggests potential for alcohol dependence.
 - d. Breathalyzer—represents blood alcohol concentration (BAC)
 - (1) Legal intoxication level in most states is 0.08%.
 - (2) Levels above 0.1% without associated behavioral symptoms indicate possible tolerance.
 2. Screening instruments (partial list)
 - a. CAGE questionnaire
 - b. Self Administered Alcohol Screening Test (SAAST)
 - c. Drug Abuse Screening Test, short version (DAST-10)
 - d. Addiction Severity Index (ASI)
 - e. National Institute of Drug & Alcohol (NIDA) Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST)—online and print versions available at: <http://www.drugabuse.gov/nidamed/screening>

- Assessment—involves careful interview skills that are goal-directed and focused on the presenting symptoms and problems in major areas of functioning. The interview is adapted to the client's age, culture, and current cognitive ability.
 1. Interview elements
 - a. Drug and/or drink of choice—include amount, frequency of use, duration of use, route of administration, time and amount of last use
 - b. Other substances used
 - c. Past history of and response to withdrawal
 - d. History of delirium tremens, seizures, falls, blackouts or alcoholic amnesia, injury to self or others
 - e. Changes in mood and behavior (anger, apathy, anxiety, depression, labile mood, irritability, low or high energy, impulsivity, isolation, change in peer group, secretive-ness, guardedness, or paranoia)
 - f. Sleep pattern and eating habits
 - g. Problems with interpersonal and social relationships, finances, occupation, school, family, legal system, medical disorders, psychiatric disorders
 - h. Family history of alcohol, drug, and/or psychiatric illness
 - i. Access and availability of substances
 - j. Context of substance use (solitary vs social consumption)
 - k. Previous treatments and longest periods of sobriety
 - l. Presence of defense mechanisms, such as denial, minimization, and rationalization, warrant a collateral interview with family members or significant others
 - m. Assess motivation and stage of/readiness for change (Prochaska, DiClemente & Norcross, 1992):
 - (1) Precontemplation—personal realization and decreased defensiveness and rationalization through social pressure, dramatic experience, media, consequences, and social norms
 - (2) Contemplation—shifting decisional balance, making a commitment to a change attempt, and resolving ambivalence
 - (3) Preparation—commitment, plan, and concrete strategies
 - (4) Action—daily implementation of plan, coping with withdrawal and desire to use, behavioral coping activities
 - (5) Maintenance—lifestyle changes, shifts in social network, behavioral coping activities
 2. Physical and mental status examination—system-by-system assessment for presence and stage of physical withdrawal as well as medical complications
 - a. Vital signs
 - b. Urine/blood drug screens, breathalyzer
 - c. Assessment for trauma—broken bones, bruises, lacerations, edema
 - d. Assessment for dehydration and malnutrition, weight loss
 - e. Assessment for masses and lesions
 - f. Evaluation of respiratory, cardiac, and gastrointestinal status
 - g. Evaluation of neurologic status
 - (1) Orientation to time, place, person, date, day of the week
 - (2) Assessment of cognitive functioning for confusion or delirium, concentration and attention, recent and remote memory, abstract reasoning, problem-solving ability, thought disturbances and sensory perceptual distortions
 - (3) Pupil size
 - (4) Checking reflexes for hyperreflexia
 - (5) Assessment for numbness and tingling in extremities
- Medical complications associated with SUD (substance abuse or dependence)
 1. Hepatic complications—alcoholic fatty liver, alcoholic hepatitis, alcoholic cirrhosis
 2. Gastrointestinal complications—esophagitis, gastritis, pancreatitis associated with alcohol
 3. Cardiovascular complications—cardiomyopathy, hypertension, arrhythmias associated with alcohol and cocaine
 4. Neurologic complications
 - a. Stroke, seizures associated with alcohol and cocaine
 - b. Polyneuropathy, alcoholic dementia, Wernicke-Korsakoff Syndrome (thiamine deficiency) associated with alcohol
 5. Nutritional complications—vitamin and iron deficiency, malnutrition associated with alcohol
 6. Pulmonary damage associated with smoking crack, cannabis, and nicotine
 7. Infectious disease—increased chance of hepatitis, HIV, sexually transmitted diseases, cellulitis, endocarditis associated with high risk addiction behaviors
 - a. Unprotected sexual promiscuity and prostitution
 - b. Intravenous route of administration
 8. Obstetrical complications
 - a. Noncompliance with prenatal care (associated with SUD in pregnancy)
 - b. Premature labor and delivery, spontaneous abortion, abruptio placenta associated with cocaine and crack addiction

- c. Hypertension, spontaneous abortion, abruptio placenta, premature delivery, and postpartum hemorrhage associated with heroin addiction
 - d. Miscarriage and spontaneous abortion associated with alcohol
 - e. Earlier menopause, osteoporosis, reduced fertility, and increased risk of strokes when taking oral contraceptives associated with tobacco addiction; spontaneous abortion, unexplained vaginal bleeding, abruptio placenta and placenta previa associated with tobacco addiction
9. Teratogenic complications
- a. Low birth weight, prematurity, small head circumference, anomalies associated with cocaine, cannabis, nicotine
 - b. Neonatal abstinence syndrome related to withdrawal from narcotics occurs anytime between birth to the sixth day of life
 - (1) Irritability, shrill or persistent cry, inability to self-regulate state, more sensitive to external stimuli, sleep-wake pattern disturbance
 - (2) Disturbed feeding problems, gastrointestinal disturbances such as vomiting and diarrhea, respiratory depression, and hypoxia
 - (3) Frequent yawning, nasal flaring, and sneezing
 - (4) Jitteriness, increased muscle tone, tremors, depressed normal neurologic reflexes, temperature instability, seizures
 - c. Fetal alcohol syndrome (FAS) characterized by:
 - (1) Growth retardation
 - (2) Central nervous system involvement—developmental delay, neurologic or intellectual impairment
 - (3) Facial dysmorphism
- Mental status variations and clinical manifestations—See **Table 4-1** (APA 2006, 2007; Sadock & Sadock, 2007)

■ **Table 4-1** Mental Status Variation & Clinical Manifestations of Substances-Induced Disorders

Substance	Intoxication Effects	Withdrawal (WD) Features	Pharmacologic Treatment
Alcohol	Disinhibition & increased confidence Slurred speech Impaired insight, judgment, & memory Decreased concentration Altered motor skills & sensory perception Mood swings	Onset usually 6 hours after a substantial fall in blood alcohol concentration, peaks at about 24–36 hours and subsides after 48 hours <ul style="list-style-type: none"> • Tremulousness • Malaise • Anorexia, nausea, vomiting • Hyperreflexia • Tachycardia, increased blood pressure • Irritability • Insomnia • Diaphoresis • Perceptual distortions Severe WD—delirium tremens (DT) (5% incidence)—Onset 72–96 hours after cessation of drinking <ul style="list-style-type: none"> • Gross tremors and agitation • Disorientation • Confusion • Hallucinations • Increased psychomotor and autonomic nervous system activity • Seizures 	Withdrawal & Detox—benzodiazepines <ul style="list-style-type: none"> • Chlodiazepoxide (Librium) • Diazepam (Valium) • Lorazepam (Ativan) Haloperidol—for DTs Dependence treatment—(reduce craving &/or promote abstinence) <ul style="list-style-type: none"> • Disulfiram (Antabuse) • Naltexone (ReVia, Vivitrol) • Acamprosate (Campral) • SSRIs

■ **Table 4-1** Mental Status Variation & Clinical Manifestations of Substances-Induced Disorders (*continued*)

Substance	Intoxication Effects	Withdrawal (WD) Features	Pharmacologic Treatment
Amphetamines (stimulants e.g., cocaine, methamphetamine)	Euphoria Grandiosity Psychomotor agitation or retardation Hypervigilance Impaired judgment Alteration in blood pressure Tachycardia/Bradycardia, chest pain, cardiac arrhythmias Visual/tactile hallucinations	Onset variable due to typical binge pattern of abuse but symptoms can occur 9–96 hours after last use <ul style="list-style-type: none"> • Insomnia/Hypersomnia • Increased appetite • Psychomotor agitation or retardation • Fatigue • Depression • Vivid/Unpleasant dreams • Irritability • Anxiety 	Supportive rather than biochemical intervention
Caffeine	Restlessness/ Nervousness/ Excitability Insomnia Muscle twitching Diuresis Rambling thoughts & speech Tachycardia/Cardiac arrhythmia GI disturbance Excessive energy Psychomotor agitation	Onset 12–24 hours after last dose, peak in 24–48 hours <ul style="list-style-type: none"> • Marked anxiety/depression • Marked fatigue/drowsiness • Nausea/Vomiting • Headache • Muscle aches 	Analgesics (aspirin) for relief of head & muscle aches; Rarely—benzodiazepines in small doses for up to 10 days
Cannabis (e.g., marijuana, hashish)	Excitement & dissociation of ideas Distortions of time & space Diminished attention span & memory Deterioration of motor skills Increased appetite Dry mouth Tachycardia	None specific—may experience craving, irritability	Supportive therapies (individual, family, group) rather than biochemical intervention
Hallucinogens (e.g., LSD, MDMA/ Ecstasy)	Anxiety & feeling loss of control Paranoid ideation/ suspiciousness Delusions & hallucinations Confusion & delirium Distortion of time, place, distance Impaired judgment Physical symptoms include: dilated pupils, sweating, tachycardia, palpitations, blurred vision and tremors	None specific—psychological rather than physiological withdrawal	During intoxication—psychological support/ “talking down”

(continues)

■ **Table 4-1** Mental Status Variation & Clinical Manifestations of Substances-Induced Disorders (*continued*)

Substance	Intoxication Effects	Withdrawal (WD) Features	Pharmacologic Treatment
Inhalants • Hydrocarbon solvents (gasoline & glues) • Aerosol propellants • Anesthetics & gases (chloroform, nitrous oxide)	Euphoria Dizziness Blurred vision Loss of inhibition Headache General muscle weakness Depressed reflexes Slurred speech Loss of motor coordination	None specific—May experience GI problems, anorexia, confusion, and headache	Supportive rather than biochemical intervention
Narcotic analgesics (opioids)	Euphoria & sense of well being Analgesia, sedation & somnolence Lethargy & apathy Pupillary constriction Decreased respirations & hypotension	Onset depends on drug's half life and chronicity of use, peak in 36–72 hours • Muscle aches • Lacrimation or rhinorrhea • Dilated pupils • Yawning • Nausea/Vomiting/Diarrhea • Dysphoric mood • Fever • Insomnia	Overdose treatment—Naloxone (Narcan) Withdrawal & Detox— • Methodone • Buprenorphine • Clonidine (Catapres)—off label Abstinence—Naltrexone (ReVia, Vivitrol)
Nicotine	At toxicity levels • Nausea/Vomiting • Salivation • Poor concentration • Weakness • Tachycardia • Tremor • "Cold sweats"	Onset within 2 hours after last use peak in 24–48 hours • Anxiety/Restlessness • Dysphoria or depressed mood • Irritability/Frustration/Anger • Insomnia • Poor concentration • Increased appetite/Weight gain • Bradycardia	Nicotine replacement therapies Nicotine gum, lozenges, patches, and nasal spray • Varenicline (Chantix) • Bupropion (Zyban) • Mecamylamine (Inversine) • Clonidine (Catapres)—off label
Sedative Hypnotics (e.g., benzodiazepines, barbiturates)	Disinhibition & increased confidence Slurred speech Impaired insight, judgement & memory Decreased concentration Altered motor skills & sensory perception Mood swings	Onset with short-acting drugs 12–24 hours, long-acting drugs 5–8 days • Seizures • Insomnia and nightmares • Slurred speech • Nausea or vomiting • Confusion, delirium, memory problems, hallucinations (tactile, visual, auditory) • Restlessness, anxiety, tremors, diaphoresis, hyperpyrexia, muscle spasms • Tachycardia, palpitations	Overdose—gastric lavage, activated charcoal, monitor VS & CNS functions—can be lethal for barbiturates Withdrawal—long-acting benzodiazepines or phenobarbital tapering doses down

- Dual diagnosis (comorbidity)—concomitant existence of a substance use and psychiatric disorder; many co-occurring psychiatric symptoms remit with 2 to 4 weeks of abstinence from substances; the most common co-occurring psychiatric disorders include antisocial personality, affective and anxiety disorders, and schizophrenia
- Nursing diagnosis—several of the 2009-2011 NANDA International (2009) nursing diagnoses can be applied to substance-related disorders, including:
 1. Behavior, risk-prone health
 2. Coping, defensive
 3. Coping, ineffective
 4. Denial, ineffective
 5. Powerlessness
 6. Self-Esteem, chronic low
 7. Self-Esteem, situational low
 8. Self-Esteem, risk for situational low
 9. Neglect, self
 10. Violence, risk for self-directed
 11. Family Processes, dysfunctional
 12. Health Behavior, risk-prone
 13. Health Management, ineffective self
 14. Knowledge, deficient (specify)
- Genetic/biologic origins
Strong evidence exists as to the genetics of alcohol abuse. Gene variants on chromosomes 5 and 8 have been identified as contributing to addictive behavior.
 1. Children of alcoholics are three to four times more likely to experience alcohol and/or drug problems; family history—positive individuals have less sensitivity to effects of alcohol (high tolerance).
 2. Certain individuals, particularly those with Asian heritage, have a genetic inactivity of enzyme, aldehyde dehydrogenase, which results in a build up of toxic alcohol metabolite, acetaldehyde, causing symptoms of flushing, headaches, tachycardia, and discomfort.
 3. Chemical imbalance in neurotransmitter levels leads to self-medication with substances of abuse in an attempt to correct imbalance; pharmacotherapy interventions act on depleted neurotransmitter levels.
- Biochemical interventions—act on depleted neurotransmitter systems (serotonin, dopamine, GABA) (APA, 2006).
 1. Agents to treat withdrawal (detoxification)
 - a. Alcohol, sedative/hypnotics
 - (1) Benzodiazepines—short-acting lorazepam (Ativan) 1 to 4 mg every 2–6 hours, or oxazepam (Serax) 15 to 60 mg every 6 hours initially, with dosage tapered on subsequent days (15% to 25% per day); adverse effects include memory disruption, lethargy, motor impairment, disinhibition and high abuse potential.
 - (2) Carbamazepine (Tegretol)—200 mg 4 times daily, then tapered off in reduced doses over 5 to 7 days; useful for mild/moderate withdrawal symptoms; less sedating than benzodiazepines.
 - (3) Adjunct medications—clonidine (see under Opiates/Narcotics); haloperidol for agitation, or psychotic symptoms associated with DTs.
 - (4) Supplements—thiamine (Vitamin B₁) 100 mg daily to avoid Wernicke encephalopathy; folic acid (Vitamin B₉) 1 mg daily.
 - b. Opiates/Narcotics
 - (1) Methodone (Dolophine) in tapered doses to slowly withdraw from opioid agent—must be part of FDA approved methodone program (Schedule II controlled substance).
 - (2) Buprenorphine (Buprenex, Subutex)—4 to 8 mg per day (Schedule III controlled substance)—opioid partial agonist antagonist—reduces heroin craving; use of opiates and other illicit drugs such as cocaine thereby retaining clients in treatment longer; adverse effects include constipation and symptoms of opiate withdrawal.
 - (3) Clonidine (Catapres)—0.4 to 0.6 mg per day in two divided doses (an alpha adrenergic agonist); may also be useful adjunct treatment for autonomic hyperactivity in alcohol withdrawal—Caution: may cause hypotension.
 - (a) Clonidine transdermal patch—0.1 to 0.3 mg per day reduces excessive noradrenergic activity in the locus ceruleus of the brain; has no effect on craving, insomnia, or muscle aches or pains; adverse effects include hypotension, sedation, dry mouth, and dizziness.
 - (4) Propranolol (Inderal)—10 mg q 6 hours—a beta-adrenergic antagonist with the same effects as clonidine; has also shown promise in reducing symptoms of cocaine withdrawal; Caution: may cause hypotension—decreases blood pressure, tachycardia, diaphoresis, and tremors.

2. Agents to decrease craving—used with psychosocial therapy
 - a. Alcohol
 - (1) Naltrexone (ReVia)—50 mg per day (not only increases abstinence, but also reduces days of heavy drinking); opioid antagonist reduces the reinforcement value of alcohol by decreasing the activity of the opioid system that is activated by alcohol; side effects include increased liver enzymes, nausea, abdominal distress, joint and muscle pain, early insomnia, and anxiety (also available in once-weekly injectable—Vivাত্রol).
 - (2) SSRIs (fluoxetine, paroxetine, sertraline, citalopram) have demonstrated efficacy in reducing consumption, promoting abstinence, and preventing relapse through the medication's effect on the (5-HT₃) serotonin system.
 - b. Cocaine/Crack
 - (1) Bromocriptine (Parlodel)—2.5–10.0 mg daily (a dopamine agonist); is more effective in acute phases of treatment, replenishing depleted neurotransmitters; side effects include dizziness, headache, nausea, GI distress, orthostatic hypotension, and sleepiness.
 - (2) Amantidine (Symmetrel)—200–400 mg daily. The same mechanism of action and side effects of bromocriptine (see previous paragraph).
 - (3) Carbamazepine (Tegretol)—200–1000 mg daily; blocks the dopamine receptor sensitivity caused by chronic cocaine use; side effects include sedation, dizziness, nausea, and vomiting, hepatotoxicity, agranulocytosis, platelet dysfunction, thrombocytopenia, and tremors.
 - (4) Desipramine (Norpramine)—tricyclic antidepressant, 2.5 mg per kg daily; used to reverse cocaine-induced neurochemical damage with anhedonia and depression; adverse effects include arrhythmias, insomnia, anxiety, dry mouth, and additive cardiotoxicity when taken with cocaine; delayed onset of action is a drawback.
 3. Maintenance agents—used with psychosocial therapies
 - a. Alcohol
 - (1) Acamprosate (Campral)—thought to balance neuronal excitation and inhibition through effects on GABA and glutamate; 666 mg PO three times daily is most effective when treatment goal is complete abstinence.
 - b. Opioids/Narcotics
 - (1) Methadone—opioid agonist; 40–120 mg decreases high-risk behaviors associated with heroin use (criminal activity, prostitution, IV drug use); adverse effects include sweating, constipation, nervousness, insomnia, decreased sex drive, difficult ejaculation, and low grade opioid withdrawal—must be part of methadone program.
 - (2) Buprenorphine—partial opioid agonist; 4–8 mg per day blocks narcotic effects.
 4. Agents to decrease consumption—used with psychosocial therapies
 - a. Alcohol
 - (1) Disulfiram (Antabuse)—aversive or alcohol-sensitizing agent; 250–500 mg daily interferes with the metabolism of alcohol, producing unpleasant side effects when mixed with alcohol; symptoms include facial flushing, heart palpitations, increased heart rate, dyspnea, nausea, vomiting, and decreased blood pressure; clients should be instructed to avoid over-the-counter cough medicines, aftershave lotions, vinegar, mouthwashes, nonalcoholic beer (contains small amount of alcohol) and food cooked with alcohol while taking this drug and for 14 days after drug has been discontinued.
 - b. Opioids/Narcotics
 - (1) Naltrexone—50 mg daily or three doses weekly of 100 mg on Monday and Wednesday and 150 mg on Friday will block the euphoric effects.
 5. Agents to treat protracted abstinence—continued unpleasant state of low grade withdrawal, including sleep disruption, anhedonia, anergia, irritability, nervousness, restlessness, conditioned cravings
 - a. SSRIs—fluoxetine, paroxetine, sertraline, citalopram
 - b. Tricyclic antidepressants—imipramine, desipramine
- Intrapersonal origins/Psychotherapeutic interventions
 1. Psychodynamic Theory
 - a. Substance use is an adaptive attempt to cope with, or compensate for psychological deficits such as dysregulation of affect,

- poor object relations, internal conflicts and impaired judgment and self-care.
- b. Substance abuse is a response to an underlying internal conflict. This conflict is between an internal need and an external limitation.
 - c. Substances are used to avoid feelings of anxiety, anger, shame, depression, low self-esteem.
 - d. Use of immature, rigid defense mechanisms such as denial, dependency, regression, displacement, and depression accompany substance addiction.
 - e. Psychological dysfunctions are often the consequence of substance use rather than the cause.
2. Social Learning Theory views addiction as the result of maladaptive coping skills.
 - a. Personal experience and past learning
 - b. Situational antecedents
 - c. Biologic make-up
 - d. Cognitive processes
 - e. Reinforcement contingencies
 3. Psychotherapeutic interventions
 - a. Interventions linked to Psychodynamic Theory include:
 - (1) Promoting identification as a “recovering” person
 - (2) Fostering expression of honest feelings and reinforcing efforts to cope in more appropriate ways
 - (3) Helping client explore, accept, and own both positive and negative aspects of self
 - (4) Helping client identify aspects of self that he/she would like to change
 - (5) Helping client regain a feeling of empowerment by pointing out the choices he/she has available
 - (6) Helping client recognize and focus on strengths and accomplishments
 - (7) Confronting and exploring defense mechanisms such as denial, minimization dependency, regression, projection and displacement
 - (8) Establishing parameters such as structure and clear boundaries
 - b. Interventions linked to Social Learning Theory consist of cognitive-behavioral/relapse prevention and behavioral therapies; goals of treatment are to facilitate changes in personal habits and lifestyle so that clients may anticipate and cope with problems and high-risk situations; most common high-risk situations associated with 75% of relapses include negative emotional states, interpersonal conflict, and social pressure. Interventions include:
 - (1) Identifying high risk people, places, situations
 - (2) Identifying negative emotions—boredom, loneliness, depression, anxiety, anger, guilt, shame, self-depreciation
 - (3) Monitoring thinking associated with feelings
 - (4) Planning in advance successful avoidance and coping strategies
 - (5) Using slips, lapses, and relapses as corrective learning experiences not as treatment failures
 - c. Evidence-Based Behavior Therapies for Drug & Alcohol Treatment (See **Table 4-2**) (National Institute on Drug Abuse, 2009)
- Family dynamics/Family therapy—identifies substance abuse as the presenting symptom of an underlying family system dysfunction (Bowen, 1978).
 1. Families are undifferentiated. Members cannot act independently of the whole.
 2. Family system is highly stressed and basic nurturing needs are unmet. There is suppression and denial of emotional expression. Communication is indirect, inconsistent, and conflictual. Boundaries are weak and constantly changing. Families accommodate the addiction, thus “enabling” or making it easier for the addicted member to continue using.
 3. Substance abuse is the central theme around which family life is organized. Family rituals and routines, interactional patterns, and problem solving revolve around the addict (Steinglass et al., 1987).
 4. Codependency is a condition afflicting the significant other that is characterized by preoccupation, dependency on and obsession with the addicted individual. Codependent individuals are often adult children of alcoholics (ACOA) and/or share the following similar characteristics:
 - a. Low self-esteem and loss of identity
 - b. Seeking external sources of fulfillment
 - c. Need for approval from others
 - d. Fear of abandonment
 - e. Inability to express anger
 - f. Possible behavior that is controlling, rigid, perfectionistic, and overresponsible
 - g. Meeting others’ needs at the expense of their own needs
 5. Strategies in family therapy
 - a. Assessing the family system—level of denial, level of education and insight—use genogram
 - b. Looking for strengths to reinforce

■ Table 4-2 Evidence-Based Behavior Therapies for Drug & Alcohol Treatment

Therapy Name	Brief Description	Strategies Used	Efficacy with Substance
Cognitive Behavioral Therapy (CBT)	Based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Using various strategies to enhance self-control, individuals learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur.	Exploring positive and negative consequences of continued use, self-monitoring to recognize drug cravings and to identify high-risk situations for use, and developing strategies for coping with high-risk situations and the desire to use. A central element of this treatment is anticipating likely problems and helping patients develop effective coping strategies.	Alcohol Marijuana Cocaine Methamphetamine Nicotine
Community Reinforcement Approach (CRA) Plus Vouchers	An intensive 24-week outpatient therapy for treatment of cocaine and alcohol addiction. Treatment goals are twofold: 1. To maintain abstinence long enough for patients to learn new life skills 2. To reduce alcohol consumption when drinking is associated with cocaine use—clinic-monitored disulfiram (Antabuse) therapy may be used	Patients attend one to two individual counseling sessions weekly that focus on improving family relations, learning skills to minimize drug use, vocational counseling, and developing new recreational activities and social networks. Patients submit urine samples 2 or 3 times weekly and receive vouchers for cocaine-negative results. The value of the vouchers increases with consecutive clean samples and may be exchanged for retail goods that are consistent with a cocaine-free lifestyle.	Alcohol Cocaine
Contingency Management Interventions/Motivational Incentives	Involves giving patients an opportunity to earn low-cost incentives in exchange for drug-free urine samples.	Incentives include prizes given immediately or vouchers exchangeable for food items, movie passes, and other personal goods.	Alcohol Stimulants Opioids Marijuana Nicotine
Matrix Model	Provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Addresses issues critical to addiction and relapse with direction and support from a trained therapist.	Uses detailed treatment manuals with worksheets for individual sessions; other components include family education groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis, and social support groups.	Stimulants (e.g., cocaine, methamphetamine)

■ **Table 4-2** Evidence-Based Behavior Therapies for Drug & Alcohol Treatment (*continued*)

Therapy Name	Brief Description	Strategies Used	Efficacy with Substance
Motivational Enhancement Therapy (MET)	A patient-centered counseling approach for initiating behavior change by helping individuals resolve ambivalence about engaging in treatment and stopping drug use. Evokes rapid and internally motivated change, rather than guiding people stepwise through the recovery process.	Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed. Therapist monitors change, reviews cessation strategies used, and continues to encourage commitment to change or sustained abstinence.	Alcohol Marijuana Nicotine
12-Step Facilitation Therapy	An active engagement strategy designed to increase the likelihood of a substance abuser becoming affiliated with and actively involved in 12-step self-help groups and, thus, promote abstinence.	Three key aspects: (1) <u>acceptance</u> that drug addiction is a chronic, progressive disease over which one has no control, and that abstinence is the only alternative; (2) <u>surrender</u> of oneself to a higher power; and (3) <u>active involvement</u> in 12-step meetings and related activities.	Alcohol Stimulants Opioids

(National Institute on Drug Abuse, 2009)

- c. Discouraging blaming members
 - d. Educating family about chemical dependency and referring to AL-ANON/AL-ATEEN for support
 - e. Assisting with the process of emotional separation and reactivity to the substance abuse behavior
 - f. Modeling effective communication and attitudes
 - g. Supporting/reinforcing healthy change
- Disease model
 1. Substance abuse is a medical and spiritual disease.
 2. There is a biomedical internal causation for chemical dependency that prevents certain individuals from being able to control and predict their drinking in a consistent manner.
 3. Bio-psycho-social-spiritual maintenance model asserts that excessive alcohol and other drug use leads to profound biologic, social, psychological, and spiritual negative consequences. The distress associated with these multidimensional negative consequences leads to further
- excessive alcohol and drug use. Thus, a vicious addiction cycle develops that maintains the problematic alcohol and drug use.
- Sociocultural Theories include factors such as ethnic use patterns, religious beliefs and rituals, gender issues, and peer pressure as influencing alcohol and drug use.
 - Group approaches—used more frequently in substance abuse treatment. Advantages include:
 1. Peer support and confrontation
 2. Reflection on family of origin issues
 3. Place to practice newly learned interpersonal skills
 4. Specific groups include:
 - a. Psychoeducational groups—didactic lectures and discussions on such topics as the disease concept of addiction, the addictive cycle, biopsychosocial consequences of substance abuse, dual diagnosis, relapse prevention, communication skills, assertiveness, and relaxation
 - b. Self-help groups

- (1) Grounded in the conception that substance abuse is a medical and spiritual disease. The belief is that there is an internal causation for chemical dependency beyond the individual's control.
 - (2) Groups offer support and mutual sharing. The group is open to all who share the common goal of recovery from a variety of substances and conditions.
 - (3) The following 12 steps provide the roadmap one must follow to reach recovery:
 - (a) Admit powerlessness and unmanageability of life
 - (b) Look to Greater Power to restore sanity
 - (c) Turn life and will over to God
 - (d) Take a moral inventory
 - (e) Admitting nature of wrongs
 - (f) Be ready to have God remove character defects
 - (g) Ask God to remove shortcomings
 - (h) Make a list of people harmed and willingness to make amends
 - (i) Make amends
 - (j) Continue personal inventory
 - (k) Improve conscious contact with God
 - (l) Carry message of spiritual awakening to other alcoholics
 - (4) Critics of the twelve steps believe this approach is not appropriate for everyone and complain about the reference to God. Proponents endorse a broader, more spiritual versus religious definition of God or Higher Power.
- Milieu interventions—based on staff providing a safe, corrective environment that enhances the development of more adaptive coping skills and interpersonal behaviors.
 1. Management of withdrawal—detoxification occurs in the early phase of recovery and involves safely tapering off of substance of abuse, thereby minimizing the physical discomfort associated with withdrawal. Guidelines for withdrawal management include:
 - a. Monitor vital signs and severity of withdrawal (see symptoms associated with specific drugs) and medicate as ordered. Use Clinical Instrument for Withdrawal from Alcohol (CIWA) to measure both objective and subjective symptoms of withdrawal. This enables the nurse to more accurately and safely quantify the amount of detoxification medication that is administered.
 - b. Assess and monitor level of consciousness, orientation, thought processes and sensory perceptual alterations.
 - c. Assess for tremulousness and agitation.
 - d. Provide a quiet, dimly lit environment with low stimulation.
 - e. Implement fall precautions.
 - f. Implement seizure precautions for alcohol, benzodiazepines, and sedative/hypnotics.
 - g. Provide nutritional support—administer vitamin and mineral supplements as ordered; alleviate gastrointestinal distress.
 - h. Maintain hydration—monitor intake and output, assess water loss from diaphoresis.
 - i. Implement measures to help client sleep and relax: stress management, breathing retraining, progressive muscle tension relaxation, yoga, meditation, acupuncture, therapeutic touch.
 - j. Convey acceptance and reassurance.
 - k. Reorient when indicated.
 2. Psychosocial supportive measures during rehabilitative phase of recovery include:
 - a. Formulating treatment goals and expected outcomes with patient
 - b. Role modeling self-acceptance, assertiveness, and responsibility
 - c. Maintaining consistency in care—requires a high degree of communication among staff
 - d. Confronting in an empathetic, respectful manner, always focusing on the dysfunctional behavior and not the individual
 - e. Identifying and working through countertransference issues
 - f. Providing structure—use daily activity schedule
 - g. Use of self disclosure only when appropriate and in the context of therapy
 - h. Use of behavioral contracts with contingencies
 - (1) Reinforce compliance and achievement
 - (2) Administer consequences for noncompliance
 - i. Providing on the spot conflict management
 - j. Assisting with task assignments and homework
 - k. Using rehearsal and role playing of newly learned skills
 3. Psychiatric and mental health advanced practice nurse interventions include:

- a. Theory-based psychotherapy—individual, group, family
 - b. Evaluation, treatment recommendation and appropriate referral
 - c. Consultant as an expert in the field of chemical dependency
 - d. Staff support and management functions
 - e. Interventions for the patient presenting with complex problems
 - f. Staff education and supervision
 - g. Preventative functions—community awareness and education
 - h. Research functions—participation in and/or initiation of protocols that may improve future interventions and care of the substance abusing population
 - i. Professional development—committee memberships, publications, presentations, learning opportunities
 - j. Medication evaluation and monitoring if psychiatric and mental health advanced practice nurse granted prescriptive authority
- Community resources
 1. Self-help support group meetings
 - a. Alcoholics Anonymous (AA)
 - b. Narcotics Anonymous (NA)
 - c. Cocaine Anonymous (CA)
 - d. Secular Organizations for Sobriety (SOS); geared more toward individuals with agnostic view of spirituality
 - e. AL-ANON, NAR-ANON and AL-ATEEN—family/significant others and teenagers living with or involved with a substance abuser
 - f. Adult Children of Alcoholics (ACOA)
 2. Prevention groups—special-interest groups developed for community awareness and education, public policy making, introducing and changing legislation related to alcohol and substance use
 - a. Drug Abuse Readiness Education (DARE)
 - b. Mothers Against Drunk Drivers (MADD)
- Impaired nurses—a resolution passed at the American Nurses' Association (ANA) Congress in 2002 advocates for the use of an “alternatives to discipline” model (also known as peer-assistance programs) in addressing a nurse's needs when substance-related or psychiatric disorders interfere with the practice of nursing. According to Cahill (1992) nurses are at higher risk due to:
 1. Accessibility to drugs and addictive substances
 2. Mistaken belief that health professionals can “self-medicate safely”
3. Role strain and work stress (long working hours, physical and emotional exhaustion)
 4. Treatment approaches include:
 - a. Intervention—structured method of penetrating the delusional system of chemically dependent persons for the purpose of facilitating insight into the addictive problem and entry into treatment
 - (1) Use team approach, nonpunitive attitude; 2–10 professional associates of impaired colleague who share a nonjudgmental attitude (to include one recovering peer and one with experience in chemical dependency if possible).
 - (2) Present documented evidence, always prefacing testimony with positive remarks.
 - (3) Give impaired nurse a chance to respond.
 - (4) State available options and allow an opportunity for voluntary entry into treatment.
 - (a) Diversion programs—facilitate reentry into practice without licensure sanctions.
 - (b) Regulatory legal action—nurse reported to the state board for suspected chemical dependency is dealt with under the State Nurse Practice Act and the Administrative Procedure Act.
 - (c) Criminal legal action—nurse who diverts a control substance from a facility or obtains a controlled substance by fraud is in violation of the Controlled Substance Act.
 - (5) Make arrangements to monitor progress.
 - b. Specialized inpatient program, AA and/or NA meetings for healthcare professionals
 - c. Employee assistance programs
 - d. Peer assistance support from state and district associations
 - e. Reentry back into the workplace
 - (1) Restrictions on handling medications for a certain period of time
 - (2) Urine drug screening
 - (3) Regular documented attendance for outpatient treatment and AA/NA meetings
 - (4) Stable work shifts (minimize variable shift work)
 - (5) Clear job performance expectations with supervision and regular evaluations

■ QUESTIONS

Select the best answer

- Ms. P. presents to the community substance abuse center for an evaluation. She states that she does not have a substance abuse problem but agreed to the evaluation at her husband's insistence. The appropriate initial statement would be:
 - "Do you drink often?"
 - "Your husband is concerned about your drinking?"
 - "What makes you think that you do not have a drinking problem?"
 - "How much do you drink?"
- According to Prochaska and DiClemente, at what stage of change would Ms. P. be in?
 - Contemplation
 - Action
 - Denial
 - Precontemplation
- Mr. C., a 40-year-old male with a diagnosis of alcohol dependence, is admitted to the inpatient unit for detoxification. Which of the following measures would NOT be implemented at this time?
 - Monitor vital signs
 - Provide quiet, dimly lit atmosphere
 - Confront denial
 - Encourage fluids by mouth
- Mr. C. completes detoxification and rehabilitation and is discharged on Disulfiram (Antabuse), 250 mg to be taken every morning. Which of the following substances can Mr. C. continue to take?
 - Mouthwash
 - Cough elixirs
 - Nonalcoholic beer
 - Antidepressant medication
- When assessing whether or not a patient has a problem with alcohol or drugs, which criterion is the best indicator:
 - How much a person uses
 - How often a person uses
 - The level of interference with physical, emotional, and social functioning
 - Positive laboratory findings
- Which of the following is NOT a sign of delirium tremens?
 - Confusion
 - Tactile hallucinations
 - Seizures
 - Stroke
- Ms. D. is admitted to the emergency room with suicidal ideations. Urine drug screen reveals the presence of cocaine in the urine. When questioned with this finding, Ms. D. denies any use of cocaine. The most appropriate nursing response would be:
 - "This test is very accurate, Ms. D., you must not be telling the truth."
 - "You are depressed because you have used cocaine."
 - "Were you in a room with other people who were smoking crack?"
 - "Have you ever used drugs in the past?"
- Which of the following questions would NOT be important in assessing potential withdrawal from alcohol?
 - "When was your last drink and how much did you consume?"
 - "Have you experienced any 'blackouts'?"
 - "During the last month, what is the longest period of time that you have gone without alcohol?"
 - "Do you experience any physical discomfort when you go without alcohol for a few hours or a few days?"
- Mr. G., a 50-year-old chronic alcoholic, is recently admitted to the inpatient unit. It has been 48 hours since his last drink. Mr. G. states that he feels strange and everything around him seems unreal. The nurse notices that Mr. G. has scratches on both arms. The nurse should suspect:
 - Drug seeking behavior
 - Onset of psychosis
 - Onset of delirium tremens
 - Wernicke-Korsakoff syndrome
- Which laboratory value is NOT necessarily altered by alcoholism?
 - Aspartate aminotransferase (AST)
 - Gamma-glutamyltransferase (GGT)
 - Mean corpuscular value (MCV)
 - White blood cell count (WBC)
- Genetic studies in alcoholism support which of the following statements:
 - Alcoholism is mostly influenced by environmental factors.
 - Children of alcoholics are four times more likely to have problems with alcohol or drugs.

- c. There is no definitive research that links alcoholism to genetic etiology.
- d. If both parents have alcoholism there is a 75% chance that each child will have an alcohol or drug problem.
12. Mr. F. is participating in a 6-week intensive outpatient substance abuse treatment program for his crack/cocaine addiction. During the third week of treatment he tests positive for cocaine in his urine. The most appropriate intervention would be to:
- Refer to inpatient treatment
 - Dismiss from the intensive outpatient program
 - Meet with the patient individually to discuss the slip/relapse
 - Confront the patient in group
13. Which of the following is NOT necessarily an alcohol-related medical complication?
- Arteriosclerosis
 - Cardiomyopathy
 - Cirrhosis of the liver
 - Gastritis
14. There has been an increase in the number of infectious diseases associated with the current drug epidemic. Which of the following infectious diseases is NOT necessarily associated with addictive behavior?
- Sexually transmitted diseases
 - HIV, AIDS
 - Hepatitis
 - Encephalitis
15. Nurse K. is a nurse counselor working for a university. Ms. G. is a 22-year-old sophomore who has been referred to nurse K. for an evaluation because of her declining grades and poor class attendance. What would be the most appropriate line of questioning for nurse K. to pursue?
- "Your advisor tells me that you are doing poorly in school?"
 - "Have you been spending more time partying than concentrating on your schoolwork?"
 - "Can you tell me what has been happening around you that may be affecting your school work?"
 - "Are you using any drugs?"
16. Ms. G. continues to smoke marijuana, and her school problems are getting worse. Your best intervention would be to:
- Call her parents and inform them of her drug use
 - Tell her she will be expelled if she does not quit using
 - Refer to substance treatment and monitor compliance and progress
 - Do not intervene, as patient probably needs to suffer the consequences of her use
17. Which of the following medical complications is NOT necessarily associated with cocaine/crack abuse:
- Kidney failure
 - Seizures
 - Stroke
 - Cardiac Arrhythmias
18. Sedatives/hypnotics are cross-addicted with:
- Alcohol
 - Opiates
 - Stimulants
 - Hallucinogens
19. Mr. L. is a 50-year-old male with a history of chronic back pain from a car injury that occurred 5 years ago. He has been taking Darvocet-N 100 over the past several years and reports taking up to 15 tablets a day. His medical doctor no longer feels comfortable giving Mr. L. prescriptions for pain and refers him to substance abuse treatment. Mr. L. is admitted to the inpatient unit for narcotic detoxification. He is very fearful that he will be denied pain medication and left to suffer. The most appropriate nursing intervention would be to:
- Reassure Mr. L. that his pain will be managed while his narcotic is being slowly tapered
 - Explain to Mr. L. that he is addicted to narcotics and must not use them anymore
 - Explain to Mr. L. that his pain threshold has been lowered due to his narcotic abuse and he will not need pain medication
 - Tell Mr. L. that he will have Tylenol and aspirin available for pain management
20. Which of the following is NOT a symptom of opiate withdrawal?
- Muscle cramps
 - Tachycardia
 - Pupillary constriction
 - Diarrhea
21. Which of the following nursing diagnoses would be the least appropriate for Mr. L.'s plan of care?

- a. Injury, potential for
 - b. Comfort, alteration in
 - c. Self-care deficit
 - d. Knowledge deficit
22. The benefit of methadone maintenance over heroin use is that it:
- a. Serves as an anticraving agent
 - b. Diminishes risky behavior associated with heroin use
 - c. Is effective as a detoxification agent
 - d. Has no adverse effects
23. Mr. T. is a 37-year-old male admitted for depression. When the nurse admitting Mr. T. asked him about his alcohol use, he stated he had a couple of beers after work every day. He also said that his wife was threatening to leave him. When Mrs. T. came to the hospital to visit her husband, his primary nurse met with them together. Mrs. T. stated that she was tired of putting Mr. T. to bed every night and calling his job stating he was sick when he was really hung over. Mrs. T. states that she also makes herself available at all times to pick up Mr. T. if he has been out drinking. She states that she cares about her husband and does not want to see him get hurt. This behavior is typical of:
- a. Caring
 - b. Supporting
 - c. Controlling
 - d. Enabling
24. Ms. K., a 30-year-old female, has finished a cognitive behavioral intensive outpatient treatment program for her crack/cocaine addiction. For follow-up she plans to attend a weekly process group. According to Prochaska and DiClemente, what stage of change would this client be entering?
- a. Action
 - b. Maintenance
 - c. Aftercare
 - d. Preparation
25. Which of the following is *less* likely to be a limitation of urine drug testing for substances of abuse?
- a. Often produces false positives
 - b. "Short" window of detection of metabolites
 - c. Intermittent abuse patterns of abusers
 - d. Issues of civil liberties
26. Which of the following characteristics is NOT necessarily present in fetal alcohol syndrome?
- a. Heart defects
 - b. Facial dysmorphism
 - c. Growth retardation
 - d. Central nervous system dysfunction
27. The advanced practice nurse in PMH leads a multifamily group. Ms. T. is a 40-year-old housewife who is very angry at her husband because he recently spent the couple's entire savings on cocaine. Ms. T. feels very frustrated with her husband's addiction and would like to learn to support him in his recovery. The APN-PMH's best suggestion would be for Ms. T.:
- a. To leave her husband
 - b. To take charge of the family finances
 - c. To not get involved in her husband's recovery
 - d. To attend AL-ANON meetings to explore how significant others cope with their loved one's addiction
28. From a family systems perspective, chemical dependency can be viewed as:
- a. A lack of the family's ability to problem solve
 - b. Lack of communication
 - c. Lack of family organization and interactional patterns
 - d. A symptom of underlying family dysfunction
29. Ms. R. is a 50-year-old woman married to an alcoholic. During individual counseling Ms. R. states that her husband's drinking interferes with their social activities. His behavior when drinking embarrasses and humiliates her. An appropriate response would be to advise Ms. R. to:
- a. Stop going to activities
 - b. Continue to go to activities without focusing on her husband's drinking, letting him take responsibility for the consequences of his drinking behavior
 - c. Encourage Ms. R. to keep a watchful eye on her husband, frequently reminding him how much he has had to drink
 - d. Make sure she is available at activities so that she can drive her husband safely home
30. Which of the following goals would NOT be appropriate for the milieu management of a residential substance abuse program?
- a. To maintain a restricted environment
 - b. To maintain the safety of the patient
 - c. To provide consistent, structured care
 - d. To support the patient's recovery effort

31. Ms. G. is a 67-year-old female with a long history of alcoholism. She currently has cirrhosis of the liver. In order to be put on a list to receive a liver transplant, she must complete an inpatient substance abuse program. Additionally, she must sustain 6 months of abstinence. On admission Ms. G. states that the only reason she is here is to receive a new liver. An appropriate initial response would be:
- "How did you get cirrhosis of the liver?"
 - "You sound angry about having to participate in substance abuse treatment."
 - "Treatment requires having insight into your alcoholism."
 - "You are concerned about your liver disease?"
32. An evaluation criterion for Ms. G.'s plan of care would be to:
- Understand the reasons for her drinking
 - Verbalize her dependence on alcohol
 - Recognize situations that put her at high risk for drinking
 - Discuss her alcoholism openly in group
33. An example of a violation of the Controlled Substance Act would be:
- Driving under the influence of alcohol
 - Drinking or using drugs at work
 - Possession of an illegal substance outside of work
 - Diverting a controlled substance from a facility
34. RJ is a 16-year-old who presents to the county emergency room one night accompanied by two of his peers. His friends state that RJ just started acting very weird while they were attending a concert. The nurse notices that RJ is anxious, agitated, confused, paranoid, and that his pupils are dilated. RJ is convinced that everything is changing shape and color. Based on this information, the nurse should suspect:
- Schizophrenia
 - A brief psychotic episode
 - A panic attack
 - Hallucinogen intoxication
35. The primary nurse is assigned a 24-year-old woman with a crack cocaine dependence. The nurse meets with the client to discuss a plan of care. The nurse and client decide on an activity that will enhance the client's self-esteem and empowerment. Which of the following models is providing the theoretical framework for this intervention?
- Disease model
 - Nursing Light model
 - Social Learning theory
 - Family Systems theory
36. AL-ANON would most probably recommend to the spouse of an alcoholic individual:
- To continue the same behavior
 - That you are powerless over the alcoholic individual, so take care of yourself
 - To learn how you can change the alcoholic individual
 - To get a divorce
37. A common physical complication of alcohol dependence, which contributes to memory impairment is:
- Decreased serotonin levels
 - Elevated liver enzymes
 - B-vitamin deficiency
 - Gastritis
38. The 12 steps of Alcoholic and Narcotics Anonymous describe:
- A spiritual approach to living
 - How the organizations were developed
 - What goes on in meetings
 - God as a higher power
39. What are the characteristics of therapists who are most successful in treating substance use disorders?
- They confront and challenge the client's denial.
 - They take control, and clearly tell their clients what they need to do to recover.
 - They show high levels of empathy.
 - They are recovering from addiction themselves.
40. Mr. J. is a 28-year-old male with a diagnosis of polysubstance dependence and panic disorder. Mr. J. states that if his anxiety were treated he would have no need to abuse addictive substances. Which statement best supports the nurse's understanding about the treatment of dual diagnosis?
- The anxiety is probably caused by drugs and will remit with cessation of drug use.
 - The substance abuse is an attempt by the patient to self-medicate his panic disorder.
 - Both the substance abuse and the panic disorder must be treated concurrently to maximize treatment outcome.
 - The patient who is adequately treated for panic disorder can return to controlled drug use.

41. The efficacy of Motivational Enhancement Therapy has been demonstrated with:
- Alcohol abuse
 - Narcotic abuse
 - Nicotine dependence
 - Both a and c are correct
42. CBT is an evidence-based therapy shown to be effective in treating substances of abuse.
- True for all substances of abuse
 - True for most substances of abuse
 - False because there is insufficient empirical evidence related to CBT
 - Absolutely false
43. MJ is a 29-year-old male seeking assistance in reducing episodes of heavy alcohol consumption. The best medication to consider and discuss with him is:
- Disulfiram (Antabuse)
 - Naltexone (ReVia, Vivitrol)
 - Both a and b are correct
 - Neither medication should be used with alcohol

■ ANSWERS

- | | |
|--------------|--------------|
| 1. b | 23. d |
| 2. d | 24. b |
| 3. c | 25. a |
| 4. d | 26. a |
| 5. c | 27. d |
| 6. d | 28. d |
| 7. d | 29. b |
| 8. c | 30. a |
| 9. c | 31. d |
| 10. d | 32. b |
| 11. b | 33. d |
| 12. c | 34. d |
| 13. a | 35. b |
| 14. d | 36. b |
| 15. c | 37. c |
| 16. c | 38. a |
| 17. a | 39. c |
| 18. a | 40. c |
| 19. a | 41. d |
| 20. c | 42. b |
| 21. c | 43. b |
| 22. b | |

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Anxiety and Stress-Related Disorders

■ ANXIETY DISORDERS

- Overview
Anxiety disorders are among the most common mental disorders in the general population, affecting about 40 million (18.1%) adults (aged 18 and older) in the United States (Kessler, Chiu, Demler, & Walters, 2005). This cluster of disorders is characterized by the type, degree, and duration of anxiety or worry experienced in response to one or more perceived stressors. The most common anxiety disorders are specific (simple) phobias (8.7%), social anxiety (phobia) (6.8%), posttraumatic stress disorder (3.5%), generalized anxiety disorder (3.1%), and panic disorder (2.7%); other anxiety disorders occur in less than 2% of the population (Kessler, Chiu, Demler, & Walters, 2005).
- Levels of anxiety (Videbeck, 2006)
 - I. Mild—slight physical arousal, sharp perceptions, ability to learn well
 - II. Moderate—physical symptoms apparent, narrowing of perceptual field, selective attention
 - III. Severe—physical symptoms problematic, difficulty concentrating, very apprehensive, may develop ritualistic behavior
 - IV. Panic—terror, little ability to concentrate, difficulty breathing, palpitations, fear of dying, may be suicidal
- Types of coping (Keltner, Schwecke, & Bostrom, 2007)
 1. Adaptive—active problem solving is attempted with limited experience of anxiety.

2. Palliative—anxiety is transient with temporary relief allowing for problem solving.
3. Maladaptive—anxiety is constant with limited success at problem solving.
4. Dysfunctional—anxiety is constant with detrimental effects on general functioning; new problems develop.

Phobias

- Definition—persistent, excessive, irrational fear of a particular object or situation that can lead to avoiding the feared object or situation
- Signs and symptoms
 1. Specific phobias
 - a. Fear of animals (snakes, spiders, dogs)
 - b. Claustrophobia
 - c. Fear of air travel
 - d. Usually limited impairment
 2. Social Phobia (social anxiety)—fear of being exposed to scrutiny, humiliated, or embarrassed by others
 - a. Specific fears—choking on food in restaurant, trembling when writing
 - b. General fears—saying foolish things
 - c. Usually mild impairment
 3. Agoraphobia—fear of being in a place or situation from which there might be difficult or embarrassing escape, or in which, should symptoms become very embarrassing or incapacitating, there might be no help available—such as:

- a. Fears of heart attack, depersonalization, loss of bladder control, etc.
 - b. Limits on travel, crowds, or being outside the home alone to avoid symptom development
 - c. Mild (some avoidance or tolerance of anxiety) to severe (housebound or unable to leave the house unaccompanied) impairment
- Differential diagnosis
 1. Panic Disorder with Agoraphobia
 2. Avoidant Personality Disorder
 3. Obsessive-Compulsive Disorder
 4. Posttraumatic Stress Disorder
 5. Schizophrenia (with delusions)
 - Mental status variations
 1. Appearance and behavior—normal unless faced with feared stimulus, then exhibits symptoms of severe anxiety
 2. Mood—commonly depressed, often related to degree of impairment
 3. Thought—persistent, irrational fear of object or situation
 - Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Insomnia
 3. Coping, ineffective
 4. Fear
 5. Powerlessness, risk for
 6. Relationships, readiness for enhanced
 7. Hopelessness
 8. Resilience, risk for compromised
 9. Self-Esteem, situational low
 10. Resilience, impaired individual
 11. Resilience, readiness for enhanced
 12. Role Performance, ineffective
 13. Coping, compromised family
 - Genetic/Biologic origins
 1. Biologic inability to habituate to certain situation
 2. Possible genetic component with higher concordance in first-degree relatives
 3. Serotonergic abnormality
 4. Possible limbic system responsibility in generating anticipatory anxiety
 - Biochemical interventions (Stahl 2008, 2009; Saddock & Saddock, 2007)
 1. Antianxiety agents in combination with behavioral approaches
 2. Antianxiety agents if behavioral approaches ineffective (See **Table 5-1**)
 - a. Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) are effective antianxiety agents (See **Table 5-2**).
 - b. Short-acting benzodiazepines (alprazolam) may be useful for specific phobias.
 - c. Beta-adrenergic antagonists that block the sympathetic response (e.g., propranolol) are helpful in situational anxiety such as stage fright.
 - d. Other antidepressants may be useful if first-line agents do not effectively reduce anxiety symptoms:
 - (1) MAOIs in particular for social phobias
 - (2) TCAs such as imipramine for panic disorders with agoraphobia
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Psychodynamic—phobia as an outward manifestation of inner, unresolved childhood conflicts
 - (1) Anxiety is displaced (when repression fails) upon an object or situation that symbolizes the conflict.
 - (2) Conflicts are often sexual (oedipal) or related to separation anxiety.
 - (3) Disorder includes disturbance of interpersonal attachment & coping.

■ **Table 5-1 Recommended First-line Medications for Selected Anxiety Disorders**

Anxiety Disorder	SSRI	SNRI	Benzodiazepine	Other
Social Phobia/Social Anxiety Disorder	X	X	X	
Posttraumatic Stress Disorder (PTSD)	X	X		
Generalized Anxiety Disorder (GAD)	X	X	X	Buspirone
Panic Disorder	X	X	X	
Obsessive-Compulsive Disorder (OCD)	X			

■ **Table 5-2** First-line Antianxiety Medications

Drug Class	Generic Name (Brand Name)	Usual Daily Dose (mg/day)	Comments
Antidepressants			
SSRI	Escitalopram (Lexapro)	10 to 20	SSRIs are first-line agents for anxiety spectrum disorders
	Fluoxetine (Prozac)	20 to 80	
	Fluvoxamine CR (Luvox CR)	100 to 300	
	Paroxetine (Paxil, Pexeva)	20 to 50	
	Sertraline (Zoloft)	50 to 200	
SNRI	Duloxetine (Cymbalta)	60	
	Venlafaxine (Effexor, Effexor XR)	75 to 225	
Anxiolytics			
Azapirone	Buspirone (BuSpar)	20 to 30	May take up to 4 weeks for therapeutic effect
Benzodiazepine	Triazolam (Halcion) SA	0.125 to 0.25	Generally, benzodiazepines are used short term (about one month)
	Alprazolam (Xanax) IMA	0.75 to 6	
	Lorazepam (Ativan) IMA	2 to 6	
	Oxazepam (Serax) IMA	30 to 60	
	Flurazepam (Dalmane) LA	15 to 30	
	Clonazepam (Klonopin) LA	0.5 to 2	
	Chlordiazepoxide (Librium) LA	15 to 100	
Diazepam (Valium) LA	4 to 40		

Legend for benzodiazepines: SA = short acting; IMA = intermediate acting; LA = long acting (Sadock & Sadock, 2007; Stahl, 2008, 2009)

- b. Behavioral
 - (1) Classical conditioning response—phobia develops when anxiety occurs as one is confronted with a naturally frightening stimulus and becomes paired with a neutral stimulus.
 - (2) Operant theories—person learns to avoid a stimulus for anxiety, and the reduction in anxiety reinforces the behavior.
2. Psychotherapeutic interventions
 - a. Psychodynamic—insight-oriented therapy to resolve childhood conflicts, understand secondary gain, and to find healthy ways to deal with anxiety
 - b. Behavior (most effective treatment)
 - (1) Systematic desensitization
 - (a) Design, with client, list of anxiety-provoking stimuli related to the object/situation from the least to most frightening.
 - (b) Teach progressive muscle relaxation (PMR) to induce deep relaxation.
 - (c) Induce/maintain relaxed state, while client imagines each anxiety-provoking stimulus.
 - (d) When desensitized to one stimulus, move up the scale, until relaxation can be maintained throughout entire list of stimuli.
 - (e) Apply technique in vivo.
 - (2) Flooding—use intensive exposure to stimulus in vivo or through imagery until fear can no longer be felt.
 - (3) Neurolinguistic Programming
 - c. Hypnosis—used to support acceptance that the phobic object/situation is not dangerous, or to assist in relaxation when confronted with the feared object/situation

- Family dynamics/Family therapy—used in the following situations:
 1. Role performance (work, family, social contacts) is impaired, family dynamics are altered, and other members assume additional responsibilities.
 2. Children sense fears of outside world or objects.
 3. There is need for role restructuring, support of therapy and change, and reduction of secondary gain of all members.
- Group approaches
 1. Therapy
 - a. Psychodynamic insight-oriented group therapy
 - b. Psychoeducational group—focus on understanding phobic disorders and learning relaxation techniques
 - c. Social skills training—modeling, rehearsing, coaching to improve communication
 - d. Supportive therapy to provide reality testing and feedback within a group of others seeking to make similar changes—may provide “here and now” experience in facing phobic social situations
 2. Self-help groups (affiliated with Phobia Society of America, Rockville, MD) may be present in some communities.
- Milieu interventions (unlikely to be hospitalized unless severely impaired)
 1. Provide safe, supportive environment, free of ridicule for phobia.
 2. Institute goal-oriented contract for treatment.
 3. Employ anxiety-reducing techniques (PMR, breathing, etc.) to decrease general arousal.
 4. Conduct systematic desensitization (imagined or in vivo).
 5. Engage in activities that increase feelings of power and self-esteem.
 6. Reinforce what is learned in individual, group, and family sessions.
 7. Provide referrals to outpatient support groups.
- Community resources
 1. Outpatient therapy
 2. Support groups
- Signs and symptoms
 1. Stressors may include war experiences, assault, rape, serious accidents, abuse, and natural catastrophes (van der Kolk, McFarlane, & Weisaeth, 1996).
 2. Common trauma experience symptoms include overwhelming fear, loss of control, helplessness, and fear of being annihilated.
 - a. Person witnesses or experiences events that involve actual or threatened death or severe physical harm.
 - b. Person reacts with fear, helplessness, or horror (APA, 2000).
 3. Recurrent intrusive thoughts of trauma occur in dreams, thoughts, flashbacks, or events similar to stressor.
 4. Numbing or constriction (avoidance) responses include:
 - a. Avoidance of thoughts/feelings/recollections about trauma
 - b. Avoidance of persons/situations that provoke memory of original trauma
 - c. Psychogenic amnesia, dissociation
 - d. Marked diminished interest in significant activities, persons, or the future
 5. Increased arousal responses include sleep disturbances, temper outbursts, hypervigilance and difficulty concentrating, and exaggerated startle response (APA, 2000).
 6. Response may be delayed by weeks to many years.
 7. Standard definition of PTSD (DSM) tends better to fit survivors of circumscribed events and fails to address symptoms and personality manifestation resulting from prolonged, repeated trauma (Herman, 1992).
 8. Posttraumatic Stress Disorder, dissociation, somatization, and affect dysregulation are highly interrelated (van der Kolk, Peclowitz, Roth, Mandel, McFarlane, & Herman, 1997).
- Differential diagnosis
 1. Factitious Disorder
 2. Borderline Personality Disorder
 3. Schizophrenia
 4. Depression
 5. Panic Disorder
 6. Generalized Anxiety Disorder
 7. Acute Stress Disorder (APA, 2000)
 - a. Similar origin and presentation as PTSD, but occurs within 4 weeks of traumatic event.
 - b. Symptoms last from 2 days to 4 weeks.
 8. Frequently misdiagnosed due to symptoms—hallucinations, depression, addiction, and somatic complaints (Symes, 1995)
 9. High rates of comorbidity (Friedman, 1996)

Posttraumatic Stress Disorder (PTSD)

- Definition—a response resulting from exposure to a severe emotionally or physically traumatic event characterized by: (1) intrusive reexperiencing of the trauma; (2) avoidance behaviors and emotional numbing; and (3) increased arousal (American Psychiatric Association [APA], 2000)

- Mental status variations
 1. Behavior—vigilant, restless
 2. Mood—anxious, depressed, blunted affect, guilty
 3. Perceptual Experiences—flashbacks, derealization, dissociation
 4. Thought—preoccupation with trauma
 5. Memory—impaired
 6. Concentration—impaired
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Insomnia
 3. Coping, ineffective
 4. Fear
 5. Rape-Trauma Syndrome
 6. Hopelessness
 7. Self-Esteem, situational low
 8. Post-Trauma Syndrome
 9. Suicide, risk for
 10. Violence, (actual/) risk for self-directed, or other-directed
- Genetic/Biologic origins
 1. Increased baseline sympathetic arousal may predispose; after trauma, baseline elevated.
 2. Trauma response includes the following:
 - a. Immediate, excessive arousal, especially cardiovascular and neuromuscular systems
 - b. Arousal of sympathetic system that leads to difficulty in distinguishing perceptual cues
 - c. Original hyperarousal easily evoked after trauma by variety of cues.
 - d. Autonomic arousal becomes neurologically entrained (van der Kolk, McFarlane, & Weisaeth, 1996).
 3. Regulation of endogenous opioids altered
 - a. When stressor subsides, opioids may decrease.
 - b. Opioid withdrawal symptoms similar to PTSD.
 - c. Individual may be “addicted” to trauma.
- Biochemical interventions (Stahl, 2008)
 1. Antidepressants
 - a. Serotonin selective reuptake inhibitors (SSRIs)—first-line treatment option
 - (1) SSRIs may not be as effective for combat veterans—alpha-adrenergic antagonist-prazosin (Minipress) has shown promise in treating combat-related PTSD (Benedek, Friedman, Zatzick, & Ursano, 2009).
 - b. Serotonin norepinephrine reuptake inhibitors (SNRIs)—first-line treatment option (duloxetine (Cymbalta), venlafaxine (Effexor))
 - c. Tricyclic antidepressants (TCAs)
 - d. Monoamine oxidase inhibitors (MAOIs)
 2. Other pharmacologic options
 - a. Propranolol (Inderal)
 - b. Carbamazepine (Tegretol)
 - c. Gabapentin (Neurontin)
 - d. Benzodiazepines (Ativan, Valium, Xanax, etc.)
 3. Avoid MAOIs/benzodiazepines if abusing drugs/alcohol
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Psychodynamic view—trauma reactivates previous, unresolved childhood conflicts.
 - (1) Regression, repression, denial and undoing defense mechanisms
 - (2) Secondary gain when dependency needs met
 - b. Cognitive—brain attempts to process through alternate blocking and acknowledging the event until a new mental scheme that incorporates the trauma is devised (Herman, 1992).
 - c. Personal resilience—persons who construct meaning out of the event, make connections with others, who actively attempt to cope, and who have strong internal locus of control withstand trauma with fewer symptoms (Herman, 1992).
 - d. There is some evidence that those who dissociate at time of trauma have higher risk for PTSD.
 - e. Epidemiological studies—27% of women and 16% of men experienced sexual abuse as children; 33% of survivors who had physical contact without penetration, and 64% of those with penetration developed PTSD (Rodriguez, Ryan, Vande Kemp, & Foy, 1997).
 2. Psychotherapeutic interventions: (Sadock & Sadock, 2007)
 - a. Interventions for Acute Stress Disorder (ASD) involve crisis intervention strategies with support, education, enhancement of coping mechanisms, and acceptance of the event (Sadock & Sadock, 2007).
 - b. The two most common and effective therapies used for PTSD are:
 - (1) Exposure therapy—employs strategies (imagery, in vivo exposure) that promote reexperiencing of the traumatic event (e.g., exposure-based cognitive

- behavioral therapy, implosive therapy, and systematic desensitization).
 - (2) Stress management—used to teach relaxation techniques and cognitive restructuring such that one’s ability to cope with stress is improved.
 - c. Other psychotherapeutic interventions used in treating PTSD include:
 - (1) Psychoeducation regarding the recovery process (tailored to particular traumas)
 - (2) Expressive therapies (art, dance, music) to translate visual and sensorimotor memories, especially those not encoded in cognitive systems, into meaningful symbols and verbal representations to be integrated
 - (3) Eye Movement Desensitization and Reprocessing (EMDR) to decrease symptoms of trauma—continues to be researched (Benedek, Friedman, Zatzick, & Ursano, 2009)
- Family dynamics/Family therapy
 1. Family roles can be altered as PTSD symptoms are experienced.
 2. Some children develop affective symptoms, become rescuers or disengage from a parent who has PTSD.
 3. Family may expect more rapid recovery than is possible.
 4. Family can help clarify events, listen, and correct distortions.
 5. Abusive families-of-origin may deny, punish, and attempt to enforce conspiracy of silence.
 6. Family therapy guidelines
 - a. Support victim in recovery.
 - b. Meet needs of all family members.
 - c. Maintain awareness of how trauma affects views of self, family, and world.
 - d. Develop shared frame of reference for trauma.
 - e. Bring out central issues of blame, responsibility, and trust.
 - Group approaches (group experiences with survivors of similar traumas can be helpful, variable in length)
 1. Adult survivors of childhood sexual abuse
 - a. Long-term group therapy, usually outpatient
 - b. Goals
 - (1) Reduce isolation, shame, guilt, and sense of deviance.
 - (2) Restructure family-induced behaviors.
 - (3) Develop new, more realistic patterns of interaction.
 - c. Group as surrogate family
 - (1) Victims often blamed by family for disclosing or over-reacting.
 - (2) Group serves as training ground for new behaviors.
 - (a) Analyze effect of family’s messages and beliefs on view of self and world.
 - (b) Learn and practice assertive behaviors.
 - (c) Do not reinforce helplessness or powerlessness.
 - (3) Support and validate strengths/worth.
 - (4) Handle successfully the displaced hostility, regression, dissociation, extreme, anxiety or depression, self destructive behaviors.
 - (5) Use 12-step group programs.
 - (6) Teach short-term stress management.
 - (7) Trauma—use focused groups.
 - 2. Combat trauma groups
 - b. Goals
 - (1) Share experiences.
 - (2) Work through problems in social adaptation.
 - (3) Manage aggression toward others.
 - (4) Make sense of trauma in life.
- Milieu interventions
 1. Create a safe environment, including a trusting relationship with staff and no-harm contract.
 2. Educate client about recovery process.
 3. Assist client to employ stress management techniques (relaxation techniques, exercise, cognitive strategies).
 - a. Reduce general arousal.
 - b. Employ techniques when anxiety increases or with intrusive memories.
 4. Support client’s ability to gain control over memories, to:
 - a. Retrieve during therapy.
 - b. Set aside.
 5. Teach client to manage physiological symptoms of PTSD, including sleep disorders.
 6. Listen to client’s story, respecting ability to disclose and to stop remembering.
 7. Engage in activities that promote self-esteem.
 8. Assist in making plans to use leisure time.
 9. Encourage social interaction.
 10. Address spiritual issues.
 11. Develop system of social support in community.
 12. Assist to devise realistic plans for future, including therapy, occupation, and relationships (solution-focused plan).

- Community resources
 1. Twelve-step programs (useful with co-occurring substance use disorder)
 2. Community outreach program
 3. Battered Women's Shelter for Domestic (Spouse) Abuse
 - a. Abuse includes physical battery, verbal threats, intimidating gestures, forced sexual activity, isolation, and economic deprivation (Campbell, Harris, & Lee, 1995).
 - b. Women are more commonly hurt than men; 16% of pregnant women are abused (McFarlane, Parker, & Soeken, 1995).
 - c. Models of explanation
 - (1) Perpetrator psychopathology, including substance abuse
 - (2) Family violence with generational transmission, and violence within entire system (abused wives use severe violence in conflicts with children)
 - (3) Violence instead of appropriate coping by perpetrator in stressful situation
 - (4) Gender relations in which men choose violence when control over women is threatened
 - d. Phases of domestic violence (Weingourt, 1996)
 - (1) Escalation (tension building) phase—broad spectrum of coercive tactics by perpetrator; isolation of victim
 - (2) Incident (battering) phase—intense, dramatic show of force to instill fear of repetition if victim resists control
 - (3) De-escalation (honeymoon) phase—perpetrator assuages guilt, expresses remorse, and reassures that this will never happen again; victim wants to believe, desires the relationship, and looks to self for responsibility for the relationship
 - e. Assessment for abuse essential
 - f. Safety planning for family member
 - g. Discussion of options
 - h. Referral to community resources for shelter, legal and support services, and case management
 - i. Treatment of emotional responses to abuse—anxiety, depression, guilt, substance abuse, isolation
 4. National Organization for Victim Assistance (Washington, DC)—a clearinghouse for all victim assistance (<http://www.trynova.org>)

Generalized Anxiety Disorder (GAD)

- Definition—unrealistic or excessive anxiety or worry about several events or activities accompanied by symptoms of motor tension, autonomic arousal, and vigilance
- Signs and symptoms
 1. Motor tension—shaky, muscle tension, fatigability
 2. Autonomic arousal—shortness of breath, tachycardia, dry mouth, dizziness, nausea, diarrhea, dysphagia
 3. Vigilance—insomnia, feeling “keyed up”
 4. Not limited to discrete periods or discrete stimuli
 5. Often accompanied by depression or another anxiety disorder
 6. Considerable impairment in quality of life
- Differential diagnosis
 1. Physical disorders such as hyperthyroidism and mitral valve prolapse
 2. Caffeine or stimulant abuse
 3. Withdrawal from alcohol or sedatives
 4. Panic Disorder or Obsessive-Compulsive Disorder
 5. Anxiety Disorder due to a general medical condition (APA, 2000)
- Mental status variations
 1. Appearance—sweating, cold, clammy hands, exaggerated startle response, flushing, or chills
 2. Psychomotor activity—restlessness, trembling, twitching
 3. Mood—irritable, anxious, apprehensive
 4. Concentration—difficult to concentrate
 5. Insight—impaired; clients often seek treatment for physical symptoms and do not associate physical and emotional responses with anxiety.
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Insomnia
 3. Coping, ineffective
 4. Fear
 5. Powerlessness, risk for
 6. Coping, compromised family
 7. Knowledge, deficient (specify)
 8. Role performance, ineffective
 9. Sleep pattern, disturbed
- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Some evidence exists of genetic link (25% first-degree relatives).

2. Persons with GAD have increased sympathetic tone, greater response, and slower adaptation to stress.
 3. Gamma aminobutyric acid (GABA), which is a principle inhibitory CNS neurotransmitter, may have diminished activity.
 4. Decreased activity occurs in basal ganglia and limbic system, and frontal cortex; increased activity in cerebellum and some cortical structures.
 5. Possible genetic link exists between alcoholism and anxiety disorders, particularly in males.
 6. Worry is negatively reinforced by decrease in aversive somatic activation (autonomic hyperactivity) (Freeston, Dugas, & Ladouceur, 1996).
- Biochemical interventions (Stahl, 2008)
 1. SSRI (avoid fluoxetine) & SNRI antidepressants, and buspirone (BuSpar) are considered first-line agents in treating GAD.
 2. After failure of trials with the above agents, sedating antidepressants such as mirtazapine, trazodone, or tricyclic antidepressant (TCAs), or sedating antihistamines such as hydroxyzine may be useful.
 3. Benzodiazepines (BZDs) may be used as a first-line treatment or as an augmenting agent for GAD.
 - a. Reluctance in using benzodiazepine exists due to the potential for abuse and dependence, and the long-term nature of GAD. However, these agents have been useful in reducing anxiety while achieving therapeutic responses from first-line agents; augmenting the therapeutic response of other GAD medications; and in providing relief when intermittent surges of anxiety are experienced.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Psychodynamic—anxiety results from unconscious conflict or emergence of unacceptable drives (often related to dependent, sexual, or aggressive content).
 - (1) Anxiety serves as a signal that repression of drive or conflict is not working.
 - (2) If repression doesn't contain drives, then other defense mechanisms employed (conversion, displacement, regression).
 - b. Behavioral—anxiety is a conditioned response to a specific stimulus, or a learned, internal response (perhaps from imitating parental anxiety responses or reinforced by others).
 - c. Cognitive—anxiety results from faulty or dysfunctional thoughts about events. Individuals:
 - (1) Overestimate danger.
 - (2) Underestimate ability to cope.
 - 2. Psychotherapeutic interventions
 - a. Psychodynamic
 - (1) Long-term, insight-oriented therapy
 - (2) Focus on resolution of conflicts, underlying anxiety
 - b. Behavioral
 - (1) Relaxation training—Progressive Muscle Relaxation (PMR) or Autogenic Training Techniques
 - (2) Breathing techniques
 - (3) Biofeedback
 - (4) Identification of physical responses that trigger anxiety
 - (5) Training components such as problem solving and social skills (Harvey & Rapee, 1995)
 - c. Cognitive
 - (1) Identifying and challenging dysfunctional thoughts (self-statements) that trigger anxiety
 - (2) Replacing with positive coping statements
 - (3) Evaluating accurately presence of danger
 - (4) Encouraging use of log (diaries) and homework for subsequent analysis of relationship between thoughts and feeling of anxiety
 - d. Solution-focused therapy
 - Family dynamics/Family therapy
 1. Children of parents with GAD are likely to see the world as dangerous and themselves as vulnerable. Children may be:
 - a. Excessively protected.
 - b. Excessively dependent.
 2. Family member with GAD may exhibit altered role performance and require other family members to assume greater or inappropriate responsibility (Barloon, 1993).
 3. Family member with GAD may become family's "weak one," or the scapegoat.
 4. Family treatment emphasizes the following:
 - a. Knowledge of GAD and treatment
 - b. Cognitive restructuring for all family members to challenge and correct collective assumptions about danger and coping
 - c. Promotion of differentiation, especially in children

- d. Reestablishment of healthy role performance
- Group approaches
 1. Therapy—group therapy offers opportunities for feedback, realistic self-appraisal, and support when changing behavior patterns.
 - a. Insight-oriented approach to resolve unconscious conflicts
 - b. Psychoeducational approaches to increase understanding of nature of GAD and to learn coping strategies
 - c. Cognitive group therapy to challenge and correct dysfunctional cognitions
 - d. Assertiveness training
- Milieu interventions
 1. Create a safe, supportive environment.
 2. Use goal-oriented contract to focus treatment.
 3. Use diary/logs to record manifestation of anxiety (thoughts, emotions, physiological responses), the situation, course of events, efficacy of intervention.
 4. Teach role of dysfunctional cognitions (danger and inability to cope) in creating/maintaining anxiety.
 5. Teach analysis of negative self-statements and replace with rational, positive statements and receive feedback from other clients.
 6. Teach relaxation techniques, monitor practice of relaxation techniques, and assist to implement when experiencing anxiety.
 - a. Breathing techniques
 - b. Progressive muscle relaxation
 - c. Autogenic training
 7. Assist to develop alternative means of coping such as exercising, taking warm baths, or talking to staff and other clients.
 8. Promote activities that increase self-confidence through progressively more difficult challenges.
 9. Plan leisure activities to deal with “free time.”
 10. Encourage resumption of family, work, and social roles.
 11. Refer to partial hospitalization program or outpatient services.
- Community resources
 1. GAD often treated by primary care providers such as family doctors and nurse practitioners.
 - a. Advanced practice PMH nurse may provide consultation, individual, group, and family therapy.
 - b. Work collaboratively.
 2. Provide support groups or parenting classes for persons with anxiety disorders.

3. Teach how to access general community resources to enhance support base.

Panic Disorder

- Definition—recurrent, unexpected, intense periods of extreme apprehension and terror without clear precipitant
- Signs and symptoms
 1. Attack begins with rapidly increasing symptoms of fear and doom, palpitations, tachycardia, dyspnea, sweating, hyperventilation.
 2. Attack lasts 30 to 60 minutes; may include symptoms of depersonalization, derealization, paresthesia, fainting, dizziness, choking, nausea, chest pain, flushes or chills.
 - a. First attacks are often in phobogenic situation.
 - b. Subsequent attacks are spontaneous (uncued, unexpected).
 3. Clients usually try to seek help, focusing on cardiac or respiratory symptoms. Clients often:
 - a. Believe they are dying.
 - b. Are seen in emergency room.
 - c. Fear going “crazy.”
 4. Panic response may be accompanied by agoraphobia, fearing panic attacks will occur in setting without help.
 5. Between episodes client exhibits anticipatory anxiety, vigilant for onset of another attack.
 6. Attacks range from mild (one attack per month or limited number of symptoms), to severe (eight panic attacks per month).
 7. Attacks are often accompanied by depression.
- Differential diagnosis
 1. Note whether Panic Disorder is or is not accompanied by agoraphobia.
 2. Physical disorders such as mitral valve prolapse, hyperthyroidism, hypoglycemia, or pheochromocytoma
 3. Withdrawal from psychoactive substances
 4. Caffeine or stimulant abuse
 5. Alcohol abuse
 6. GAD, Posttraumatic Stress Disorder (PTSD)
 7. Somatization Disorder
- Mental status variations
 1. Appearance—anxious, perspiring, choking, difficulty breathing
 2. Behavior—trembling, hyperventilation
 3. Mood—may be depressed (including suicidal)
 4. Speech—stammering, difficulty speaking
 5. Thought—ruminating, preoccupation with fear of death or doom
 6. Memory—impaired

7. Concentration—decreased, confusion
 8. Orientation—confused
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Powerlessness
 3. Fear
 4. Hopelessness
 5. Self-Esteem, chronic low
 6. Role Performance, ineffective
 7. Knowledge, deficient (specify)
 8. Violence, (actual/) risk for self-directed
 9. Social Isolation
 10. Coping, ineffective
 - Genetic/Biologic origins (APA, 2009; Sadock & Sadock, 2007)
 1. First-degree relatives of clients with Panic Disorder are 4-to-8 times more likely to experience a panic attack and with early onset (before age 20) the rate increases to 17.
 2. A genetic link has been implicated with a higher concordance rate among monozygotic twins; although no specific chromosomal location has been identified.
 3. Abnormal regulation of the noradrenergic systems in the brain is involved with panic attacks and Panic Disorder.
 4. Neurotransmitters involved in Panic Disorder include: serotonin, norepinephrine, and GABA.
 5. Brain imaging studies have implicated pathological involvement in several regions of the brain (temporal lobe, hippocampus, and amygdala), and cerebral vasoconstriction—possible relationship of CNS lesions with abnormal signal activity or asymmetric right temporal lobe atrophy, abnormal activity in hippocampus and right frontal cortex.
 6. An association between mitral valve prolapse and panic has been dismissed as a result of existing evidence.
 - Biochemical interventions (APA, 2009; Stahl, 2008)
 1. First-line treatment agents are antidepressants (SSRIs & SRNIs), and benzodiazepines. Although equally effective, TCAs are not a first-line option, due to significant cardiac and anticholinergic side effects.
 2. Other psychopharmacologic treatments that may be helpful (as second-line &/or augmenting agents) include sedating antidepressants (mirtazapine, trazodone) and atypical antipsychotics.
 3. While pharmacologic interventions may be successful in eliminating primary symptoms, combined pharmacologic and psychotherapeutic methods may be of greatest benefit for those diagnosed with a Panic Disorder.
 - Intrapersonal origins/Psychotherapeutic interventions (APA, 2009; Sadock & Sadock, 2008)
 1. Origins
 - a. Psychodynamic—panic occurs when defenses against anxiety (repression, displacement, and avoidance) are ineffective.
 - (1) Symbolic nature is often related to abandonment and separation anxiety.
 - (2) Traumatic separations in childhood may increase vulnerability by producing autonomic nervous system stimulation (Shear, 1996).
 - (3) Interpersonal problems in assertiveness and sociability may contribute (Battaglia, 1995).
 - b. Behavioral
 - (1) Parental behavior modeling or classical conditioning
 - (2) Demonstration of cognitions of exaggerated vulnerability, inability to cope, and general negative views of self; catastrophic interpretations of anxiety symptoms that provide more arousal and symptoms
 - (3) Stressful life events—persons with Panic Disorder report greater frequency of life events that pose danger and threat.
 - c. Cognitive
 - (1) Worry about recurring panic attacks
 - (2) False beliefs and cognitive distortions
 2. Psychotherapeutic interventions
 - a. Psychodynamic—insight-oriented therapy to focus on origin of anxiety, symbolism, secondary gain, and resolution of early conflicts
 - b. Behavioral
 - (1) Psychoeducation regarding origin and maintenance of panic attacks
 - (2) Desensitization—real or imagined phobic situation
 - (3) Cognitive restructuring to decrease self-statements that promote anxiety and to increase positive, coping statements, coupled with exposure to avoided situations or to somatic sensations of anxiety (Otto & Whittal, 1995)
 - (4) Reinforcement of mastery
 - (5) Relaxation techniques—breathing, PMR, and imagery
 - (6) Continued vulnerability and episodic exacerbations after successful symptom removal

- c. Cognitive and cognitive behavior therapies have been successful in treating panic symptoms.
 - (1) Cognitive therapy—focus on false beliefs and information about one's panic attacks
 - (2) Cognitive behavioral therapy (CBT)—seeks to identify and refute mistaken beliefs and about physical symptoms and their consequences.
 - (a) Panic-focused CBT—frequently incorporates the following treatment components: psychoeducation, self-monitoring, cognitive restructuring, exposure strategies (to reduce fear cues), behavior modification (targeting anxiety reduction), and relapse prevention (APA, 2009).
 - Family dynamics/Family therapy
 1. Clients with agoraphobia may always require family members to stay close by, resulting in:
 - a. Marital discord
 - b. Dependence upon children
 2. Altered role performance (work, family, social situations) increases responsibility of other family members.
Therapeutic approaches include:
 - a. Family education about origin, nature, and treatment of disorder
 - b. Family therapy to restructure communication and roles to support change
 3. Family is work essential due to chronic nature of Panic Disorder (Pollak & Smoller, 1995; Shear, 1995).
 - Group approaches
 1. Therapy to improve coping and/or social support
 - a. Insight-oriented therapy
 - b. Cognitive therapy
 - c. Support groups where stable, intimate relationships can buffer anxiety
 2. Self-help—community self-help groups encourage acceptance and improved life functioning when residual symptoms persist.
 - Milieu interventions
 1. Provide safe, supportive environment.
 2. Establish goal-oriented treatment contract.
 3. Assist client to employ relaxation and cognitive techniques when panic attack first begins.
 4. Label experience as a “panic attack” and anxiety.
 5. Promote socialization with peers.
 6. Engage in activities that promote self-esteem.
 - 7. Assist client's use of cognitive strategies to decrease anticipatory anxiety associated with possible future panic attacks.
 - 8. Reinforce learning from individual, group, and family sessions.
 - 9. Refer to outpatient therapy.
 - Community resources
 1. Outpatient therapy
 2. Support groups
- ### Obsessive-Compulsive Disorder (OCD)
- Definition—recurrent persistent obsessions and/or compulsions that interfere with functional abilities, occupation, social activities, and interpersonal activities
 - Signs and symptoms
 1. Obsession—unwanted, repeated, and uncontrollable thoughts, images, or impulses
 - a. Inability to break thought cycle through distraction in conversation or other tasks
 - b. Common themes of losing things, blasphemy, fears of disease, contamination, sexual behavior, or aggression
 - c. Increased anxiety if resisted
 2. Compulsions—repeated, unwanted patterns of behavior that are often responses to obsessions
 - a. Excessive cleaning, washing, checking, counting, or repeating
 - b. Increased anxiety and dread if compulsions are resisted
 3. Intervention usually not sought until basic needs are not met or when physical and/or emotional exhaustion occurs of either client or significant other.
 - a. Most clients present with both obsessions and compulsions.
 - b. Individuals often delay treatment for several years.
 - Differential diagnosis
 1. Obsessive-Compulsive Personality Disorder
 2. Major depression with obsessive thoughts
 3. Hypochondriasis
 4. Tourette's Syndrome
 5. Temporal lobe epilepsy
 6. Schizophrenia
 - Mental status variations
 1. Appearance—special dress pattern, abraded hands
 2. Behavior—ordering and arranging environment of examiner, touching, licking, spitting, repeating rituals

3. Mood—depressed, anxious
 4. Thought—intrusive sounds, words, music, sexual images or impulses; thoughts of doom, concerns with germs, dirt, etc.
 5. Insight—understands that obsessions and compulsions are irrational
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Powerlessness
 3. Powerlessness, risk for
 4. Role Performance, ineffective
 5. Coping, compromised family
 6. Loneliness, risk for
 7. Social Isolation
 8. Coping, ineffective
 - Genetic/Biologic origins (APA, 2007; Sadock & Sadock, 2007)
 1. Serotonin is implicated by observations that OCD symptoms decrease with selective serotonin reuptake inhibitors (SSRIs) and increase with serotonin antagonists.
 2. Some evidence suggests increased prevalence of OCD in first-degree relatives with the disorder; and a genetic linkage on chromosome 9p24.
 - Biochemical interventions (APA, 2007; Stahl, 2008)
 1. SSRIs are the first-line treatment agent for OCD.
 2. TCAs, specifically clomipramine & SNRIs may be considered with multiple failed SSRI response.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Psychodynamic—unacceptable thoughts and impulses are isolated, but threaten to break through into consciousness so that compulsive acts are performed to undo the possible consequences, should the unacceptable become conscious.
 - (1) Symptoms may arise during anal stage since much OCD involves cleanliness or aggressive preoccupation.
 - (2) Note both ambivalence and magical thinking.
 - b. Behavioral
 - (1) Obsessions act as conditioned stimulus to anxiety.
 - (2) Compulsions arise when a behavior reduces the anxiety associated with the obsessions.
 2. Psychotherapeutic interventions (APA, 2007)
 - a. Insight-oriented, psychodynamic therapy has little evidence to support its use in OCD treatment.
 - b. Behavioral and cognitive behavioral therapies have greatest effectiveness.
 - (1) Combine exposure with response delay (ERD) with pharmacotherapy.
 - (2) Employ gradual extinction of rituals by exposure to anxiety-producing situations until habituation occurs with strict abstinence from performing rituals (Abramowitz, 1997).
 - (3) Reduce obsessive thoughts by thought-stopping (such as snapping a rubber band on the wrist when obsessive thought appears).
 - (4) Reduce obsessive thoughts through semantic satiation (write a few words of the obsession and then rewrite or say aloud many times until fear is no longer evoked).
 - Family dynamics/Family therapy
 1. Family members may constantly reassure the client, which reinforces the obsession.
 2. Family may assist patient to avoid situations that trigger OCD, which worsens the fear cycle.
 3. Therapeutic approaches include:
 - a. Emphasize remaining neutral (not reinforcement through reassurance).
 - b. Avoid reasoning with client (increases anxiety).
 - c. Avoid ridicule.
 - d. Assist with response delay.
 - e. Design with family, ways to use time freed up by successful treatment of symptoms (Shear, 1995).
 - Group approaches
 1. Supportive group therapy
 2. Self-help groups in community are often affiliates of Obsessive Compulsive Foundation Inc.
 - Milieu interventions (Keltner et al., 2007)
 1. Incorporate relaxation exercises, recreational or social skills development, and successful problem-solving opportunities.
 2. Promote stress management (provide education and practice exercises).
 3. Conduct CBT, communication, or assertiveness training groups.
 4. Always focus care upon the needs of the patient/client.
 5. Promote activities that reduce anxiety such as physical activity, and vary sufficiently in order not to reinforce or promote developing a new ritual.

- Community resources—OCD Foundation (<http://www.ocdfoundation.org>)

■ SOMATOFORM DISORDERS

- Definition—“Soma” is the Greek term for body. Somatoform disorders are characterized by bodily signs and symptoms for which there is no discernable physiological cause.

Conversion Disorder

- Definition—loss or change in physical functioning not explained by any known pathophysiological disorder
- Signs and symptoms
 1. Temporally related to psychological factors
 2. Fulfills a need or deals with a conflict
 3. Not under voluntary control
 4. Examples—paralysis, blindness, mutism, paresthesias, pseudocyesis, vomiting
- Differential diagnosis
 1. Rule out medical disorders, especially neurologic diseases.
 2. Schizophrenia
 3. Depression
 4. Somatization Disorder
 5. Hypochondriasis
- Mental status variations
 1. Mood—la belle indifference, inappropriate for physical symptoms
 2. Perceptual disturbances—may be blind, but does not bump into objects; stocking or glove anesthesia
 3. Insight—unaware of relationship between psychological conflict and appearance of symptoms
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Knowledge, deficient (specify)
 3. Family Processes, dysfunctional
 4. Coping, ineffective
 5. Communication, impaired verbal
 6. Possibly—Sensory Perception, disturbed
- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. CNS arousal disturbance may diminish awareness of bodily sensations.
 2. Subtle impairments in verbal communication, memory, alteration, suggestibility noted in neuropsychological testing.
- Biochemical interventions—none indicated
- Intrapersonal origins/Psychotherapeutic interventions (Sadock & Sadock, 2007)
 1. Origins
 - a. Conversion of anxiety into physical symptom
 - (1) Conflict is usually sexual or aggressive.
 - (2) Symptom allows both disguising impulse and partially expressing it.
 - (3) Symptoms have symbolic relationship to conflict.
 - (4) Symptoms communicate special needs.
 - b. Symptoms reinforced by family or society, plus secondary gain.
 - c. Symptoms replace verbal language.
 2. Psychotherapeutic interventions
 - a. Psychodynamic insight-oriented psychotherapy is used to explore conflicts.
 - b. Focus therapy on stress and coping.
 - c. Employ brief, solution-focused psychotherapy.
 - d. Hypnosis, anxiolytics, and relaxation exercises may be useful.
 - e. Telling patient that their symptoms are imaginary can make them worse.
- Family dynamics/Family therapy
 1. Family rules negate direct expression of conflict.
 2. Illness may be family-accepted means to avoid taking action.
 3. Family may encourage secondary gain.
 4. Employ therapy to improve verbal communication, conflict resolution, and restructuring of family interactional patterns.
- Group approaches
 1. Emphasis on coping with stress
 2. Assertiveness training
- Milieu interventions
 1. Minimize sick role behavior.
 2. Encourage verbal expression of needs and conflicts.
 3. Assist staff and patients to reinforce verbalization and functional behavior, and ignore impairments to reduce secondary gain.
 4. Help client understand relationships between conflict, symptoms, and gain.
 5. Teach new coping skills to decrease anxiety.

Hypochondriasis

- Definition—preoccupation with, and unrealistic interpretation of, physical symptoms and sensations as a serious disease lasting 6 months or more

- Signs and symptoms
 1. Preoccupation with health state in spite of medical reassurance
 2. Not of delusional quality (can admit possibility of exaggeration)
 3. May be organ-system related or related to a particular bodily function
 4. Experience of anguish over physical state
 5. Tendency to see multiple practitioners
- Differential diagnoses
 1. Medical disorders with multiple organ system involvement (AIDS, endocrine disorders, MS, Systemic lupus erythematosus (SLE), some neoplasms)
 2. Generalized Anxiety Disorder
 3. Panic Disorder
 4. Conversion Disorder and Somatization Disorder
- Mental status variations
 1. Appearance—apprehensive, anguished
 2. Mood—depressed, anxious
 3. Thought—preoccupied with seriousness of physical symptoms
 4. Insight—impaired
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Fear
 3. Role Performance, ineffective
 4. Coping, ineffective
 5. Social Interaction, impaired
- Genetic/Biologic origins
 1. Some evidence of increased prevalence in twins
 2. Physiologically lower threshold tolerance for discomfort
- Biochemical interventions (Sadock & Sadock, 2007)
 1. Medication only for coexistent anxiety or depression
 2. Avoid reinforcing through medication
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Repression of aggressive and hostile impulses with displacement into somatic complaints
 - (1) Anger originates in past losses.
 - (2) Displacement solicits help (which later is rejected).
 - b. Cognitive schema focusing on bodily sensations—tendency to amplify and misinterpret symptoms of emotional arousal and to think in concrete rather than emotional terms
 - c. Sick role as respite from responsibilities of life
 - d. May begin with physical illnesses in childhood or following a severe medical problem as an adult
 - e. Atonement for real or imagined wrong doings (Ford, Katon, & Lipkin, 1993)
- 2. Psychotherapeutic interventions
 - a. Usually resistant to psychiatric treatment unless it occurs in medical setting.
 - b. Focus on stress reduction and coping.
 - c. Avoid reinforcements of sick role as a solution to life problems.
- Family dynamics/Family therapy
 1. Family may reinforce sick role behavior.
 2. Family conflict occurs over client distress and medical treatment.
 3. Family roles may be altered.
 4. Family may have low ability to deal directly with stressful situations or obligations.
- Group approaches
 1. Social support
 2. Social interaction
- Milieu interventions
 1. Clients often treated on medical unit.
 2. Teach rational interpretation of bodily sensations.
 3. Assist to identify relationship between physical symptoms and stress.
 4. Teach techniques to cope with anxiety including talking, exercise, and relaxation techniques.
 5. Meet physical needs, but avoid reinforcing.
 6. Encourage social interaction and constructive use of leisure time.
 7. Teach problem-solving techniques for personal difficulties.
 8. Refer to outpatient therapy.

Somatization Disorder

- Definition—a chronic relapsing syndrome of multiple somatic symptoms for which there is no medical explanation
- Signs and symptoms
 1. Symptoms include gastrointestinal, pain, cardiopulmonary, conversion, sexual, and female reproductive.
 2. History of several years' duration, beginning before age 30.

3. High utilization of health services—physician visits, excessive surgery, psychiatric services, multiple medications
 4. Association with changes in life style due to illness
 5. Typically, new symptoms arise during times of emotional distress.
- Differential diagnosis
 1. Rule out medical disorders.
 2. Schizophrenia
 3. Depression
 4. Substance use
 5. Other somatoform disorders
 - Mental status variations
 1. Insight—unawareness of relationship between psychological conflict and appearance of symptoms
 - Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Coping, readiness for enhanced family
 3. Coping, ineffective
 4. Possibly—Sensory Perception, disturbed
 - Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Possible neuropsychological basis characterized by attention and cognitive impairments
 2. Brain imaging studies suggest decreased metabolism in frontal lobes and nondominant cerebral hemisphere.
 3. An increased risk (10–20%) for Somatization Disorder among first-degree relatives
 - Biochemical interventions—none indicated
 - Intrapersonal origins/Psychotherapeutic interventions (Sadock & Sadock, 2007)
 1. Origins—The cause of Somatization Disorder is not known. From a behavioral perspective, the disorder is thought to be learned from a parent, or result from unstable or physically abusive homes.
 2. Psychotherapeutic interventions—include consistency in the therapeutic alliance, regularly scheduled appointments, psychotherapy to enhance coping, and crisis intervention.
 - Family dynamics/Family therapy
 1. Children taught to somatize, rather than to deal with issues verbally.
 2. Readjust roles to accommodate symptoms and illness behavior.
 3. Clients use somatization as means to mediate relationships.
 - 4. Female clients often choose alcoholics or men with antisocial personality disorders as partners.
 - 5. Focus therapy on clear, congruent communication, role restructuring, and increasing self-esteem of family members.
 - Group approaches
 1. Time-limited group therapy with emphasis on improving socialization skills and ability to cope
 2. Group therapy with emphasis on how to cope with multiple medical problems
 - Milieu interventions
 1. Monitor and assess client's physical status.
 2. Attend to physical needs in supportive, but nonreinforcing way.
 3. Reinforce verbal expression of needs and feelings.
 4. Assist other staff and patients to understand that physical complaints are experienced as “real” (Ford et al., 1993).
 5. Help client realize connection between psychological stress and onset of somatic symptoms.
 6. Teach new coping skills including use of social relationships and other techniques to decrease anxiety.
 7. Maintain consistent approach by all personnel.
 8. Support self-care abilities and appropriate role performance, including occupational.

Pain Disorder

- Definition—severe prolonged pain where there is no organic basis for the pain and/or the intensity
- Signs and symptoms
 1. Various manifestations—low back pain, headache, or chronic pelvic pain
 2. Preoccupation with pain
 3. Often a follow-up to physical trauma
 4. Analgesics usually not helpful
 5. Frequent visits to physicians for relief
 6. Client refusal to consider psychological origins
 7. Depression usually present
 8. Difficulties in diagnosing because of diverse definitions of pain
- Differential diagnosis
 1. Organic disorders
 2. Depression
 3. Hypochondriasis
 4. Conversion Disorder

- Mental status variations
 1. Appearance—antalgic position, diaphoretic, tense
 2. Behavior—restless
 3. Mood—depressed
 4. Thought—preoccupied with pain
 5. Concentration—impaired
 6. Insight—unaware of psychological factors
 - Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Hopelessness
 3. Role Performance, ineffective
 4. Knowledge, deficient (specify)
 5. Pain, chronic
 6. Coping, ineffective
 7. Social Interaction, impaired
 8. Mobility, impaired physical
 - Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Serotonin is implicated in the modulation of pain.
 2. Endorphin deficiency
 - Biochemical interventions (Sadock & Sadock, 2007)
 1. Analgesics and antianxiety agents are ineffective; possibility of addiction.
 2. Antidepressants (TCAs & SSRIs—e.g., amitriptyline, imipramine, doxepin; anaftranil, sertraline)
 3. Amphetamine, with analgesic effects, might be a useful augmenting agent with SSRIs—use this with caution and monitor dosages carefully.
 4. Some evidence suggests SNRIs as useful in treating Pain Disorder (Stahl, 2008)
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Punishment for guilt
 - b. Pain behavior reinforcement by attentiveness or avoidance of unwanted responsibilities
 - c. Control of others
 - d. Stabilization of marriage/family relationships
 2. Psychotherapeutic interventions
 - a. Rehabilitating client to usual social/occupational roles
 - b. Discussion of psychological causes and secondary gain common to all pain
 - c. Cognitive restructuring
 - d. Relaxation techniques
 - e. Supportive psychotherapy
 - f. Biofeedback
 - g. Transcutaneous nerve stimulation
 - h. Exercise programs/physical therapy
 - i. Acupuncture
 - j. Pain control program
 - Family dynamics/Family therapy
 1. Family as a whole may be stabilized by pain experience.
 2. Teach family members how to respond to client's pain.
 3. Discuss secondary gain and power in sick role behavior.
 4. Restructure roles, communication patterns, and responsibilities.
 5. Deal with issues of individual and family self-esteem.
 - Group approaches
 1. Pain support groups
 2. Exercise groups
 3. Psychoeducational (pain management) groups
 4. Assertiveness training
 - Milieu intervention
 1. Help client apply relaxation and cognitive techniques for pain relief and tension reduction.
 2. Encourage social interaction and participation in activities.
 3. Teach about relationship between stress and pain, and effects of relaxation.
 4. Encourage verbal, rather than somatic, communications.
 5. Avoid reinforcing pain behaviors.
 6. Encourage self-care in ADLs.
 7. Help client to find ways of assisting others.
 8. Design plan for use of leisure.
 9. Refer to pain control program—rehabilitation, pain management, and vocational training.
 - Community resources—pain management clinics
- FACTITIOUS DISORDERS**
- Definition—physical or psychological symptoms intentionally produced or feigned (APA, 2000)
 - Signs and symptoms
 1. Desire for role of patient
 2. Compulsive quality
 3. Traveling from hospital to hospital, seeking admission for different illnesses under different names
 4. Extremely convincing in presentation of physical or psychological symptoms
 - a. With physical presentation of symptoms, may be called “Munchausen” syndrome.

- b. Another person (child, parent, ward) is presented as the ill one by a caregiver—known as fictitious disorder by proxy (Sadock & Sadock, 2007).
- Differential diagnosis
 1. True physical disorder
 2. Somatoform Disorder
 3. Personality disorders
 4. Schizophrenia
 5. Malingering
 6. Substance abuse
 7. Ganser's syndrome—Persons with this disorder respond to questions with astonishingly incorrect answers (e.g., 2 plus 2 equals “13”). Most commonly associated with prison inmates, may be a variant of malingering.
- Mental status variations
 1. Variance depends upon symptoms produced
 2. Thoughts—conflicts and discrepancies in content
 3. Information not corroborated by significant other
- Nursing diagnoses (NANDA, 2009)
 1. Communication, impaired
 2. Coping, ineffective
 3. Role Performance, ineffective
- Genetic/Biologic origins—none identified
- Biochemical interventions
 1. SSRIs may be of limited use in decreasing associated impulsive behavior when present.
 2. All medications should be monitored carefully, because of potential for abuse.
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Discovery of caretakers or hospital as caring with previous illnesses and seeking continuance
 - b. History of parental deprivation
 - c. Seeking punishment through surgery or painful treatment
 - d. Identifying with relatives with genuine illnesses
 - e. Defenses employed—repression, identification, identification with aggressor, and symbolization
 2. Psychotherapeutic intervention
 - a. Early recognition and referral for Fictitious Disorder is important in order to avoid unnecessary medical treatment.

- b. Avoid setting client up as adversary.
 - c. No specific therapy has been found to be effective.
- Family dynamics/Family therapy
 1. Provide psychoeducation about disorder.
 2. Assist family not to enable client, but to support therapy.
- Group approaches—none
- Milieu interventions
 1. Create a safe environment.
 2. Assist caregivers to understand nature of disorder.
 3. Avoid reinforcing gain from illness.
 4. Assist to find means to meet needs for nurturance.

■ DISSOCIATIVE DISORDERS

- Definition—Dissociative disorders are characterized by disturbances in the integrated functions of consciousness, identity, memory, and/or perception. The onset of these disorders may be sudden or gradual, and the duration transient or chronic (APA, 2000; Sadock & Sadock, 2007).

Dissociative Amnesia

- Definition—dissociative disorder in which person is suddenly unable to recall memories of important personal events that were stressful or traumatic in nature (Keltner et al., 2007)
- Signs and symptoms
 1. Not ordinary forgetfulness
 2. Client can recall other information, learn, and function coherently.
 3. Most commonly occurs during wars and natural disasters.
 4. Amnesia types
 - a. Localized—short time period
 - b. Generalized—for whole lifetime of experiences
 - c. Selective—amnesia for some, but not all events
 - d. Continuous—forgets successive events as they occur, but alert at the time
 5. Primary and secondary gain
 6. Terminates abruptly
- Differential diagnosis
 1. Medical conditions—delirium, dementia, neoplasms, infections, epilepsy, postconcussion
 2. Wernicke-Korsakoff syndrome
 3. ECT

- 4. Substance-related amnesia (LSD, steroids, benzodiazepines, barbiturates)
- 5. Transient global amnesia usually caused by TIAs
- 6. Dissociative Disorders (DID)
- 7. Acute or Posttraumatic Stress Disorder
- Mental status variations
 1. Mood—often depressed
 2. Memory—impaired
 3. Orientation—variable
 4. Insight—impaired
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety
 2. Coping, ineffective
 3. Powerlessness
- Genetic/Biologic origins—no definitive explanations
- Biochemical interventions—none indicated
- Intrapersonal origins/Psychotherapeutic interventions (Sadock & Sadock, 2007)
 1. Origins
 - a. Psychoanalytic—expressed or fantasized forbidden wish
 - (1) Usually sexual or aggressive
 - (2) Cannot deal with, so uses repression and denial
 - b. Emotional trauma
 - (1) Strong emotional response
 - (2) Psychological conflict
 2. Psychotherapeutic intervention
 - a. Psychotherapy to deal with emotional responses to trauma
 - b. Psychotherapy aimed at resolution of unacceptable impulses or behavior
 - c. Psychotherapy to correct cognitive distortions (cognitive therapy)
 - d. Hypnosis to aid in controlled recall of dissociated memories
 - e. Stress management
- Family dynamics/Family therapy
 1. If natural disaster affected all family members, reconstruct collective memory.
 2. All family members affected by client's distress.
 - a. Family education to understand condition of individual client
 - b. Family therapy to help family members make sense of trauma and/or impulse expression
- Group approaches
 1. If traumatic event, may benefit from support group of survivors.
 2. Group psychotherapy usually not indicated.

- Milieu intervention
 1. Treat primarily on outpatient basis or in general hospital.
 2. Create safe environment.
 3. Mutually develop contract for care.
 4. Provide opportunities to talk about traumatic event and its meaning.
 5. Teach coping strategies to deal with anxiety actively (rather than by dissociation).
 6. Assist in devising realistic future plans.

Dissociative Fugue

- Definition—dissociative disorder characterized by physically traveling away from one's usual environment, the inability to recall important aspects of identity or the assumption of a new identity (Keltner et al., 2007)
- Signs and symptoms (APA, 2000; Keltner et al.)
 1. Old and new identities do not alternate.
 2. New identity may be partial or complete.
 3. Client does not appear to be wandering or confused.
 4. Dissociation is usually accompanied by amnesia.
 5. Dissociation lasts hours to days; rarely months.
- Differential diagnosis
 1. Organic mental disorders such as temporal lobe epilepsy
 2. Psychogenic amnesia
 3. Malingering
- Mental status variations
 1. Memory—amnesia for identity and important aspects of life
 2. Insight—unaware of memory impairment
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety
 2. Coping, ineffective
 3. Identity, disturbed personal
- Genetic/Biologic origins
 1. Origins—no definitive explanation
 2. Heavy alcohol abuse may predispose, but may be primarily psychological effect.
- Biochemical interventions—amobarbital or thio-pental for interviews to uncover identity
- Intrapersonal origins/Psychotherapeutic interventions (Sadock & Sadock, 2007)
 1. Origins

- a. Response of withdrawal (by dissociation) to psychological stressors—war, family, marital, and occupational
 - 2. Psychotherapeutic interventions
 - a. Hypnosis to uncover memories/identity
 - b. Psychotherapy
 - (a) Uncover identity and memories.
 - (b) Deal with sources of stress more effectively.
 - c. Couples therapy if marital situation a source of stress
 - d. Stress management
 - Family dynamics/Family Therapy
 - 1. Family of origin or current family setting may be source of conflict.
 - a. Family rules may prohibit overt expression of distress.
 - b. All family members affected by behavior and loss (for some period of time) of family member.
 - 2. Provide psychoeducation to understand client's condition.
 - 3. If family dynamics are source of stress, family therapy can be used to improve communication, solve problems, and deal with crisis.
 - Group approaches—if trauma victim (war, natural disaster), support groups
 - Milieu interventions
 - 1. Treat primarily on outpatient basis.
 - 2. Create safe environment.
 - 3. Help to reconstruct memories and identity.
 - 4. Assist to create meaning out of fugue episode.
 - 5. Teach coping skills to deal with anxiety.
 - 6. Refer for therapy or other continued assistance in managing stressors.
 - Community resources—support groups for managing specific stressors
- Differential diagnosis
 - 1. Organic disorder—neurologic, metabolic
 - 2. Schizophrenia
 - 3. Anxiety disorders
 - 4. Substance-Related Disorder
 - 5. Another dissociative disorder
 - Mental status variations
 - 1. Mood—anxious, depressed
 - 2. Perception—feelings of detachment from self and/or environment, feeling of physical change in body
 - 3. Insight—impaired
 - Nursing diagnoses (NANDA, 2009)
 - 1. Anxiety
 - 2. Coping, ineffective
 - 3. Identity, disturbed personal
 - 4. Sensory Perception, disturbed
 - Genetic/Biologic origins (Sadock & Sadock, 2007)
 - 1. Organic disease—migraine, neoplasms, epilepsy, and metabolic disorders
 - 2. Sensory deprivation
 - 3. Drug-induced psychoactive drugs, especially hallucinogens, cannabis
 - Biochemical interventions (Sadock & Sadock, 2007)
 - 1. SSRIs (fluoxetine, fluvoxamine) may be helpful.
 - 2. Treatment of underlying organic disorder
 - Intrapersonal origins/Psychotherapeutic interventions
 - 1. Origins
 - a. Internal conflict
 - b. Disturbance in ego functioning
 - c. Severe emotional distress
 - 2. Psychotherapeutic interventions (Sadock & Sadock, 2007)
 - a. Insight-oriented psychotherapy (limited success with most psychotherapeutic interventions)
 - b. Stress management
 - c. Relaxation training and physical exercise
 - Family dynamics/Family therapy
 - 1. Family may exhibit poor coping mechanisms to deal with internal family conflict or outside stressors.
 - a. Family myths of strength may prohibit admission of family pain.
 - b. Family rules may prohibit verbal expression of feelings.
 - 2. Provide psychoeducation about disorder.

Depersonalization Disorder

- Definition—dissociative disorder in which client experiences recurrent alterations in perception of self
- Signs and symptoms
 - 1. Client describes self as “detached from reality,” “dreamlike,” or detached from body.
 - 2. Self feels strange, unreal.
 - 3. Client is able to function during the experience.
 - 4. Client is distressed about depersonalization experience.
 - 5. Depersonalization may be episodic or chronic.

- 3. Family therapy is appropriate if family dynamics are stressors or influence coping with anxiety.
- Group approaches
 1. Support groups for specific stressors (parenting, occupational)
 2. Stress management group
- Milieu interventions (rarely treated inpatient)
 1. Create safe environment.
 2. Educate about disorder.
 3. Assist client to examine relationship between anxiety and depersonalization.
 4. Teach stress management and problem-solving techniques.
 5. Plan for use of leisure time.

Dissociative Identity Disorder (DID) or Multiple Personality Disorder (MPD)

- Definition—dissociative disorder in which person has two or more separate, distinct personalities (alters), each with relatively enduring pattern of perceiving, relating to, and thinking about, self and environment
- Signs and symptoms
 1. At least two personalities dominant, recurrent (APA, 2000).
 2. Core personality usually unaware of alters when first seeks treatment.
 3. Personalities may represent different ages, genders, races; most have at least one child alter.
 4. Personalities present with different influence and power over one another.
 5. Personalities communicate with one another through executive alter or through inner dialogue.
 6. Amnesic symptoms for childhood experiences, or “lose time” when alternate personality present for period of time.
 7. Sleep disturbances, self-mutilation, substance abuse, headaches presented.
 8. Physiological responses (including allergies) vary in different alters.
 9. Issue of therapists “creating” memories and alters presented (North, Ryall, Ricci, & Wetzel, 1993).
 - a. Verbal/nonverbal behavior of therapist may create false memories in suggestible client.
 - b. Public as well as some health care providers doubt validity of the diagnosis.
- Differential diagnosis
 1. Neurologic or seizure disorders
 2. Psychogenic fugues
 3. Psychogenic amnesia
 4. Schizophrenia
 5. Anxiety disorders
 6. Cognitive disorders
 7. Other dissociative disorder
 8. Borderline Personality Disorder
- Mental status variations
 1. Appearances—dress style, grooming, mannerisms may vary from session to session; marked changes in nonverbal behavior, handedness within sessions; blinking, eye roll, twitches with switching
 2. Speech—marked changes within brief period of time (style, accent, vocabulary)
 3. Mood—depressed, anxious; switches rapidly within sessions
 4. Thought processes—loose association with rapid switches
 5. Perceptual—hallucinations (auditory/visual); voices usually experienced within patient’s head
 6. Memory—some long-term memory deficits, blackouts or loss of time
 7. Judgment—erratic, depending upon age, personality
 8. Insight—initially not aware of alter personalities
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety
 2. Coping, ineffective
 3. Identity, disturbed personal
 4. Self-mutilation, high risk for
 5. Violence, high risk for, directed at self and/or others
- Genetic/Biologic origins
 1. Possible psychobiologic ability to dissociate or to be hypnotized
 2. Self-mutilation, possibly biologically entrained
 3. Extreme stress has long term effect on memory through release of neuropeptides/neurotransmitters that interfere with laying down of memory (Bremner, Krystal, Charney, & Southwick, 1996).
- Biochemical interventions—antidepressants (SSRIs, TCAs, MAOIs), clonidine, anticonvulsants, and benzodiazepines have been reported as effective in reducing intrusive symptoms, hyperarousal, and anxiety symptoms associated with DID (Sadock & Sadock, 2007).

- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Prolonged and severe physical, emotional, or sexual abuse as a child
 - b. Dissociation helps child cope by creating new personalities to experience and deal with various aspects of time periods of the trauma.
 - c. Alters serve various purposes (protection, expression of anger, organizer).
 2. Psychotherapeutic interventions
 - a. Individual therapy stages (Putnam, 1989)
 - (1) Making diagnosis
 - (2) Initial interventions
 - (a) Meet personalities.
 - (b) Take history.
 - (c) Develop working relationship with system.
 - (3) Initial stabilization
 - (a) Contract with alters.
 - (b) Contract with entire system.
 - (c) Stabilize uncontrollable behaviors.
 - (4) Acceptance of diagnosis
 - (a) Some alters do not accept presence of others.
 - (b) Issue throughout treatment
 - (5) Development of communication and cooperation
 - (a) Encourage internal communication.
 - (b) Establish cooperation toward common goals.
 - (c) Encourage development of internal decision-making process.
 - (d) Facilitate switching.
 - (6) Metabolism of the trauma
 - (a) Becomes major treatment task.
 - (b) Uncover trauma.
 - (c) Facilitate abreaction.
 - (7) Resolution and integration
 - (a) Some elect integration.
 - (b) Others remain multiples.
 - (8) Development of postresolution coping skills
 - (a) Learn new coping skills.
 - (b) Take on tasks previously split.
 - (c) Deal with reactive depression.
 - b. Preparation of patient for therapy re: memory (Kluft, 1996)
 - (1) Clarify that what emerges in therapy is “food for thought” not grounds for taking action.
 - (2) Recovery presented as a healing process, not detective work.
- (3) Recovery can occur even if the truth of the past remains obscure.
- (4) Memory retrieval techniques may compromise client’s credibility in legal proceedings.
- (5) Determination of what the client will come to believe about his/her past must be made by the client, not the therapist.
- (6) Techniques of memory retrieval
 - (a) Clinical interviews
 - (b) Hypnosis
 - (c) Drug-facilitated interviews
 - (d) Dream interpretation
 - (e) Reinstatement of contextual cues
 - (f) Keeping a journal
- (7) Distortions more likely if client subject to suggestion through leading questions, interviewer bias, reinforcement of subject/material, or focus on material difficult to verify.
 - c. Hypnosis uniformly endorsed (Putnam & Lowenstein, 1993).
- Family dynamics/Family therapy
 1. Family-of-origin characteristics
 - a. United front to community, but internal, severe conflict
 - b. Socially isolated
 - c. One caretaker with severe pathology; one abuses, one labels
 - d. Contradictory messages to child, inconsistent expectations
 - e. Rigid religious/mystical beliefs
 - f. Secrecy and denial
 2. Family therapy with family of origin; adjunct to primary individual therapy
 - a. Complicated by severe family pathology and secrecy
 - b. Occasionally includes selected family members
 - c. Abusers not included in therapy
 3. Family therapy with partners and children
 - a. Marital therapy is helpful adjunct.
 - b. Help family members avoid promoting dissociation.
 - c. Help to deal with hostile personalities.
 - d. Understand process of therapy and integration.
 - e. Evaluate children and treat for abuse (if present).
 - f. Confirm children’s experience with parental behavior and label DID symptoms as illness.

- Milieu interventions
 1. Hospitalize when self-harm or danger toward others is indicated.
 - a. Support during abreaction.
 - b. Provide structure and safety.
 - c. Create mutually designed contract so that treatment goals understood by alters.
 - d. Establish primary nurse for each shift.
 2. Maintain consistent, accurate understanding of DID and client by all staff members to avoid splitting.
 3. Provide safe, consistent environment.
 4. No-harm contract—homicide, suicide, self-mutilation
 5. Teach techniques to provide:
 - a. Anxiety reduction
 - b. Personal, emotional safety
 - c. Control of switching
 - d. Avoidance of self-mutilation, based upon particular meaning of the behavior
 6. Educate about nature of disorder, existence and function of personalities, course of therapy, and integration.
 7. Assist staff and clients to treat alters as they present.
 8. Help other clients understand DID client's behavior, attention from the staff, and their own reactions—include inward nontherapy activities, but exclude from general group sessions.

■ ADJUSTMENT DISORDER

- Definition—maladaptive or pathological response to a psychosocial stressor (Strain, Hammer, Huer-tas, Lam, & Fulop, 1993)
- Signs and symptoms
 1. Sources of stressors—events, such as job loss, acute or chronic illness, divorce, or specific developmental milestones (beginning school, getting married, etc.)
 - a. The more numerous or more disturbing the stressors, the greater effect on adjustment.
 - b. Previous history of Adjustment Disorder puts person at more risk.
 2. Distress experienced is in excess to what is expected.
 3. Significant impairment presents in social, occupational, or school functioning (APA, 2000).
 4. Symptoms occur within 3 months of stressor's onset.
 - a. Symptoms may be delayed.
 - b. Disorder may continue with prolonged stressor or inability to adapt.
 5. Commonly diagnosed in medical settings.

6. Manifestations vary:
 - a. Depressed mood
 - (1) Sadness
 - (2) Tearfulness
 - (3) Hopelessness
 - b. Anxiety
 - (1) Palpitations
 - (2) Agitation
 - (3) Jitteriness
 - c. Conduct disturbances
 - (1) Violating rights of others
 - (2) Violating social norms
 - d. Combinations of the above
 7. Physical complaints such as headache or back-ache are more common in the elderly.
- Differential diagnosis (Sadock & Sadock, 2007)
 1. Anxiety disorders (GAD, ASD/PTSD)
 2. Depression
 3. Uncomplicated bereavement
 4. Brief psychotic disorder
 5. Substance-Related Disorder
 6. Somatization Disorder
 7. Conduct Disorder
 - Mental status variations
 1. Varies considerably, depending upon manifestation.
 2. Appearance—visibly distressed
 3. Psychomotor activity—restless, agitated
 4. Mood—anxious and/or depressed
 5. Concentration—impaired
 6. Thought—preoccupation with stressors or physical symptoms
 7. Insight—may attribute symptoms to onset of stressor
 - Nursing diagnoses (NANDA, 2009)
 1. Anxiety (specify level)
 2. Powerlessness, risk for
 3. Resilience, risk for compromised
 4. Self-Esteem, situational low
 5. Post-Trauma Syndrome, risk for
 6. Knowledge, deficient (specify)
 7. Coping, ineffective
 - Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Possible constitutional predisposition
 2. Contribution of environmental and genetic factors likely in developing an Adjustment Disorder
 - Biochemical interventions—no evidence to support the efficacy of pharmacologic interventions (Sadock & Sadock, 2007)

- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Psychoanalytic—early parent-child relationship shapes ability to respond to stressors in later life.
 - b. Cognitive/Behavioral
 - (1) Cognitive coping styles reflect personal attitude and meaning of the event.
 - (2) Field independent persons use isolation and intellectualization.
 - (3) Field dependent persons use repression and denial.
 2. Psychotherapeutic interventions (intervention of choice for adjustment disorders)
 - a. Crisis intervention/brief therapies
 - (1) Clarify meaning of the event.
 - (2) Engage social support.
 - (3) Create active interventions to ameliorate the stressor.
 - b. Processing of memories/associations elicited by the stressor
 - (1) Initiate dose-by-dose approach to difficult topics.
 - (2) Teach techniques to keep emotions at tolerable level.
 - c. Cognitive/Behavioral
 - (1) Desensitization
 - (2) Flooding
 - (3) Stress management techniques
 - (a) Autogenic Training/PMR
 - (b) Hypnosis
 - (c) Meditation
 - (4) Assertiveness Training
 - (5) Cognitive restructuring
 - d. Interpersonal support and reassurance
- Family dynamics/Family therapy
 1. Family members affected by client's response to stressors, or may have experienced the stressors themselves.
 2. Family therapy
 - a. Clarify meaning of the event.
 - b. Support effective coping techniques of individuals and entire family system.
 - c. Decrease secondary gain system-wide.
 - d. Facilitate decision-making and reality-testing.
 - e. Educate about the course of adapting to a stressor.
- Group approaches
 1. Short-term group psychotherapy with problem-solving, supportive focus
 2. Self-help groups developed to deal with particular stressors (e.g., divorce, death, stroke, diabetes)
 - a. Common bond
 - b. Experience in adjusting
 - c. Chance to share coping techniques
 - d. Source of continuing support
 - e. Pragmatic in nature
- Milieu interventions (inpatient or home setting)
 1. Protect from excessive stimulation.
 2. Provide structure in activities, environment, and safety.
 3. Teach about adjustment process.
 4. Support biologic functioning (eating, sleeping, etc.).
 5. Emphasize trust in the future, social support, and self-efficacy.
 6. Focus on active recollection, retelling story while differentiating between reality and fantasy (group and/or family helpful).
 7. Reinforce increased communication with others.
 8. Reduce external demands to allow for work on stressors.
 9. Reinforce conscious control over ruminations or recollections.
 10. Deal with recurrent stressors, shame over vulnerability, anger, and sadness.
- Community resources
 1. Refer to community self-help groups.
 2. Refer to community resources to deal with specific stressors.
 3. Mobilize neighbors, churches, and other naturally occurring groups to lend help.

■ QUESTIONS

Select the best answer

1. Ms. Smith, who has panic attacks, comes to where you, the PMH nurse, are sitting and says, "It's happening again. I can't breathe. I know I'm going to die." She is breathing with difficulty. She has been attending a group to learn more about panic attacks and how to avert them. Your best response is:
 - a. "Let me take your blood pressure."
 - b. "You know what to do—start your exercises."
 - c. "You're experiencing anxiety; that's what you are feeling."
 - d. "Tell me what's been going on."

2. Persons with recurrent Panic Disorder usually present with:
 - a. High level of general anxiety
 - b. Cardiac/respiratory symptoms of distress
 - c. La belle indifference
 - d. Clear precipitants
3. A priority nursing diagnosis for Sandra, an agoraphobic, who will not leave her house without her husband accompanying her is:
 - a. Posttrauma response
 - b. Parenting, altered
 - c. Fear
 - d. Denial, ineffective
4. Mr. Lee has a Generalized Anxiety Disorder. You will be teaching him some relaxation techniques. When is the best time for him to learn?
 - a. When he is only mildly anxious
 - b. Immediately after feeling severe distress
 - c. In the middle of a time of moderate distress
 - d. After taking an antianxiety agent
5. Jim, who suffers from severe flashbacks of war experiences, and has just been admitted, sits on the lounge, apart from other clients. Your best response is:
 - a. Let him remain apart until he's ready to disclose
 - b. Introduce him to two other veterans on the unit with similar problems
 - c. Suggest that he work on a crossword puzzle until dinner
 - d. Observe him for flashbacks
6. Symptoms of autonomic arousal in the PTSD client include:
 - a. Hypersomnia
 - b. Tachycardia
 - c. Alexithymia
 - d. Hypotonic musculature
7. Which mental status variations would you expect for a client diagnosed as having PTSD?
 - a. Thought—delusion of grandeur
 - b. Perceptual—derealization
 - c. Memory—impaired recent memory
 - d. Mood—inappropriate, silly
8. Physiological monitoring of clients using benzodiazepines includes:
 - a. CBC with differential
 - b. Kidney function studies
 - c. Blood pressure
 - d. Serum benzodiazepine levels
9. Jerry, a miner, was injured a year ago and hasn't been able to return to work because of severe low back pain. His neurologist could find no organic reason for his continuing pain. Which of the following psychiatric diagnoses best fits Jerry's clinical picture?
 - a. Factitious Disorder
 - b. Hypochondriasis
 - c. Pain Disorder
 - d. Conversion Disorder
10. Nursing diagnoses for Jerry might include all but:
 - a. Role Performance, ineffective
 - b. Pain, chronic
 - c. Posttrauma Syndrome
 - d. Coping, ineffective
11. An explanation for Jerry's continued pain in spite of his neurologist's findings is:
 - a. Secondary gain
 - b. High endorphin levels
 - c. High serotonin levels
 - d. Repression of unacceptable impulses
12. Treatment of Jerry's chronic pain is likely to include all but which of the following?
 - a. Exercise program
 - b. Biofeedback-assisted relaxation
 - c. Pain support group
 - d. Antianxiety agents
13. John has been preparing for running a marathon for over a year. "It's my 40th birthday present to myself," he explains. The morning of the race, his wife finds him still in bed, his legs paralyzed. John tells her that he guesses he can't race after all. What mental status variations might you expect?
 - a. Mood—depressed, anxious
 - b. Mood—la belle indifference
 - c. Mood—blunted affect
 - d. Mood—relieved
14. The symptoms of a Conversion Disorder may be related to:
 - a. Heightened autonomic arousal
 - b. Displacement of aggression
 - c. Mid-life crisis
 - d. Symbolic relationship with conflict
15. Mae has an intense argument with her 15-year-old daughter who visits her daily in the hospital where Mae is being treated for hypochondriasis. Mae sends her daughter home and asks the nurse for medication for her stomach. "I wonder if she'll regret this when I'm dead of stomach cancer?" she states. Your best reply is:
 - a. "I'm sorry you're feeling this way."
 - b. "I'll get the medication for you."
 - c. "I'll get the nurse to talk to your daughter."
 - d. "I'll get the nurse to talk to your daughter."

- a. "Let's talk about what just happened."
 b. "This antacid will help."
 c. "Teenagers just go through those phases."
 d. "Mae, there is *no* sign of stomach cancer. You're not about to die."
16. A client with a Conversion Disorder hospitalized in a psychiatric facility will require which approach by nursing staff?
- a. Anticipate and meet self-care needs of client.
 b. Encourage attendance at expressive therapies.
 c. Reinforce verbal expression of needs.
 d. Remind the client that his difficulties are not real.
17. When a DID client is hospitalized for serious self-inflicted cuts, the no-harm contract should include:
- a. Ward privileges gained for no self-harm
 b. Clear alternatives to follow when feeling the urge to cut
 c. Provision of antipsychotics for increased agitation
 d. Discharge from the hospital if there is self-harm
18. Which is true about the resolution of DID?
- a. Clients must integrate alters.
 b. All traumatic incidents must be remembered.
 c. Many clients experience a reactive depression.
 d. Some alters always exist, although hidden.
19. Given the diagnosis of Depersonalization Disorder, which nursing diagnosis is most likely to result from assessment?
- a. Powerlessness
 b. Grieving, dysfunctional
 c. Identity, disturbed personal
 d. Depersonalization alteration
20. Treatment of Dissociative Amnesia includes all modalities *except*:
- a. Hypnosis
 b. Stress management
 c. Antianxiety agents
 d. Psychotherapy
21. Mrs. Peters, who has experienced a traumatic automobile accident in which three persons were burned to death, tells you that she just wants to "put it behind me." She refuses to talk about the accident or attend activities, and says, "I just want my nerve pills." Your best response is:
- a. "Nerve pills are highly addictive. You need to learn to relax."
 b. "I can see why you'd like to put it behind you. It must have been very scary."
 c. "You are right. It's important to carry on and not dwell on the past."
 d. "I hope you'll talk to your doctor about this."
22. Mrs. Peters asks why she has to go to art therapy this morning. "I'm no artist. My hobby is gardening. I'd rather go gardening. I'd rather just stay here and watch a little television." Which is your best response?
- a. "Art therapy is one way to express yourself. You don't have to be an artist—just be willing to try the activity."
 b. "Art therapy may give you an idea about undiscovered talents. You just might be a great artist inside."
 c. "Art therapy is good, but I'll see if we can't schedule you for the green house activity instead."
 d. "I'll stay here and talk with you while you watch TV."
23. Mrs. Peters finally decides to participate in art therapy. She returns to the unit red-eyed and clutching a paper covered with heavy red scrawls. She stops and shows it to you. The best response would be:
- a. "That's really good. That red must be the fire."
 b. "Let's put this up for the other patients to see."
 c. "This is very strong—tell me about it."
 d. "If art therapy was too troubling, I do have some medication for you."
24. Mary has been diagnosed as having a De-personalization Disorder. Which experience might she relate during your initial nursing assessment?
- a. "This feeling is so weird—I feel just 'unreal.'"
 b. "I haven't been able to take care of the kids; I just sit around."
 c. "It's no big deal."
 d. "I have dreams that I just can't get out of."
25. Joe, now age 34, was sexually abused by a youth group leader when he was 14. Joe is most likely to present with which of the following statements?

- a. "I have really close friends, both males and females."
 - b. "I've told so many people my story that it is getting a little old."
 - c. "I don't see how some little thing that happened 20 years ago is influencing my life now."
 - d. "I have a great sex life."
26. Mary is thinking about entering a women's shelter if her husband starts to abuse her one more time. Her chief concern should be to:
- a. Try to make the relationship work since he has promised to stop abusing her.
 - b. Develop a safety plan for her and her children if he begins to escalate.
 - c. Let him know she is pregnant because a man is unlikely to hurt a pregnant woman.
 - d. Acknowledge her role in causing the abuse.
27. Chris, a successful music major, is preparing for his recital next week. He has experienced severe stage fright in the past and once, refused to perform at all. Which of the following biochemical approaches is most likely to be employed in conjunction with behavioral therapy for his difficulty?
- a. Mono-amine oxidase inhibitor
 - b. Tricyclic antidepressant
 - c. Beta-adrenergic antagonist
 - d. Antiparkinsonism agent
28. Your client, Fred, attends a men's group for adult survivors of childhood sexual abuse. Some men in the group are currently confronting their families, but Fred is unsure of his course of action. Your best response is:
- a. "Most families welcome the honesty as difficult as it is for everyone."
 - b. "You've been learning to be assertive. This is probably the next step."
 - c. "If you don't confront your father now, you'll always feel powerless."
 - d. "That's a difficult decision. What would you like to have happen with your family?"
29. A Vietnam veteran who served at a field hospital late in the war becomes symptomatic of PTSD after a long period of what seemed excellent adjustment. Her husband and children have joined her in your office to talk about what's happening. They ask if she has PTSD. What is your best response?
- a. "Yes, she has PTSD, but we are going to let 'bygones be bygones' and work on other things in therapy."
 - b. "I think there is a different problem. PTSD occurs much sooner."
 - c. "She has symptoms of PTSD that are difficult not just for her, but for all of you."
 - d. "The problem is rooted in the past, family can do nothing now."
30. Family therapy for the PTSD client and her family will meet all but one of the following goals:
- a. Develop a shared frame of reference for the trauma
 - b. Support the victim in recovery
 - c. Reduce secondary gain by limiting trauma talk to therapy session only
 - d. Address issues of trust, responsibility, and blame
31. Now, three weeks after the hurricane, Charley cannot remember anything about his 36-hour ordeal, trapped under debris from his house until he was finally rescued. This is best described as:
- a. Dissociative Amnesia, localized
 - b. Dissociative Amnesia, generalized
 - c. Dissociative Amnesia, continuous
 - d. Dissociative Amnesia, selective
32. A community support group for flood victims asks you, the advanced practice PMH nurse, to talk about symptoms of PTSD. The group has been meeting since the disaster 6 months ago. One woman asks why she continues to have periodic, recurrent dreams and thoughts about the flood. Which is your best reply?
- a. "Your mind is attempting to work through what happened, a little bit at a time."
 - b. "You are probably thinking too much. Try to stop these thoughts."
 - c. "You could be guilty about surviving."
 - d. "At this time, you have a serious problem. Have you seen your doctor?"
33. One hypothesis about why PTSD clients may continue to engage in dangerous activities and have recurrent interpersonal difficulties is related to:
- a. Serotonin excesses
 - b. Autonomic entrainment
 - c. Endogenous opioid withdrawal
 - d. Dysregulation of GABA
34. Leonard has recently avoided going out to eat with his family at restaurants. He claims the food is better at home, and that other people may watch him eat and critique his table

- manners. The most appropriate psychiatric diagnosis is:
- Schizophrenia with delusions
 - Agoraphobia
 - Avoidant Personality Disorder
 - Social Phobia
35. The client presenting with a Somatization Disorder typically:
- Exaggerates the seriousness of minor symptoms into major health problems
 - Refuses medication, preferring to "work it out alone"
 - Has a chaotic social life
 - Understands the stress-physical symptoms relationship
36. Joan, who obsessively thinks about her children dying in a house fire, is learning to use thought-stopping techniques. Such techniques include:
- Practicing progressive muscle relaxation
 - Discussing with a staff member the likelihood of a house fire
 - Snapping a rubber band on her wrist when the thought of fire occurs
 - Reminding herself of the home fire alarm system
37. Anxiety-reducing techniques such as autogenic training or progressive muscle relaxation are best employed by a person who fears flying on airplanes:
- When anxiety rises to intolerable levels
 - When the plane takes off and lands
 - Prior to feeling autonomic arousal
 - Only in practice settings
38. The psychoanalytic explanation for a phobic disorder involves:
- Classical conditioned responses
 - Reaction formation
 - Displacement
 - Avoidance
39. Group therapies for the treatment of agoraphobia include:
- Social skills training
 - Medication education
 - Art or movement therapies
 - Gestalt approaches
40. Systematic desensitization includes all but which of the following?
- In vivo exposure
 - Deep muscle relaxation
 - Understanding why stimuli are anxiety provoking
 - Cognitive coping self-statements
41. Peggy is hospitalized because of emotional exhaustion. Her husband reports that she has become increasingly preoccupied with cleaning the house over the past year. Always a meticulous housekeeper, she is now afraid that the house is contaminated by environmental toxins. She is up most of the night, trying to clean and decontaminate. When her husband attempts to have her rest, she becomes distraught. The most accurate psychiatric diagnosis is:
- Obsessive-Compulsive Disorder
 - Obsessive-Compulsive Personality Disorder
 - Schizophrenia, paranoid type
 - Major Depression
42. Probable nursing diagnoses include all but:
- Coping, ineffective
 - Anxiety
 - Role Performance, ineffective
 - Home Maintenance Management, impaired
43. Clomipramine (Anafranil), 250 mg every morning, is ordered for Peggy. After taking the medication for a week, she complains of being too sleepy to participate in morning activities. Which of the following actions might the advanced practice nurse suggest?
- Tell her the sleepiness will soon disappear.
 - Recommend the medication be taken at bedtime.
 - Request the medication be discontinued immediately.
 - Reschedule her activities to late afternoon.
44. The most effective treatment of Panic Disorder is:
- Reworking previous traumatic separations
 - Family therapy
 - Cognitive restructuring
 - Provision of a stress-free environment
45. Persons prone to high levels of anxiety tend to have which dysfunctional thoughts?
- Negative views about the self, world, and future
 - Overestimation of the support of others
 - Overestimation of danger
 - "Black or white" thinking
46. Mrs. Stevens has been taking alprazolam (Xanax) 2.0 mg/day for six months. She wants to become pregnant and, in preparation, goes off the medication. She currently experiences little anxiety. She has learned a variety of coping

techniques in therapy. Your best response to her desire to discontinue the Xanax is:

- a. "Since you are doing so well, go ahead and stop taking your Xanax."
 - b. "You should remain on benzodiazepines for at least one year."
 - c. "Should you decide to discontinue Xanax, it's important to very slowly reduce the dose."
 - d. "You might want to try a shorter-acting medication like Oxazepam (Serax) as a substitute."
47. Susan was admitted at 3 a.m. to the emergency department of a medical center, complaining of stomach pain that she believes is cancer. Although she admits to having eaten some "real spicy food" the evening before, she is insistent on having an upper and lower GI series immediately. She is anxious, despite her doctor's reassurance. Which is a likely psychiatric diagnosis?
- a. Conversion Disorder
 - b. Hypochondriasis
 - c. Pain Disorder
 - d. Generalized Anxiety Disorder
48. A primary focus of treatment for Susan will be:
- a. Dietary instructions and antacids
 - b. Stress management techniques
 - c. Insight-focused psychotherapy
 - d. Rehabilitation efforts
49. Upon questioning your client during the intake interview, she relates that she hears voices inside her head, as if in a conversation. Which psychiatric diagnosis best fits these experiences?
- a. Schizophrenia
 - b. PTSD
 - c. DID
 - d. Panic Disorder
50. Family therapy with partners and children of DID clients is aimed at which of the following?
- a. Help children access child alters.
 - b. Help children deal with hostile alters.
 - c. Help children ignore inconsistent parental behavior.
 - d. Help children parent the child alters.
51. The most efficacious approach for dealing with a client who has a Somatization Disorder is to:
- a. Use antidepressants.
 - b. Closely collaborate with the primary care provider.
 - c. Confront the unreality of the symptoms.
 - d. Provide brief, problem-focused therapy.
52. Seth, age 72, has almost doubled the amount of diazepam (Valium) prescribed for him, claiming that his "nerves are shot" and the medicine doesn't do enough for him. Which sign of toxicity is the nurse likely to see?
- a. Nausea and vomiting
 - b. Rapid speech with flight of ideas
 - c. Psychomotor excitation
 - d. Short-term memory impairment
53. Ellie has a past history of cutting and burning her arms and ankles when anxious or dissociating. She admits to "little cuts" last night when thinking about working with a new therapist. Which is the best initial strategy of the advanced practice nurse when beginning therapy with Ellie?
- a. Assist Ellie to identify the patterns and function of self-injury.
 - b. Give her telephone numbers so that the nurse can be reached whenever Ellie begins to feel self-injurious.
 - c. Define self-injury as unacceptable and as grounds for termination of the therapeutic relationship.
 - d. Ignore the behavior so as not to reinforce it.
54. Mild-to-moderate anxiety in response to a stressor is most likely to present in patients with:
- a. Generalized Anxiety Disorder
 - b. Adjustment Disorder with anxiety
 - c. Acute Stress Disorder
 - d. Obsessive Compulsive Disorder
55. Buspirone (BuSpar) is:
- a. An effective SNRI used in treating anxiety
 - b. An effective anxiolytic used in treating anxiety
 - c. A controlled substance due to the potential for abuse and dependence
 - d. Both a and c are correct
56. SSRIs are first-line agents for treating anxiety in the following disorder(s):
- a. Generalized Anxiety Disorder
 - b. Panic Disorder
 - c. Obsessive-Compulsive Personality Disorder
 - d. Both a and b are correct
57. Which medication would be *least* beneficial in treating PTSD?
- a. Fluvoxamine
 - b. Fluoxetine
 - c. Alprazolam
 - d. Paroxetine

■ ANSWERS

- | | |
|-------|-------|
| 1. c | 30. c |
| 2. b | 31. a |
| 3. c | 32. a |
| 4. a | 33. c |
| 5. b | 34. d |
| 6. b | 35. c |
| 7. b | 36. c |
| 8. a | 37. c |
| 9. c | 38. c |
| 10. c | 39. a |
| 11. a | 40. c |
| 12. d | 41. a |
| 13. b | 42. d |
| 14. d | 43. b |
| 15. a | 44. c |
| 16. c | 45. c |
| 17. b | 46. c |
| 18. c | 47. b |
| 19. c | 48. b |
| 20. c | 49. c |
| 21. b | 50. b |
| 22. a | 51. b |
| 23. c | 52. d |
| 24. a | 53. a |
| 25. c | 54. b |
| 26. b | 55. b |
| 27. c | 56. d |
| 28. d | 57. c |
| 29. c | |

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Schizophrenia and Other Psychotic Disorders

■ OVERVIEW OF DISORDERS

Schizophrenia

- Definition—a clinical syndrome characterized by disturbances in perception, thought process, reality testing, affect, behavior, attention, and motivation; typically appears in late adolescence or early adulthood and is considered a chronic disorder with alternating periods of exacerbation and remission (Keltner, Schwecke, & Bostrom, 2007)
- Epidemiology (National Institute of Mental Health, 2006)
 1. Diagnosis rate for US population is 1.1%.
 2. Prevalence rate is equal among men and women, although age of onset is later in females than in males.
- Signs and symptoms (American Psychiatric Association [APA], 2000)
 1. The DSM-IV-TR criteria for diagnosis of Schizophrenia includes the presence of two (or more) of the following for a significant portion of time during a 1-month period (or less if successfully treated):
 - a. Delusions—fixed false beliefs that are inconsistent with one’s culture (See also Delusional Disorder) and include:
 - (1) Thought broadcasting—belief that one’s thoughts are being transmitted such that one’s thoughts are being perceived by others
 - (2) Thought insertion—belief that one’s thoughts are not one’s own, but rather are inserted into one’s mind through external means (Sadock & Sadock, 2007)
 - b. Hallucinations—false sensory perceptions that involve one or more of the five senses (most common: auditory and visual), and are inconsistent with reality
 - c. Disorganized speech—derailment or incoherence
 - d. Grossly disorganized or catatonic behavior
 - e. Presence of negative symptoms— affective flattening, avolition or anhedonia
 2. NOTE: Only one of the above symptoms is necessary in the presence of:
 - a. Bizarre delusions— involving a phenomenon that would be considered completely implausible in the person’s culture (Sadock & Sadock, 2007)
 - b. Hallucinations of a voice with running commentary about the person’s behavior or thoughts
 - c. Two or more voices conversing with each other
 3. Diagnosis also includes evidence of social/ occupational dysfunction for a significant portion of time since onset of symptoms.
 - a. In adults—work, interpersonal relations or self-care below level achieved before onset
 - b. In children or adolescents—failure to achieve expected level of interpersonal, academic, or occupational achievement
 4. Continuous signs of the disturbance for at least 6 months, including:

- a. At least one month of active symptoms (or less if successfully treated) and
 - b. Prodromal and residual phases including the following negative symptoms:
 - (1) Withdrawal or social isolation
 - (2) Impairment in role functioning
 - (3) Odd behavior (e.g., talking to self in public)
 - (4) Little attention to personal hygiene, bathing, manner of dress, overall self-care, and activities of daily living
 - (5) Odd speech characterized by circumstantiality, tangentiality, poverty of speech, or poverty of content of speech
 - (6) Magical thinking including ideas of reference
 - (7) Recurrent illusions or other perceptual experiences
 - (8) Decrease in motivation, energy, or initiative
 - c. Prodromal and residual phase may also consist of two or more active phase symptoms in an attenuated form (e.g., odd beliefs, unusual perceptual experiences) or only negative symptoms.
- Subtypes of Schizophrenia
 1. Paranoid Schizophrenia—characterized by preoccupation with one or more delusions that may be persecutory, or by frequent auditory hallucinations
 2. Disorganized Schizophrenia—characterized by a flat or incongruous affect; exhibits bizarre mannerisms and social isolation; onset occurs early in life and often has persistent symptoms
 3. Catatonic Schizophrenia—identified by intense psychomotor disturbance; disturbance may take the form of stupor or excitement and is manifested by such psychomotor disturbances as posturing, immobility, catalepsy, mutism, and negativism
 4. Undifferentiated Schizophrenia—person clearly meets the diagnostic criteria but does not fit into one subtype or another (Sadock & Sadock, 2007).
 5. Residual Schizophrenia—absence of hallucinations and delusions; two or more residual symptoms are continued
 - Differential diagnosis/Related disorders (Sadock & Sadock, 2007)
It is important that the presence of psychotic symptoms be assessed in relationship to nonpsychiatric/medical conditions and other related, concomitant, or neurologic disorders.

1. Nonpsychiatric condition causing psychotic symptoms—medical work-up is important to rule out conditions including neoplasm, cerebrovascular disease or trauma, emboli, narcolepsy, encephalitis, Huntington's disease, temporal lobe epilepsy, heavy metal poisoning, neurosyphilis, vitamin B12 deficiency, and AIDS.
2. Mood disorder with psychotic features
3. Substance-induced psychosis—acute intoxication with legal and illegal substances and/or drug reactions to medicinal drugs may induce psychotic behaviors and thought disorders, e.g., alcohol hallucinosis/withdrawal, alkaloids, amphetamines, barbiturate withdrawal, hallucinogens.
4. Personality disorder—personality disorders with features similar to Schizophrenia, e.g., Schizotypal, Schizoid, and Borderline Personality Disorders
5. Other Psychotic Disorders
 - a. Delusional Disorders
 - b. Schizophreniform Disorder
 - c. Schizoaffective Disorder
 - d. Brief Psychotic Disorder
6. Dementias and delirium—especially in the elderly; may be manifested by irritability, anxiety, isolation, and agitation

Schizophreniform Disorder

- Definition/Signs and symptoms
 1. Episode of symptoms of schizophrenia that lasts at least 1 month but less than 6 months
 2. Good prognosis indicated by:
 - a. Psychotic symptoms within 4 weeks of onset
 - b. Confusion during psychosis
 - c. Good social and occupational functioning before onset
 - d. Blunted or flat affect absent (APA, 2000)
- Differential diagnosis
 1. Schizophrenia, schizoaffective, substance use, and mood disorders
 2. Medical illness or medication response

Delusional Disorder

- Definition/Signs and symptoms—active phase
 1. Nonbizarre delusions
 2. None of the following for more than a few hours:
 - a. Hallucinations
 - b. Disorganized speech
 - c. Grossly disorganized or catatonic behavior
 - d. Negative symptoms

3. Functioning is not markedly impaired except for the impact of the delusions.
 4. In the elderly, mood may be manifested by anger, paranoia, and anxiety; behaviors may include suspiciousness, aggression, and isolation.
- Types of delusions (APA, 2000; Sadock & Sadock, 2007; Videbeck, 2006)
 1. Persecutory/paranoid—belief that others are attacking, harassing, cheating, or conspiring against them (or a person close to them); e.g., belief that one is being followed by the CIA or that others are poisoning their food
 2. Jealousy—belief that one's sexual partner is unfaithful
 3. Erotomaniac—belief that someone, usually in a position of higher status or authority, is in love with them
 4. Grandiose—belief that they have special knowledge, worth, or powers; may believe they are or have a special relationship with a deity or famous person
 5. Somatic—vague or unrealistic belief that one's appearance, health, or physical functioning is deficient or unique
 6. Mixed type—a combination of more than one of the above delusions in which no one theme outweighs another
 - Differential diagnosis—Schizophrenia

Schizoaffective Disorder

- Definition—major depressive episode, or manic episode that occurs concurrently with active phase schizophrenia symptoms; during same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms, but mood symptoms are present during a substantial part of the illness (APA, 2000)

Brief Psychotic Disorder

- Definition/Signs and symptoms
 1. One of the following is present and not culturally sanctioned:
 - a. Delusions
 - b. Hallucinations
 - c. Disorganized speech
 - d. Grossly disorganized or catatonic behavior
 2. Onset is generally sudden with duration of symptoms of 1 month or less, but at least 1 day.
 3. Individual recovers to a normal level of functioning.

4. Presence or absence of marked stressors should be noted, as should onset within four weeks postpartum.

- Differential diagnosis
 1. Medical condition including epilepsy and delirium
 2. Other psychotic disorders—Schizophreniform Disorder, Schizophrenia, Schizoaffective Disorder, Delusional Disorder
 3. Substance-induced psychosis
 4. Dissociative Identity Disorder
 5. Mood disorder with psychotic features

Shared Psychotic Disorder (Folie à deux)

- Signs and symptoms (APA, 2000)
 1. Delusional system develops in the context of a close relationship with a person who already has a psychotic disorder with delusions.
 2. Delusion is similar in content to that of the person who already has the established delusion.
- Differential diagnosis
 1. Medical conditions associated with delusions and/or delirium
 2. Schizophrenia or another psychotic disorder
 3. Substance-induced psychosis

Psychotic Disorder Due to a General Medical Condition

- Signs and symptoms (APA, 2000)—delusions or hallucinations that:
 1. Do not occur exclusively during the course of delirium or dementia.
 2. Are the direct consequence of an identified medical condition as determined by
 - a. History
 - b. Physical examination
 - c. Laboratory findings
 3. Are not better accounted for by another mental disorder.

Substance-Induced Psychotic Disorder

- Definition (APA, 2000)—delusions or hallucinations (these are not included if the client has insight that they are substance induced) that:
 1. Develop during or within a month of significant substance intoxication.
 2. Are in excess of what would be expected for the amount and type of substance abused.
 3. Do not occur during the course of delirium or dementia.

- Differential diagnosis:
 1. Delirium
 2. Dementia
 3. Other psychotic disorders

Psychotic Disorder Not Otherwise Specified

- Definition (Sadock & Sadock 2007)—a variety of clinical manifestations with psychotic features that do not meet the criteria of another DSM-IV-TR psychotic disorder
- Examples (APA, 2000):
 1. Postpartum psychosis that does not meet the criteria for another medical or mental disorder
 2. Persistent auditory hallucinations with no other symptoms
 3. Persistent nonbizarre delusions with intermittent periods of overlapping mood episodes present for a substantial portion of the delusional disturbance
 4. Psychosis where a more specific diagnosis is impossible
 5. Psychotic symptoms that have lasted for less than 1 month but have not yet remitted, so that the criteria for Brief Psychotic Disorder are not met

■ INFORMATION COMMON TO SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

- Nursing diagnoses—several of the 2009–2011 NANDA International (2009) nursing diagnoses can be applied to Schizophrenia and other psychotic disorders, including:
 1. Behavior, risk-prone health
 2. Coping, defensive
 3. Coping, ineffective
 4. Denial, ineffective
 5. Powerlessness
 6. Neglect, self
 7. Violence, (actual/) risk for self-directed
 8. Social Interaction, impaired
 9. Social Isolation
 10. Self-Esteem, chronic low
 11. Resilience, impaired individual
 12. Sensory Perception, disturbed (specify)
 13. Confusion, acute or chronic
 14. Violence, (actual/) risk for other-directed
 15. Environmental Interpretation Syndrome, impaired
 16. Communication, impaired verbal
 17. Health Behavior, risk-prone
 18. Health Management, ineffective self
 19. Knowledge, deficient (specify)

- Genetic/Biologic theories (Sadock & Sadock, 2007)
 1. Genetic
 - a. The lifetime risk of developing schizophrenia when one has a parent, identical twin or sibling with schizophrenia is much higher than in the population at large.
 - b. Torrey et al. (1994) studied 66 pairs of identical twins and noted that 27 pairs were discordant for schizophrenia and 13 pairs were concordant for schizophrenia.
 - c. An exact genetic linkage has not been established. However, multiple common genetic polymorphisms have been suggested with several genes implicated in schizophrenia vulnerability. Multiple genes on several chromosomes have been identified including: chromosomes 6, 2, 11, 13, 12, 22 (Tandon, Keshavan, & Nasrallah, 2008b; Wong, Arcos-Burgos, & Licinio, 2008).
 2. Neuroanatomic models—structural functional abnormalities according to magnetic resonance imaging (MRI) and computerized tomography (CT) scans
 - a. Ventricular enlargement (lateral & 3rd ventricular enlargement)
 - (1) Neurofetal development factors—enlarged lateral and third ventricles, decrease in cranial, cerebral, and frontal brain tissue, delivery complications (may affect fetal neural development) (Fox & Kane, 1996)
 - b. Prominence of cortical sulci
 - c. Defects in limbic brain structure
 - d. Cortical atrophy/decrease in number of cortical neurons (usually more pronounced in the left hemisphere) possibly linked with negative symptoms (Walker, 1997)
 - e. Subtle neuroanatomical differences in part of the thalamus, septum, hypothalamus, hippocampus, amygdale, and cingulate gyrus (Bendik, 1996)
 - f. Reduction of 5% in brain weight and slight decrease in brain length (Keltner & Folks, 1997)
 - g. Decrease in volume of temporal lobe structures and decrease in substantia nigra and putamen (Walker, 1997)
 - h. Thickening of corpus callosum on MRI
 - i. Abnormalities in brain density and symmetry
 - j. Atrophy of portion of cerebellum
 3. Neurotransmitter models—theories/hypotheses about schizophrenia include specific and interconnected roles of various neurotransmitters:

- a. Serotonin (5HT₂) deficiency may be responsible for some forms of schizophrenia.
 - b. Glutamate—specifically, deficiency mediated excitatory neurotransmission by N-methyl D-aspartate (NMDA) receptors may be involved. This hypothesis is supported by psychosis triggered by NMDA antagonists (phencyclidine and ketamine) (Keshavan, Tandon, Boutros, & Nasrallah, 2008).
 - c. GABA—Reduced levels of GABA in prefrontal cortex may account for alterations in neuronal synchrony leading to memory impairment in schizophrenia (Keshavan et al.).
 - d. Norepinephrine (NE) may be insufficient in clients with schizophrenia that display prominent negative symptoms.
 - e. Dopamine (DA) is likely to be excessive at certain receptor sites, or persons with schizophrenia may have more dopamine receptors. D₂ receptors are present in limbic and motor neuron center; overactivity of D₂ receptors may be related to positive symptoms of schizophrenia (Harris & McMahan, 1997). Although direct evidence in support of the dopamine hypothesis of schizophrenia is sparse (Keshavan, Tandon, Boutros, & Nasrallah, 2008).
 - f. Also implicated in schizophrenia are acetylcholine muscarinic and nicotinic receptors, which play a role in regulation of neurotransmitters involved in cognition.
 - g. The *interaction* of various neurotransmitters has also been studied relative to schizophrenia.
 - h. Recent studies have examined effect of interactions between hormones and neurotransmitters in schizophrenia; patterns of dopamine-thyroid interactions and dopamine pituitary hormone secretions were found to be related to symptoms of schizophrenia.
4. Neurophysiological models
 - a. Decreased cerebral blood flow (as measured by Single Photon Emission Computed Tomography (SPECT)) (Keltner & Folks, 1997) and decreased glucose metabolism in the frontal lobes (as measured by Positron Emission Tomography (PET))
 - b. Hypofrontality may be related to changes in abstract thinking and social judgment.
 5. Immunologic/Risk factor models
 - a. Exposure to viruses, especially influenza prenatally—theorized that such exposure may create maternal antibodies that become auto-antibodies in the fetus and create source of development changes that present risk factor for schizophrenia (Cannon & Marco, 1994)
 - b. Risk factors associated with schizophrenia
 - (1) Studies of childhood encephalitis, head trauma younger than age 10, hemorrhage into the ventricles, ischemic damage to cortex associated with schizophrenia.
 - (2) Twin studies established indicators of liability, but do not predict the disease (Torrey, Bowler, Taylor & Gottesman, 1994).
 6. Theory of two types of schizophrenia
 - a. Type I—characterized by *positive* symptoms of schizophrenia, e.g., delusions, hallucinations, disorganized thinking; responds well to typical antipsychotic medications
 - b. Type II—characterized by *negative* symptoms, including withdrawal, flattening of affect, decreased motivation; respond better to newer antipsychotics (clozapine and risperidone); negative symptoms may be more related to structural defect and not dopamine function (Keltner & Folks, 1997)
- Biochemical interventions
 1. Typical antipsychotics (Sadock & Sadock, 2007; Stahl, 2008, 2009)
 - a. Used to decrease psychotic symptoms including hallucinations, delusions, and paranoia
 - b. Used short term in Schizophreniform Disorder
 - c. Mode of action—block dopamine receptors in post-synaptic neuron
 - (1) Potency related to D₂ receptor affinity in primarily four major pathways in the brain.
 - (2) Blockade of dopamine receptors in the cortex potentially makes negative symptoms worse.
 - (3) D₂ receptor blockade responsible for many side effects of typical antipsychotics (Sherr, 1996).
 - d. Medications (See **Table 6-1**)
 - (1) Fluphenazine (Prolixin), 12.5 to 50 mg every 6 hours, and haloperidol (Haldol), 6 to 20 mg daily are available in intramuscular, injectable forms that are long-acting and released over two-to-three weeks.
 - (a) Reduces need to take daily oral medications
 - (b) Helps reduce ambivalence
 - (2) Dosages vary widely among patients.

■ Table 6-1 Typical Antipsychotics

Classification	Generic (Trade Name)	Acute Adult Dose Range (mg/day)	Maintenance Dose Range (mg/day)
Phenothiazines	Chlorpromazine (Thorazine)	100 to 1600 PO 25 to 200 IM	50 to 400 PO
	Thioridazine (Mellaril)	200 to 800 PO	100 to 300 PO
	Mesoridazine (Serentil)	100 to 400 PO 25 to 200 IM	30 to 150 PO
	Perphenazine (Trilafon)	12 to 64 PO 15 to 30 IM	8 to 24 PO
	Trifluoperazine (Stelazine)	4 to 40 PO 4 to 10 IM	5 to 20 PO
	Fluphenazine (Prolixin)	2.5 to 40.0 PO 5 to 20 IM	1.0 to 15.0 PO 12.5 to 50 IM (decanoate or enanthate, weekly or biweekly)
Thioxanthenes	Thiothixene (Navane)	6 to 100 PO 8 to 30 IM	6 to 30 PO
Butyrophenones	Haloperidol (Haldol)	5 to 20 PO 12.5 to 25 IM (decanoate)	1 to 10 PO 25 to 200 IM (decanoate, monthly)
Dibenzoxazepines	Loxapine (Loxitane)	20 to 250 PO 20 to 75 IM	20 to 100 PO
Dihydroindolones	Molindone (Moban)	50 to 225 PO	5 to 150 PO

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

e. Potential side effects of typical antipsychotics

- (1) Anticholinergic effects occur due to interference of nerve impulses by acetylcholine and epinephrine; include constipation, dry mouth, blurred vision, urinary retention and hesitancy; bethanecol is sometimes given for urinary retention.
- (2) Extrapyramidal symptoms can occur due to medication's effects on the extrapyramidal tracts of central nervous system.
 - (a) Acute dystonia—muscle spasms may occur early in treatment, sometimes after first dose; occur in up to 10% of clients:
 - i. Blepharospasm (eye closing)
 - ii. Torticollis (neck muscle contraction, pulling head to side)
 - iii. Oculogyric crisis (severe upward deviation of the eyeballs)
 - iv. Opisthotonos (severe dorsal arching of neck and back)

- v. Severe spasms of tongue and larynx can result in dysphagia (difficulty swallowing) and compromised airway.
 - vi. Treatment—anticholinergic drugs; severe painful symptoms benefit from IM dose cogentin 2 mg or benedryl 50 mg that may be repeated in 30 minutes if no resolution of symptoms.
- (b) Neuroleptic-induced pseudoparkinsonism—dopamine blockade in nigrostriatal pathways results in clinical symptoms such as:
- i. Tremors
 - ii. Bradykinesia/akinesia (slowness, absence of movement)
 - iii. Cogwheel rigidity (slow, regular, muscular movements)
 - iv. Postural instability, shuffling gait, loss of mobility in the facial muscles (mask-like faces), hypersalivation and drooling

- v. Pill-rolling of fingers
- vi. Affects up to 15% of clients
- (c) Akathisia—may occur weeks or months after treatment; occurs in approximately 25% of persons treated with neuroleptics.
 - i. Objective symptoms—restlessness, pacing, rocking (shifting from one foot to another), and foot tapping
 - ii. Subjective symptoms—descriptions of inner restlessness, tension, irritability, and inability to sit still or lie down
 - iii. Differentiation between akathisia and anxiety and psychomotor agitation of worsening psychosis is important.
 - iv. May respond to reduction of antipsychotic medication.
 - v. Anticholinergic treatment generally has limited effect except in high doses that are often not well tolerated.
 - vi. Beta-blockers may be most effective adjunctive treatment—propranolol (Inderal) 160 mg/day; nadolol (Corgard) 80 mg/day.
- (d) Tardive Dyskinesia (TD)—(tardive means “late”—dyskinesia involves difficulty performing movements)—TD is abnormal repetitive movement that is irreversible in 50% of cases even after withdrawal of drug; TD tends to occur later in treatment with antipsychotic agents.
 - i. Oral (lip smacking, puckering), buccal, lingual (tongue protrusion) masticatory, and eyelid (blinking) movement; choreiform movements that may at first occur anywhere in the body, including arms, legs, fingers, feet, and trunk.
 - ii. Less commonly involves muscles in swallowing reflex or diaphragm—can lead to choking or respiratory compromise.
 - iii. Clients are often less aware of the movements than those around them who generally report them.
- iv. Careful assessment of symptoms of TD using standard instruments, such as Abnormal Involuntary Movement Scale (AIMS), is a nursing responsibility.
- v. Pathophysiology of TD is only partially understood, but includes an understanding of possible increase in dopamine receptors after long-term blockade with neuroleptics and/or development of hypersensitivity of dopamine receptors.
- vi. Discontinuing drug may result initially in withdrawal dyskinesia.
- vii. Benzodiazepines may bring temporary relief.
- viii. Approximately 50% will not return to normal movement even after withdrawal of drug.
- ix. Some clients seem to respond to treatment with clozapine (Clozaril).
- (3) Treatment of EPS and Pseudoparkinsonism
 - (a) Anticholinergic drugs
 - i. Contraindication—narrow angle glaucoma
 - ii. Relative contraindications—dehydration, cardiac arrhythmias, and benign prostatic hypertrophy
 - iii. Caution—older clients and those on additional medications with anticholinergic effects must be monitored.
 - iv. Excess anticholinergic medication may result in urinary retention, paralytic ileus and memory problems, sometimes called anticholinergic delirium (includes disorientation).
 - v. Other side effects may include blurred vision, dry mouth, and tachycardia.
 - (b) Dopamine agonists (See **Table 6-2** for medications to treat extrapyramidal symptoms)
- (4) Neuroleptic Malignant Syndrome (NMS)—rare, potentially fatal idiosyncratic reaction to antipsychotics

■ **Table 6-2** Medications Used to Treat Extrapyrarnidal Symptoms (EPS) & Pseudoparkinsonism

Classification	Generic Name	Trade Name	Dose & Route
Anticholinergics	Benztrapine	Cogentin	1 to 4 mg PO/IM/IV, 1 to 3 times/day
	Trihexypheridyl	Artane	2 to 5 mg PO, 3 to 4 times/day
Antihistamine	Diphenhydramine	Benadryl	25 to 50 mg PO/IM/IV, every 4 to 6 hrs
Dopamine Agonist	Amantadine	Symmetrel	100 mg PO, 2 times daily

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

- (a) Characterized by muscular rigidity, hyperthermia, autonomic instability.
 - (b) Laboratory findings can include leukocytosis (15,000 to 300,000), elevated creatinine phosphokinase (CPK) (may be > 3000 IU/mL); myoglobinuria.
 - (c) May occur any time during treatment but is more frequent shortly after initiation of antipsychotics or dose increases; rapid administration of a high potency antipsychotic and an increased number of IM injections may increase risk.
 - (d) Treatment of NMS requires discontinuation of antipsychotic drugs and maintenance of nutrition, cooling, and hydration.
 - (e) Ventilation may be required for respiratory failure; renal dialysis for renal failure.
 - (f) Muscle relaxant IV can be administered to reduce rigidity.
 - (g) Dopaminergic drugs such as bromocriptine (Parlodel), amantadine (Symmetrel) and anticholinergics
- (5) Other side effects of typical antipsychotics
- (a) Reduction of seizure threshold, especially with the use of low-potency agents
 - (b) ECG changes (conduction delays); and rarely sudden death; more common with low-potency drugs
 - (c) Photosensitivity—may continue up to a month after drug discontinued.
 - (d) High doses of thioridazine (Mellaril) can lead to pigmentary retinopathy and permanent blindness.
 - (e) Sexual dysfunction, including retrograde ejaculation, impaired erection, inhibition of orgasm and amenorrhea
- (f) Orthostatic hypotension, sedation, weight gain
 - (g) Cholestatic jaundice—in chlorpromazine, usually self-limiting
 - (h) Agranulocytosis—signs of an infection such as sore throat, flu-like symptoms, and fever may indicate medical emergency and require immediate evaluation.
- (6) Treatment of side effects—dose reduction, changing to another drug and adding an adjunctive agent are considered in light of efficacy of antipsychotic drug and side effect profile of individual client.
2. Atypical antipsychotics (Sadock & Sadock, 2007; Stahl, 2008, 2009) (See also **Table 6-3**)
 - a. Clozapine (Clozaril)
 - (1) Indicated for treatment of refractory schizophrenia (Littrell, 1994)
 - (a) Found to improve response in clients who have failed to respond to two antipsychotics of different chemical classes given at doses of 800 chlorpromazine equivalents a day for at least 6 weeks
 - (b) Restricted indication due to 1% risk of agranulocytosis (Littrell, 1994)
 - (2) Mode of action—blocks dopamine receptors; considerable 5HT₂ blockade
 - (3) Side effects
 - (a) Agranulocytosis
 - i. Take complete blood count prior to therapy and white blood cell count (WBC) weekly for duration of treatment.
 - ii. Greatest risk period is first 6 months of treatment, and risk peaks at approximately 3 months; cases have occurred after 2 years of treatment.

■ **Table 6-3** Atypical Antipsychotic Agents

Generic Name	Trade Name(s)	Oral Dosage Range	Maximum Dose	Monitoring & Other Comments
Aripiprazole	Abilify	15 to 30 mg/day	30 mg/day	Increased suicide risk Available in disintegrating tablet form
Clozapine	Clozaril FazaClo (ODT)	300 to 450 mg/day	900 mg/day	Only drug for treatment resistant schizophrenia Monitor WBCs due to agranulocytosis risk Monitor weight
Olanzapine	Zyprexa Zyprexa Zydis (ODT)	10 to 20 mg/day	20 mg/day	Increased suicide risk Monitor weight
Quetiapine	Seroquel, Seroquel XR	300 to 800 mg/day (may divide dose)	800 mg/day	Increased suicide risk Monitor for cataracts
Paliperidone	Invega	6 mg/day	12 mg/day	Extended-release preparation
Risperidone	Risperdal	2 to 8 mg/day	16 mg/day	Long-acting depot dose: 25–50 mg IM q 2 weeks
Ziprasidone	Geodon	80 to 160 mg in divided dose	100 mg/day	IM form (10–20 mg, max. 40 mg/day), discontinue IM dose within 3 days Prolongs QTc interval more than other antipsychotic medications—monitor ECG if cardiac condition

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2008, 2009)

- iii. Recovery usually complete if drug stopped before clinical symptoms of infection appear.
- iv. If agranulocytosis occurs, drug is not restarted.
- (b) Because there is less penetration into the striatum where EPS occur, there is minimal EPS or tardive dyskinesia compared to typical antipsychotics.
- (c) Seizures—dose-related side effect
 - i. Maximum daily dose is 900 mg.
 - ii. Overall seizure incidence is approximately 3%.
 - iii. Valproate (Depakote), most common antiseizure medication, may be added; carbamazepine (Tegretol) is avoided because of possibility of decreased white blood cell count.
- iv. Myoclonic jerking may precede seizures and may indicate need to hold or reduce total daily dose.
- (d) Anticholinergic effects—generally moderate, however, there is a 30% incidence of hypersalivation; dose reduction or addition of anticholinergics may help nighttime hypersalivation.
- (e) Rapid changes in clozapine dose or sudden discontinuation can result in serious rebound psychosis and anticholinergic rebound (nausea, vomiting, and diarrhea).
- (f) Noncompliance for several days and reintroduction at previous dose could result in syncopal episodes, orthostatic hypotension, or seizures.

- (g) Other side effects
 - i. Sedation, tachycardia, hypotension, GI upset, benign hyperthermia, constipation, headaches (most diminish substantially with time)
 - ii. Tachycardia (increases of 25 beats/minute) may persist—can be treated with beta-blockers.
 - iii. Benign hyperthermia usually develops in first 3 weeks of treatment; usually remits on its own.
 - iv. Some clients complain of vague burning in stomach; may be relieved by food with resultant weight gain.
- (4) Dosage and efficacy
 - (a) Start at 12.5 mg with increases of 25 mg each day for 5 to 7 days; low dose initiation reduces risk of orthostatic hypotension.
 - (b) Most clients respond to 300 to 600 mg/day, usually given in divided dose 2 times per day or at bedtime.
 - (c) Medication is distributed to outpatients for 7 days if WBC > 3000.
 - (d) Effective with both “positive” and “negative” symptoms of schizophrenia.
 - (e) Gradual improvement over several months with possibility of continued improvement throughout first year.
 - (f) Some clients have remarkable response in psychotic symptoms, daily function and social organization; report “thinking more clearly” leading to medication and treatment compliance.
 - (g) Nurse is pivotal in setting up atmosphere that improves compliance.
- b. Risperidone (Risperdal, Consta)
 - (1) Mode of action
 - (a) Blocks serotonin and dopamine (D2) receptors in limbic tract that improves positive symptoms
 - (b) Also blocks 5HT2 receptors in cortical regions of brain; frees dopamine in area and improves negative symptoms (Keltner & Folks, 1997)
 - (2) Side effects
 - (a) Unlikely to cause tardive dyskinesia; however clients should be monitored over time
 - (b) EPS—dose-related side effects
 - (c) Does not cause agranulocytosis
 - (d) Has mild alpha blockade and histamine blockade, resulting in some risk of orthostatic hypotension and sedation
 - (e) Other side effects—anxiety, dizziness, constipation, nausea, tachycardia (Keltner and Folks, 1997); insomnia, agitation, headache, rhinitis, weight gain
 - (3) Dosage and efficacy
 - (a) Starting dose in adults is 1 mg b.i.d. increased by 1 mg b.i.d. daily to initial daily dose of 4 to 6 mg/day.
 - (b) In geriatric clients, dosing should be reduced by half, starting at 0.5 mg b.i.d. titrating to 1.5 mg.
 - (c) In doses beyond 8 mg/day potential loss of improvement in negative symptom response.
 - (d) May take up to 6 to 8 weeks to become maximally effective.
 - (e) Absorbed well orally, IM form not available.
- c. Olanzapine (Zyprexa)
 - (1) Mode of action
 - (a) Like risperidone is a serotonin/dopamine antagonist (Littrell, 1997) and is known as a Multi-Acting Receptor Targeted Antipsychotic (MARTA).
 - (b) Binds to both serotonin 5HT2 and dopamine D2 receptors, with a greater affinity for serotonin, decreasing positive and negative symptoms.
 - (2) Side effects
 - (a) Decreased risk for causing EPS
 - (b) Minimal risk of prolactin elevation
 - (c) Neurologic side effects—limited to akathisia (5%), tremor (47%), and hypertonia (4%)
 - (d) Other side effects include somnolence (26%), agitation (23%), and insomnia (20%)
 - (e) Nervousness and dizziness also reported
 - (f) To date, no reported cases of tardive dyskinesia
 - (3) Dosage and efficacy

- (a) Recommended initial dose is 5 to 10 mg with a target dose of 10 mg within a few days.
 - (b) Because of the relatively short time to steady state, recommended that patient remain on a dose for 5 to 7 days before increasing.
 - (c) Mean 30-hour half-life of olanzapine allows for once-a-day dosing, usually at bedtime.
 - (d) Effective in treating positive and negative symptoms
- d. Ziprasidone (Geodon)
- (1) Mode of action
 - (a) Antagonizes D2 receptors and 5HT2 receptors
 - (2) Side effects
 - (a) Hypotension
 - (b) Dizziness
 - (c) Sedation
 - (d) Extrapyramidal symptoms
 - (e) Nausea
 - (f) Dry mouth
 - (3) Dosage and efficacy
 - (a) Recommended initial oral dose is 20 mg 2 times per day
 - (b) Available in IM formulation—recommended adult dose: 10 mg every 2 hours or 20 mg every 4 hours as needed for agitation associated with schizophrenia
 - (c) Effective in treating positive and negative symptoms
- e. Paliperidone (Invega)
- (1) Mode of action
 - (a) Like risperidone is a serotonin/dopamine antagonist
 - (b) Blocks D2 and serotonin 2A receptors, decreasing positive and negative symptoms
 - (2) Side effects
 - (a) Orthostatic hypotension
 - (b) Hyperprolactinemia
 - (c) Sedation
 - (d) Weight gain with increased risk for diabetes and dyslipidemia
 - (e) Tachycardia
 - (f) Dose-dependent EPS
 - (3) Dosage and efficacy
 - (a) Recommended initial oral dose is 6 mg daily (extended-release tablet)
 - (b) Can increase by 3 mg/day every 5 days to a maximum dose of 12 mg/day
- f. Aripiprazole (Abilify)
- (1) Mode of action
 - (a) Antagonizes serotonin 2A receptors; partial agonism at D2 receptors, and serotonin 1A receptors
 - (2) Side effects
 - (a) Headache
 - (b) Agitation
 - (c) Anxiety
 - (d) Somnolence/Insomnia
 - (e) Akathisia
 - (f) Dizziness
 - (g) Nausea/Vomiting
 - (3) Dosage and efficacy
 - (a) Recommended initial dose is 10 to 15 mg daily; increasing dose every 2 weeks to a maximum recommended 30 mg/day dose
 - (b) Anticholinergics may be useful in reducing akathisia when present.
3. Medications used for Schizoaffective Disorder—include atypical antipsychotics and mood stabilizers (such as lithium, Tegretol, and Depakote), as well as antidepressants, depending on presenting problems.
- Intrapersonal origins/Psychotherapeutic interventions
 - 1. Interactional model for schizophrenia delineates that biologic vulnerability along with environmental factors, social skills, and support of individual are factors in development of the illness.
 - 2. Psychotherapeutic intervention—acute
 - a. Nursing interventions during inpatient hospitalization
 - (1) Nurse should set a tone of quiet confidence in treatment process that conveys a sense of caring rather than judgment.
 - (2) Delivery of simple and short instructions about the facility, daily schedule and treatment process are important to building a relationship that conveys respect and concern for individual as well as their illness.
 - (3) Expected outcome of patient care for persons experiencing schizophrenia is patient will live, learn, and work at a maximum possible level of success as defined by individual (Moller & Murphy, 1995).
 - (4) Initial treatment efforts are directed at correcting instability related to major symptoms experienced and resulting disruption in activities of daily living.
 - (5) Medication management is joint effort, and must include careful

- attention to observed behaviors, client description, and client response to medication therapies.
- (6) Careful recordkeeping of descriptive information and use of Brief Symptom Rating Inventory (BSRI) assists in initial assessment phase of treatment and determines client outcome profile related to treatment and medication.
 - (7) Treatment milieu is organized to reduce sensory stimulation, while providing opportunities for simple and brief social and professional interactions.
 - (8) Schedule should provide time for rest, structured activity, and set times to speak with providers.
 - (9) Use of soft lighting, uncluttered space, and sound control can create an environment for recovery.
- b. Nursing intervention during the early acute stage of unstable neurobiologic responses requires constant observation and monitoring. Nursing interventions should focus on restoration of adaptive neurobiologic responses while providing for safety and well being (Moller & Murphy, 1995).
- (1) Assess and monitor health status and medications.
 - (2) Identify symptoms of relapse and/or factors that increase symptoms.
 - (3) Assist in management of delusions and hallucinations.
 - (4) Allow for sufficient rest for brain responses to stabilize.
 - (5) Provide a safe, protective, quiet environment.
 - (6) Reduce pressure to perform.
 - (7) Allow client to verbalize fears, concerns.
 - (8) Use clear, concise, concrete communication.
 - (9) Facilitate communication with significant others.
 - (10) Assist with activities of daily living as needed.
 - (11) Assist with anger, anxiety management, and problem solving.
 - (12) Simplify decision making.
 - (13) Assess client's risk to self and others.
- c. Communication—patient may communicate in symbols; listen actively for theme.
- d. Hallucinations
- (1) Observe patient attending to internal stimuli.
 - (2) Note if patient talks or smiles to himself/herself.
 - (3) Encourage involvement in real conversations and/or structured activities.
 - (4) Administer medication as ordered and observe response.
 - (5) Assess for content of hallucination; if patient is having command hallucinations to harm self or others, provide for safety.
 - (6) Utilize judgment when providing for increased levels of observation as patient with command hallucinations may not be able to contract for safety.
- e. Delusions—delusional individual may have delusions of grandeur, paranoia, or poverty; may think he is a public figure or may believe he is being followed by CIA.
- (1) Do not argue with client or deny belief; does not eliminate delusion nor is trust gained by this approach.
 - (2) Focus on reality and talk about reality-oriented issues in order to redirect the client from delusional topics.
 - (3) Accept client's need for belief without actually reinforcing the belief.
 - (4) For paranoid client, it is helpful to assign same staff member consistently to build trust.
 - (5) Note stressors or any escalation in anxiety that may precipitate delusional thinking; assist individual in anxiety reduction.
 - (6) If client feels food is poisoned, serve food in sealed containers.
 - (7) Paranoid thinking may cause elderly to need assistance with nutrition and hydration.
- f. Withdrawn behavior
- (1) Assist with food and fluid intake as well as hygiene.
 - (2) An accepting attitude and unconditional positive regard may decrease sense of isolation.
 - (3) Gradually introduce patient into activities.
 - (4) Give positive reinforcement for participating.
 - (5) Allow time for being alone as well as structure.
- g. Potential for harm to self
- (1) Inquire about suicidal thoughts.
 - (2) Create safe environment by removing sharp and other harmful objects.
 - (3) Encourage patient to contract for safety; if command hallucinations

- are present, contracting may not be feasible.
- h. Social isolation
 - (1) Spend time with patient.
 - (2) Make brief, frequent contacts.
 - (3) Gradually encourage participation in activities.
 - (4) Encourage structure in the day.
 - i. Alteration in nutrition
 - (1) Encourage balanced diet with high fiber.
 - (2) Monitor intake, output, and caloric count when needed.
 - (3) Limit caffeine intake.
 - (4) Provide small, frequent meals.
 - j. Potential for injury
 - (1) Decrease stimulation in environment.
 - (2) Encourage quiet time in room.
 - (3) Promote safe environment.
 - k. Management of violent behavior
 - (1) Violence against self may be in the form of suicide or self-mutilation, particularly if there are command hallucinations present.
 - (2) Violence towards others is also possibility.
 - (3) Assess characteristics such as increased pacing, clenched fists, tense expression, irritability, agitation, threatening verbalizations.
 - (4) Early intervention is important, keeping in mind use of least restrictive measures.
 - (a) Decrease stimulation in the environment.
 - (b) Administer medications per protocol/instruction and observe response.
 - (c) Provide for safe environment by removing dangerous objects.
 - (d) Encourage patient to spend quiet time in room or in quiet room.
 - (e) When approaching patient, do so from the side and not in a direct manner.
 - (f) When efforts to calm and diffuse are not successful, for safety of the patient and others, a show of force may be necessary and is sometimes sufficient in redirecting the client and de-escalating a situation.
 - (g) If redirection and medication as well as decrease in stimulation are not effective, and client is at risk of harming self or others, seclusion and restraint may be needed as a last resort; may not be used as punishment.
- (h) If seclusion or restraint is necessary: the need for continuing the restrictive intervention must be evaluated within 1 hour through face-to-face contact by the attending physician/licensed independent practitioner (LIP), or a trained and approved registered nurse or physician assistant and the physician/LIP treating that patient must be consulted as soon as possible. (*Also see discussion on seclusion and restraint in Chapter 11, page 259.*)
 - (i) Protocol for restraints include:
 - i. Position client to prevent aspiration.
 - ii. Glasses, jewelry, shoes, or belts are removed to prevent injury.
 - iii. Constant observation is recommended due to possibility of laryngeal spasms from neuroleptic medications.
 - iv. Range-of-motion to extremities should be performed every two hours and pulses, color, and temperature assessed and documented; at risk for thromboembolic events.
 - v. Nursing care includes hydration, nutrition, and attention to elimination.
 - vi. Need for seclusion and/or restraint must be documented.
 - vii. Assessment is ongoing, and patient may gradually be moved from 5-point restraints to 3-point and 2-point restraints; patient should *never* be left in only one restraint.
 - viii. Client is released from seclusion when behavior is under control and he/she is not in danger of hurting self or others.
3. Psychotherapeutic interventions—maintenance
 - a. In combination with pharmacologic management, a number of psychosocial therapeutic methods have been successful in promoting independent living, including (Sadock & Sadock, 2007):

- (1) Social skills training (behavioral skills training) used to enhance empathy and rapport with others, improve verbal/nonverbal communication and conversational skills, increase comfort in recreational and occupational activities
 - (2) Individual therapy (generally some insight into their illness is important to the success of therapy) such as CBT to address cognitive distortions, reduce distractibility, and correct errors in judgment
- Family dynamics/Family therapy
 1. No evidence that schizophrenia or other psychotic disorders are caused by family interaction patterns; therefore, family therapy is not used; important that family is involved in care of individual; family is an integral part of treatment plan and has best knowledge of individual's illness and ability to function.
 2. Illness affects entire family system including careers, finances, schedules, and social life; problems that recur most frequently are:
 - a. Failure to care for personal needs/hygiene
 - b. Difficulty handling finances
 - c. Withdrawal
 - d. Odd personal habits
 - e. Suicide threats
 - f. Concern for safety of client and family
 4. Eliminating blame is important if family members blame each other; acceptance of illness is first step toward management of illness; expectations of patient should be realistic.
 5. Anger may have to be addressed.
 6. Other questions to consider include:
 - a. Devotion of time to other family members
 - b. Respite for caregiver
 - c. Home care versus boarding home or half-way house
 7. Family members require education and instruction; discharged client may require reintegration within family and role shifting may occur; nurse should assess family attitudes toward client, overall atmosphere in family, and available emotional/social supports.
 8. Some aspects of family life have been linked to relapse in schizophrenia; concept of expressed emotion is implicated; three main components of expressed emotion are: criticism, hostility, and over-involvement; for individuals with schizophrenia with high expressed emotion, there is a higher probability of relapse (Haber, 1997).
 9. Family needs to be educated on the role of stress in the exacerbation of symptoms.
10. Environment for medication compliance is also important; 70% relapse rate if medications are not taken regularly and 30% relapse rate if medication regimen is followed.
 11. Family members can be taught to recognize symptoms that may require medication adjustment or hospitalization.
 12. Family can provide responsibilities for client, such as simple chores, to introduce a sense of routine and accomplishment.
 13. Family should encourage participation in vocational rehabilitation and other therapeutic activities.
 14. Role of the Psychiatric/Mental Health Advanced Practice Nurse (PMH-CNS & PMHNP)
 - a. Various roles exist in advanced PMH nursing practice related to psychotherapy or pharmacologic management, and combined pharmacologic management and psychotherapy (as allowed by state law/nurse practice act).
 - b. Psychotherapeutic actions of the advanced practice nurse may include:
 - (1) Help client and family learn more about illness, treatment options, and ways to live with disease in a productive fashion.
 - (2) Plan psychoeducational approaches that maximize times when client symptoms are relatively stable.
 - (3) Simplify instruction, reduce distracting stimuli, provide both visual and verbal information, and provide instruction in small segments with frequent reinforcement (Moller & Murphy, 1995).
 - (4) Initiate family education that accentuates the family's belief in their own expertise, and focuses on symptom management and self-care skills for client.
 - (5) Discuss with client and family, rationale for selection of medication regimen, options available, expected benefits, side effects and time lag in response.
 - (6) Establish a partnership with client, family members, and other health care professionals to develop treatment and rehabilitative goals.
 - (7) Provide case management that may include any/all of the following:
 - (a) Identifying and coordinating services
 - (b) Understanding appropriate use of day treatment programs, clubhouse programs, and companion

- programs etc., so they may be used as part of comprehensive treatment program
- (c) Making appointments and accompanying client if needed
 - (d) Assisting during crises
- Group approaches and self-help
 1. Traditional group therapy, insight-oriented groups or groups that are primarily interactional in nature are generally not helpful, as the individual has difficulty filtering stimuli.
 2. Self-help groups may be more beneficial—focus on educational issues, support, and destigmatization of mental illness.
 3. Social skills training can occur in groups and would include introducing oneself, starting a conversation, and listening skills; staff act as role models for implementation of these skills.
 - Milieu interventions
 1. Regular daily activities can provide a sense of predictability as well as sense of accomplishment and reward.
 2. Treatment environment should emphasize involvement, organization and standards of safety; there should be established norms and rules.
 3. Client may feel safer if periods of time are scheduled to be spent in his/her room.
 4. If client feels threatened by milieu activities, encourage involvement with only one other client.
 - Community resources
 1. The National Alliance for the Mentally Ill (NAMI) and Friends and Family of the Mentally Ill provide advocacy, support groups, and educational programs.
 2. Local chapters of Companion Peer (COMPEER) develop community connections by providing companion matching services.
 3. Local community services boards plan, implement, and evaluate a variety of programs including outpatient, day treatment, case management, crisis services, club houses, employment, and job coaching.
 4. Local community mental health center is also valuable resource; patient is followed on an outpatient basis through mental health center and receives medication through this setting.
 5. Day treatment programs
 6. Possibilities for residential placement include halfway houses or boarding homes depending on patient's abilities and skills.
 7. Supplementary security income can provide small, fixed income and may pay residential costs in boarding home.
 - 8. Transportation services are key resources to promote access.
 - 9. Psychiatric home care:
 - a. Allows for careful identification and monitoring of target symptoms and relapse prevention.
 - b. Promotes involvement of client in self-assessment.
 - c. Focuses on attainment of specific goals related to rehabilitation and maximization of functional ability.
 - d. Nurse in psychiatric home care is essentially a “guest” in client's home, which is an empowering position for the client and family and supports process of continuing outpatient care for persistent but treatable mental illness.
 - e. Nurse in psychiatric home care uses a rehabilitative model that supports client self-care and develops appropriate goals for successful, feasible outcomes that are compatible with the limitations of illness and abilities of client.

■ QUESTIONS

Select the best answer

1. Mr. Jones is a patient diagnosed with schizophrenia who is hospitalized on a psychiatric unit. You notice him standing motionless on one leg in the day area. This would most likely be an example of:
 - a. Attention-seeking behavior
 - b. Catatonic posturing
 - c. A side effect of neuroleptic medication
 - d. Catatonic stupor
2. During the initial assessment, the nurse inquires of Mr. Jones, “What brought you to the hospital?” Mr. Jones replies, “An ambulance.” This is an example of:
 - a. Deductive reasoning
 - b. Abstract thinking
 - c. Concrete thinking
 - d. Poverty of content of speech
3. Mr. Jones is informed during his hospital stay that his brother has been diagnosed with cancer and will be undergoing surgery. Mr. Jones laughs upon hearing the news. Your understanding of this is:
 - a. Mr. Jones is obviously not close to his brother.
 - b. Mr. Jones possibly has a mood disorder.
 - c. Mr. Jones is obviously anxious and upset by this news.

- d. Mr. Jones is displaying incongruence between content of communication and his emotions.
4. Mr. Jones comments that he hears voices of men telling him "bad things about myself. They say I should hurt myself." Your most appropriate initial response would be to:
 - a. Reassure Mr. Jones of his safety and security by telling him the voices aren't real
 - b. Provide for Mr. Jones' comfort and security by reminding him that he has never hurt himself in the past
 - c. Assess the command hallucinations for potential destructiveness by asking specifically for the content
 - d. Tell him to ignore the voices and administer prn medications
 5. When John, a 25-year-old graduate student diagnosed with Paranoid Schizophrenia, is ready for discharge, which of the following is important for the client and his family?
 - a. To understand all of the causal explanations of the illness so they can be discussed at home
 - b. To set up a plan to improve the outlook of the client that includes daily rules for acceptable behaviors
 - c. To understand the treatment plan, including prescribed medication, expectations concerning effects and plans for continuity of care, and professional resources
 - d. To understand that all activity is to be avoided, so that John will not get upset
 6. The patient remarks repeatedly that he believes he is Jesus Christ and has come to save the world. This can best be described as:
 - a. Defense of identification
 - b. A delusion of grandeur
 - c. An illusion
 - d. An idea of reference
 7. Mr. Brown continues to remark that the CIA is following him and that they are waiting outside the door to the emergency room. Your best response would be:
 - a. "Mr. Brown, the CIA is not following you."
 - b. "We've told the CIA to leave you alone."
 - c. "I understand you feel that they are outside, but the CIA is not there and you're safe here."
 - d. "Why do you think the CIA is out there?"
 8. You notice during the assessment period that Mr. Brown is rocking back and forth on his feet and appears to be restless. This could be an indication of:
 - a. Extreme anxiety
 - b. Neuroleptic malignant syndrome
 - c. Catatonic rigidity
 - d. Acute dystonia
 9. Ms. Smith was recently admitted to an inpatient psychiatric facility. During the assessment she seems to be mimicking your body movements. This is an example of:
 - a. Echopraxia
 - b. Echolalia
 - c. Mirroring the therapist
 - d. Akathisia
 10. Several hours after being admitted, Ms. Smith complained of feeling bugs crawling on her skin. This could be indicative of:
 - a. Alcohol withdrawal
 - b. A hallucination common among patients with schizophrenia
 - c. A side effect of neuroleptic medications
 - d. A seizure disorder
 11. Ms. Smith displays paranoid behavior on the unit and becomes particularly suspicious. She comments that she suspects the food is being poisoned. A possible intervention would be to:
 - a. Serve the food in sealed containers
 - b. Serve small, frequent meals
 - c. Have Ms. Smith eat away from the other patients
 - d. Have Ms. Smith prepare her own meals
 12. Mr. Brown has been treated for the past several years with Prolixin. You notice that he is drooling, has a tremor, and there is slight pill-rolling of the fingers. These are the extrapyramidal symptoms known as:
 - a. Anticholinergic side effects
 - b. Pseudoparkinsonism
 - c. Tardive dyskinesia
 - d. Dystonic reaction
 13. Several days into the hospitalization, Mr. Brown complains of urinary retention, an anticholinergic side effect. Which of the following medications would be best to ease the urinary retention?
 - a. Cogentin
 - b. Artane
 - c. Lasix
 - d. Bethanecol

14. Mr. Brown has been on cogentin along with haloperidol. You notice that in addition to the urinary retention, his face is flushed, and he has become disoriented. This is an example of:
- An exacerbation of the psychosis
 - Anticholinergic delirium
 - Early-onset dementia
 - Brief reactive psychosis
15. Mr. Johnson is being treated with haloperidol. He develops a fever of 102°F, muscular rigidity, altered mental status, and diaphoresis. It is determined that he is suffering from neuroleptic malignant syndrome. Which laboratory findings are *most* likely to occur?
- An elevated haloperidol level
 - A decrease in the CPK level and an elevated white blood cell count
 - An increase in the CPK level and an elevated white cell count
 - A decrease in the white cell count
16. Possible complications from neuroleptic malignant syndrome include the following:
- Muscle rigidity, hyperthermia, autonomic instability
 - Liver failure
 - Increased intracranial pressure
 - Agranulocytosis
17. Nursing care for the patient with neuroleptic malignant syndrome will include:
- The discontinuation of the neuroleptic, maintenance of skin integrity and hydration, and administration of bromocriptine
 - The gradual tapering of the neuroleptic, the administration of cogentin, and maintenance of skin integrity and hydration
 - The gradual tapering of the neuroleptic, administration of bromocriptine, and maintenance of skin integrity and hydration
 - The discontinuation of the neuroleptic, maintenance of skin integrity and hydration, and the administration of cogentin
18. Which of the following statements best describes characteristics about the onset and development of neuroleptic malignant syndrome?
- It is noted most commonly in female patients taking haloperidol, so they are most at risk.
 - The initial onset is insidious and is therefore difficult to detect.
 - It develops only after months to years of treatment with neuroleptic medications.
 - The onset may be sudden and can occur after the first dose of the medication.
19. Mr. Jones has not been eating and has difficulty bringing food to his mouth. The most appropriate intervention would be to:
- Place the spoon in the patient's hand, scoop food into it and say, "Eat a bite of this apple sauce."
 - Place the patient on a liquid supplement as this may be more easily tolerated
 - Spoon feed the patient
 - Allow patient to eat in his room as he will be more comfortable away from the other patients
20. Which best describes the action of antipsychotic medications?
- They block dopamine receptors.
 - They decrease available amounts of serotonin and norepinephrine.
 - They enhance the availability of dopamine.
 - They block reuptake of dopamine to increase availability at receptor sites.
21. As a nurse employed at the community mental health center, you are a case manager for several patients taking clozapine. Compared with conventional antipsychotics, the advantages of taking clozapine include:
- Follow-up is less frequent since tardive dyskinesia does not occur.
 - It is less likely to cause orthostasis.
 - Restlessness and tremors are less likely to occur.
 - It is more potent than phenothiazines.
22. Medication teaching about clozapine *should* include which of the following:
- Cautioning the patient to report any signs of infection including sore throat, flu-like symptoms and fever
 - The importance of being compliant with having a complete blood count drawn at least monthly
 - Notifying the physician *immediately* about lip-smacking or vermiform movements of the tongue
 - Notifying the physician immediately at the onset of diarrhea and hand tremors
23. You are caring for a patient who suffers from epilepsy and has been diagnosed recently as having schizophrenia. Teaching should include which of the following:

- a. Antipsychotic medications should be used cautiously as they increase seizure threshold.
 - b. Antipsychotic medications should be used cautiously as they decrease seizure threshold.
 - c. Antipsychotic medications do not affect seizure threshold.
 - d. Antipsychotic medications are contraindicated.
24. The following is indicative of a dystonic reaction:
- a. Oculogyric crisis and spasms of the back muscles
 - b. Cogwheel rigidity and lip-smacking movements
 - c. Shuffling gait and mask-like faces
 - d. Urinary retention and leg stiffness
25. Nursing actions during a dystonic reaction may include:
- a. Turning patient on side
 - b. Notifying physician, administration of cogentin, and making certain respiratory support equipment is available
 - c. Administration of IM physostigmine and bethanecol
 - d. Decreasing stimulation in environment as dystonia and agitation may appear similar
26. Which of the following statements about tardive dyskinesia is *most* accurate?
- a. Symptoms are generally reversible, particularly in younger patient population.
 - b. Symptoms may appear 1–10 days following administration of neuroleptic medication.
 - c. Occurs most often in dehydrated patients.
 - d. All patients on long-term neuroleptic therapy are at risk.
27. Your patient on a conventional neuroleptic medication complains of dizziness. Your *initial* intervention would be:
- a. Taking the patient's blood pressure sitting and standing
 - b. Forcing fluids
 - c. Prompt discontinuation of the medication and notifying the physician
 - d. Instructing patient to place their head between knees
28. You are working with Mr. Green who has recently been prescribed Thorazine (chlorpromazine). He comes to the nurses' stations and complains of blurred vision and constipation. Your most appropriate response would be:
- a. "I'll notify the physician right away as your dose is probably too high."
 - b. "Those are possible side effects to the medication and tolerance usually develops in several weeks. We can order a bulk diet for you."
 - c. "I'll notify the physician right away and see if we can try a different medication."
 - d. Administer an anticholinergic medication.
29. A common hypothesis regarding the biologic origin of schizophrenia is:
- a. Dopamine hypothesis, which postulates that some cases may be due to excess of dopamine in the brain and/or an excessive number of dopamine receptors
 - b. Disease is caused by enlarged lateral ventricles in the brain.
 - c. Norepinephrine hypothesis, which states that schizophrenia is due to an excess of this neurotransmitter, which causes hallucinations
 - d. All cases of schizophrenia are caused by viruses contracted in utero.
30. The most current Family Theory states:
- a. Research has indicated schizophrenia is a direct result of dysfunctional family interaction.
 - b. The individual with schizophrenia withdraws and hallucinates as a defense against a hostile family environment.
 - c. There is no proof that schizophrenia is caused by family interaction patterns.
 - d. An individual with schizophrenia is most likely to be product of a cold, aloof mother and absent, distant father.
31. According to genetic studies of schizophrenia:
- a. Genetic factors are not important to one's risk of developing schizophrenia.
 - b. A twin of a monozygotic (identical) twin with schizophrenia has a greater chance of having schizophrenia than the general population.
 - c. A twin of a monozygotic (identical) twin with schizophrenia has a lesser chance of having schizophrenia than the general population.
 - d. Genetic inheritance is most likely the only cause of schizophrenia since family interactional patterns cannot be empirically studied.
32. Mr. Jones reports that he is hearing voices telling him to cut his wrists and he is highly agitated

with complaints of fear and anxiety. The *most appropriate* intervention would be to:

- a. Administer medication, as per protocol, and encourage Mr. Jones to contract for safety and to notify nursing staff should voices increase
 - b. Administer medication, as per protocol, and encourage Mr. Jones to spend time in his room, after checking for sharp objects and ensuring the environment is safe
 - c. Administer medication, as per protocol, remove dangerous objects from patient's environment, and place him on constant observation
 - d. Administer medication, as per protocol, and place him in closed door seclusion with safety checks every 15 minutes
33. Ms. Williams, who was admitted to the unit yesterday, is withdrawn and keeps to herself on the unit. An appropriate intervention would be:
- a. Encouraging Ms. Williams to attend all activities as prescribed in order to integrate into the milieu and feel a part of the group
 - b. Encouraging Ms. Williams to spend all day and early evening on the unit and locking the door to her room
 - c. Encouraging Ms. Williams to attend activities gradually with a supportive staff member
 - d. Electing Ms. Williams as the patient representative to increase her sense of confidence
34. Ms. Williams has difficulty trusting the staff members on the unit. Which of the following interventions is *most likely* to promote trust?
- a. Using therapeutic touch in order to convey caring and concern for Ms. Williams
 - b. Encouraging patient to engage in a one-to-one session for an hour on both morning and evening shifts to convey acceptance of her
 - c. Assigning the same staff to work with Ms. Williams as often as possible
 - d. Encouraging Ms. Williams to play a game of cards with the other patients
35. David has responded well to clozapine with a maintenance dose of 400 mg per day. The psychiatric home health nurse draws blood for a weekly WBC and distributes a week's supply of medication if the WBC > 3,000. She explains the importance of compliance to the daily dose as prescribed and instructs David to call his doctor if he misses more than two doses of medication because:
- a. He will need to begin the titration process from the beginning.
 - b. Noncompliance for several days and reinstatement at the previous dose could result in syncopal episode, orthostatic hypotension or seizure.
 - c. His doctor will discontinue the medication.
 - d. He is at risk for immediate acute exacerbation of psychosis.
36. The advanced practice PMH nurse assesses the relationship between David and his family, and together they work out a plan for David to attend a social club house program 3 afternoons a week, and a referral to COMPEER. His family is told about the meeting times for the local chapter of the Alliance for the Mentally Ill. The purpose of the Alliance for the Mentally Ill is to:
- a. Provide a companion matching service to develop community connections for those with mental illness
 - b. Provide advocacy and support programs for clients and their families
 - c. Provide housing and supervision on a continuum from professional caregivers to managed properties
 - d. Provide transportation 24 hours a day
37. Mr. Parker has been diagnosed with Paranoid Schizophrenia and has stated that he believes that other patients are out to get him. Mr. Parker has escalated to the point where he is threatening others, and he is having difficulty staying in his room. The decision is made to assist Mr. Parker by having him spend some time in the quiet room. Which of the following interventions will *most likely* promote safety?
- a. Approach Mr. Parker with several other staff members in a quiet manner and escort him to the quiet room.
 - b. Approach Mr. Parker alone as he may feel more threatened with more than one staff member.
 - c. Place Mr. Parker in 4-point restraints and check on him every 15 minutes.
 - d. Force-medicate him according to hospital policy.
38. Mr. Parker begins banging his head against the wall. It becomes necessary to place Mr. Parker in mechanical restraints in order that he not hurt himself. Nursing care should include the following:

- a. Checking on Mr. Parker at least once an hour
 - b. Performing range-of-motion exercises every 2 hours and assessing circulation to the extremities
 - c. Removing all restraints if Mr. Parker becomes less agitated within 10 minutes
 - d. Gradually removing restraints until Mr. Parker has only one restraint remaining
39. The individual with schizophrenia may benefit from a group-oriented approach. Which of the following groups would be *most* appropriate?
- a. A didactic as well as supportive group that provides social skills training
 - b. Insight-oriented
 - c. Cognitive-behavioral in order to assist with difficulties with self-care
 - d. Any of the above, depending on the individual patient
40. Mr. Williams who has been hospitalized for over a month due to exacerbation of schizophrenia will soon be discharged to his home where he will live with his parents and one younger brother. Which of the following recommendations will be most helpful to the family?
- a. Provide Mr. Williams with a structured routine, including chores and other responsibilities.
 - b. Do not encourage spending time alone as this will increase a sense of isolation from the family.
 - c. Encourage Mr. Williams to take complete responsibility for medications and follow-up appointments.
 - d. Set goals for Mr. Williams as he may have difficulty doing this for himself.
41. After a short period on a typical antipsychotic, a client complains that she can't sit still and taps her foot continuously. The nurse should:
- a. Administer a prn dose of medication because she is still agitated
 - b. Understand that these symptoms are akathisia, and consider use of diphenhydramine and/or reduce the dosage of medication
 - c. Help client relax in bed and obtain an order for an antianxiety medication
 - d. Provide for vigorous activities until she settles down
42. Which of the following symptoms is considered a "negative symptom" of schizophrenia?
- a. Auditory hallucinations
 - b. Delusions

- c. Flat affect
 - d. Both a and b are correct
43. Which of the following is most effective in treating both positive and negative symptoms of schizophrenia?
- a. Risperidone
 - b. Ziprasidone
 - c. Haloperidol
 - d. Both a and b are correct

ANSWERS

- | | |
|--------------|--------------|
| 1. b | 23. b |
| 2. c | 24. a |
| 3. d | 25. b |
| 4. c | 26. d |
| 5. c | 27. a |
| 6. b | 28. b |
| 7. c | 29. a |
| 8. a | 30. c |
| 9. a | 31. b |
| 10. a | 32. c |
| 11. a | 33. c |
| 12. b | 34. c |
| 13. d | 35. b |
| 14. b | 36. b |
| 15. c | 37. a |
| 16. a | 38. b |
| 17. a | 39. a |
| 18. d | 40. a |
| 19. a | 41. b |
| 20. a | 42. c |
| 21. c | 43. d |
| 22. a | |

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Mood Disorders

■ MOOD DISORDERS—OVERVIEW

- Definition (American Psychiatric Association [APA], 2000; Sadock & Sadock, 2007)—Mood disorders are characterized by mood disturbances on a continuum from depression to mania (See **Table 7-1**). Mood is an internally experienced feeling tone, distinguished from affect, which is an external expression of the internal feeling tone.
 1. Generally involves single or recurring depressive (unipolar) and/or manic (bipolar) episodes
 2. Also occurs as part of other nonmood conditions (anxiety, cognitive, eating, psychotic, or substance-related disorders)
 3. Occurs as a consequence of nonpsychiatric medical conditions (cerebrovascular accident (CVA), diabetes, cancer, acquired immunodeficiency syndrome (AIDS), chronic fatigue syndrome (CFS), fibromyalgia, multiple sclerosis (MS)) or as a consequence of some medications or their combined use.
 4. Levels of severity include:
 - a. Mild—limited symptomatology beyond those needed for diagnosis
 - b. Moderate—intermediate severity between mild and severe
 - c. Severe *without* psychotic features—most of the diagnostic criteria have been met, and these symptoms significantly interfere with daily functioning
 - d. Severe *with* psychotic features—most of the diagnostic criteria have been met, and these symptoms significantly interfere with daily functioning *and* include the presence of delusions or hallucinations
 - (1) Mood-congruent—delusions/hallucinations consistent with mood themes such as guilt, deserved punishment for depression or power, knowledge for manic themes
 - (2) Mood-incongruent—delusions/hallucinations inconsistent with mood themes such as guilt, deserved punishment for depression or power, knowledge for manic themes (e.g., thought insertion, thought broadcasting)
- Prevalence (U.S.) (Kessler, Chiu, Demler, & Walters, 2005; Sadock & Sadock, 2007)
 1. Mood disorders are among the most prevalent mental disorders diagnosed in the general population (17% lifetime prevalence rate); 50% of suicides are associated with depression.
 2. Major depressive episode prevalence is 12% lifetime, 6.7% one year.
 3. Bipolar illness prevalence is < 1% lifetime, 2.6% one year.
 4. Dysthymia prevalence is 5% lifetime, 1.5% one year.
- Sex distribution
 1. Unipolar Disorder—females to males 2:1
 2. Bipolar Disorder—equal male-female distribution; women have higher rate of depressive episodes and rapid cycling (4 or more manic episodes in 12-month period)

■ Table 7-1 Features of Mood Disorders

Predominant Mood Features	Mood Disorder Type	Evidence of MDE	Evidence of HE	Evidence of ME	Comments/Special Features
Depressed	Major Depressive	X			Use severity specifiers
	Dysthymic				Depressed mood for 2 or more years
	Adjustment Disorder with Depressed Mood				Mild depressive symptoms associated with known stressor
	Double Depression	X			MDE with dysthymia—not a current diagnosis in DSM-IV-TR
	Depressive Personality Disorder				Pervasive pattern of depressed behavior and thoughts, tends to be pessimistic—Not a current diagnosis in DSM-IV-TR
Depressed and elevated, expansive or irritable	Bipolar I	X		X	Use severity specifiers
	Bipolar II	X	X		Note hypomanic rather than manic features
	Cyclothymic		X		Two or more years of hypomanic symptoms and periods of depressed mood
Mood symptoms subside while psychotic symptoms continue	Schizoaffective Disorder, bipolar type	X		X	Prominent features of delusions or hallucinations in absence of mood symptoms
	Schizoaffective Disorder, depressed type	X			
Variable/Nonspecific	Due to General Medical Condition	Possible	Possible	Possible	Mood symptoms are the direct result of a medical condition
	Substance Induced Mood Disorder	Possible	Possible	Possible	Mood symptoms are the direct result of a substance (medication, toxin, or substance of abuse)
	Not otherwise specified				Criteria for other mood disorders are not completely met

HE = Hypomanic Episode; MDD = Major Depressive Disorder; MDE = Major Depressive Episode; ME = Manic Episode (APA, 2000; Sadock & Sadock, 2007)

- Age distribution
 1. Onset of Bipolar Disorder is earlier (childhood to age 50) than for major depressive episode.
 2. Mean age of onset is 30 years for Bipolar Disorder.
 3. Mean age of onset is 40 years for Depressive Disorder (evidence suggests a younger onset age among those involved in substance use).
- Other etiologic factors
 1. Both Depressive Disorder and Bipolar Disorder occur less frequently among those involved in close interpersonal relationships.
 2. Higher incidence of Bipolar Disorder exists among noncollege graduates of higher socioeconomic status (no relationship for Depressive Disorder).
 3. Depressive Disorder is more common in rural vs urban areas.

■ DEPRESSIVE DISORDERS

Major Depression (unipolar, endogenous/depression in absence of external stress)

- Definition—Depressed mood or loss of interest or pleasure in all or almost all activities (anhedonia) and associated symptoms for a period of at least 2 weeks, persisting and representing a change from previous functioning; can be mild, moderate or severe, with or without psychotic features; occurs in the absence of manic features.
- Signs and symptoms—in addition to the presence of a persistent depressed mood or anhedonia, the DSM-IV-TR criteria for a major depressive episode include the presence of at least four of the following (APA, 2000):
 1. Significant weight loss or gain when not dieting (>5% of body weight in a month)
 2. Insomnia or hypersomnia
 - a. Initial insomnia/difficulty falling asleep (DFA)
 - b. Middle insomnia (waking up during sleep and difficulty falling back to sleep)
 - c. Terminal insomnia/early morning awakening (EMA)
 3. Psychomotor retardation or agitation (observable by others)
 - a. Slowed speech/pressured speech/muteness/poverty of thought
 - b. Slowed body movements/pacing, handwriting, inability to sit still, rubbing of hair, skin, clothing
 4. Fatigue or loss of energy
 5. Feelings of worthlessness or excessive or inappropriate guilt
 6. Diminished ability to think or concentrate or indecisiveness
 7. Recurrent thoughts of death (not just fear of death); recurrent thoughts of suicide without a plan, a suicide attempt, or a specific suicide plan
- Differential diagnosis
 1. Substance-related disorder (e.g., withdrawal from alcohol, cocaine)
 2. Physical health problems or disease that may cause or be associated with depressive symptoms
 3. Nonmood psychiatric disorders
 4. Prior episodes of unipolar depression or Bipolar Disorder and/or suicide attempts
 5. Nodal events/stressful life events (postpartum, death of a spouse, job loss, geographic move, illness)
 6. Bereavement (symptoms persist longer than 2 months after loss of a loved one or include psychotic symptoms)
 7. Mixed state episode (unipolar plus bipolar symptoms)
- Additional Features of Depressive Disorder that may be specified (APA, 2000)
 1. With melancholic features—a severe form of major depressive episode occurring more commonly in older persons; believed to be particularly responsive to somatic therapy; applied to the current episode only if it is the most recent episode
 2. With seasonal pattern (Seasonal Affective Disorder)—regular temporal relationship between the onset of an episode of Major Depression or Bipolar Disorder, recurrent during a particular period of the year; in the absence of obvious seasonal stressor such as regular winter unemployment; full remissions or a change from depression to hypomania or mania also occur at a characteristic time of the year
 3. With atypical features—characterized by the following features:
 - a. Mood brightening during positive events (mood reactivity)
 - b. Increased appetite (and possible weight gain)
 - c. Increased sleep (hypersomnia)
 - d. Feeling weighed down (leaden paralysis)
 - e. Persistent pattern of interpersonal rejection sensitivity
 4. With postpartum onset—depressive episode, ranging from moderate to severe, following

childbirth with or without psychotic features and/or manic episodes; onset of episode within 4 weeks postpartum

Dysthymic Disorder

- Definition—Chronic depressed mood for most of the day, for more days than not, as indicated by subjective account or observations made by others, for at least 2 years and that causes clinically significant distress or impairment in school, occupation, or other important areas of functioning; frequently occurs in the presence of a coexisting personality disturbance.
- Signs and symptoms—in addition to a chronic depressed mood, the presence of at least two of the following are described in the DSM-IV-TR (APA, 2000):
 1. Low self-esteem
 2. Feelings of hopelessness
 3. Poor concentration or difficulty making decisions
 4. Low energy or fatigue
 5. Insomnia or hypersomnia
 6. Poor appetite or overeating
- Differential diagnosis
 1. Major depressive disorder
 2. Depressive symptoms due to a medical condition or substance-related disorder

■ BIPOLAR DISORDERS

- Definition—a disorder of mood in which there is at least one or more manic or hypomanic episodes, usually with a history of one or more major depressive episodes (APA, 2000)

Bipolar I Disorder (BPD I) (APA, 2000, Sadock & Sadock, 2007)

- Definition—frank manic or hypomanic episodes with or without major depressive episodes that occur in an alternating pattern separated by hours, weeks, months, or years, interspersed with periods of euthymia (normal mood)
 1. Manic episode
 - a. A distinct period during which the predominant mood is elevated, expansive, or irritable, causing marked impairment in occupational functioning, social activities, and relationships for at least one week
 - b. Presence of at least three of the following during the same period of time:
 - (1) Inflated self-esteem or grandiosity
 - (2) Loquaciousness/pressure of speech

- (3) Flight of ideas/thoughts racing/looseness of associations
- (4) Distractibility
- (5) Increase in goal-directed activity ranging to frantic, disorganized activity
- (6) Excessive involvement in pleasurable activities with harmful consequences (i.e., spending sprees, promiscuity, reckless business decisions and investments)
- (7) Decreased need for sleep
- c. Differential diagnosis
 - (1) Mixed-state episode
 - (2) Schizoaffective Disorder
 - (3) Substance abuse
 - (4) Response to somatic antidepressant treatment (e.g., ECT, light therapy, antidepressant medication)
2. Hypomanic episode
 - a. A distinct period of sustained, elevated, expansive, or irritable mood, lasting throughout 4 days, that is clearly different from the nondepressed mood
 - b. At least three of the following symptoms have been present to a significant degree:
 - (1) Inflated self-esteem or grandiosity
 - (2) Decreased need for sleep
 - (3) More talkative or pressure to keep talking
 - (4) Flight of ideas/thoughts racing
 - (5) Distractibility
 - (6) Increase in goal-directed activity
 - (7) Excessive involvement in pleasurable activities
 - c. Associated with:
 - (1) Unequivocal change in functioning
 - (2) Disturbance in mood and change in functioning are observable by others
 - (3) Episode not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization
 - (4) No psychotic features
 - d. Differential diagnosis—medication, substance abuse or general medical condition (e.g., hyperthyroidism)
3. Depressive episode
 - a. Definition—previously has had at least one manic episode, but currently in a major depressive episode
 - b. Signs and symptoms—see Major Depression

Bipolar II Disorder (BP II) (APA, 2000, Sadock & Sadock, 2007)

- Definition—one or more major depressive episodes with at least one episode of hypomania that

cause clinically significant distress or impairment in social occupational or other important areas of functioning

- Differential diagnosis
 1. Has never had a mixed episode
 2. Has never had a manic episode
 3. Mood symptoms not accounted for by Schizoaffective Disorder; not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified
 4. Not precipitated by somatic antidepressant treatment

Cyclothymic Disorder (APA, 2000, Sadock & Sadock, 2007)

- Definition—a chronic mood disturbance of at least 2-years duration involving numerous hypomanic episodes and periods of depressed mood or loss of interest or pleasure
- Differential diagnosis
 1. Not without hypomanic or depressive symptoms for more than 2 months during a 2-year period
 2. Has not met criteria for a major depressive, mixed or manic episode
- Signs and symptoms
 1. For symptoms of depression, see Depressive Disorders
 2. For symptoms relating to hypomania, see Bipolar Disorders
- Therapeutic interventions (Sadock & Sadock, 2007)
 1. Biologic therapy is fundamentally the same as for bipolar disorders. Studies support the use of antimanic agents such as valproate (Depakene) and carbamazepine; there is limited data available for the use of lithium with cyclothymia
 2. Psychotherapy is best used to address educational and coping needs of patients with cyclothymia

MOOD DISORDER DUE TO ... (INDICATE GENERAL MEDICAL CONDITION) (APA, 2000, Sadock & Sadock, 2007)

- Definition—prominent and persistent disturbance in mood judged to be due to direct physiological effects of a general medical condition; e.g., stroke, endocrine or autoimmune conditions, viral or other infections, which causes *clinically significant*

distress or impairment in social, occupational, or other important areas of functioning

- Signs and symptoms
 1. Depressed mood or anhedonia
 2. Elevated, expansive or irritable mood
 3. Evidence from history, physical exam, or laboratory findings that the mood disturbance is the direct physiological consequence of a general medical condition
- Differential diagnosis
 1. Not better accounted for by another mental/psychiatric disorder
 2. Does not occur exclusively during the course of delirium

SUBSTANCE-INDUCED MOOD DISORDER (APA, 2000, Sadock & Sadock, 2007)

- Definition—permanent and persistent disturbance in mood that is judged to be due to the direct physiological effects of substance; e.g., drug abuse, medications, somatic treatments for depression, toxin exposure that arises *only in association* with intoxication or withdrawal states causing clinically significant distress or impairment to social, occupational, or other important areas of functioning
- Signs and symptoms
 1. Prominent and persistent mood disturbance that predominates the majority of time; characterized by either depressed mood or anhedonia, and/or elevated, expansive or irritable mood
 2. Evidence from history, physical exam, and/or laboratory results that either occurrence within a month of intoxication or withdrawal of medications is etiologically related to the disturbance
- Differential diagnosis
 1. Mood disorder that is not substance induced
 2. Does not occur exclusively during a delirium

SUICIDE (Sadock & Sadock, 2007)

- Definition—a self-directed act to end one's life that may be associated with:
 1. Major Depression
 2. Bipolar Disorder
 3. Schizophrenia (command hallucinations)
 4. Alcohol and drug use or withdrawal
 5. Impulse control disorders

- Involves:
 1. Behavior changes
 2. Anxiety
 3. Insomnia
 4. Anorexia
 5. Expression of anger, helplessness, or hopelessness
 6. Giving away personal possessions, closing bank accounts
 7. Sudden calmness or improvement in a depressed client
 8. Questions about guns, poisons, or other lethal instruments
 9. Social withdrawal/isolation (physical or social)
 10. Stress (e.g., loss of health, significant other, job)
 11. Feelings of worthlessness (e.g., everyone would be better off without me)
- Lethality of suicide threat—direct relationship with the risk of death from suicide gesture
 1. Low lethality—low death risk (holding breath, superficial cutting of wrists)
 2. Moderate lethality—moderate death risk (overdose of drug or toxic agent)
 3. High lethality—death is likely (hanging, gunshot, driving into a train)
- Risk factors related to suicide:
 1. Caucasian/White race
 2. Male gender
 3. Advanced Age (3:1 risk for ≥ 75 years)
 4. Current depression
 5. Living alone/Isolation
 6. Lethality of suicide plan
 7. Previous suicidal behavior
 8. Presence of psychotic symptoms
 9. Physical illness
 10. Hopelessness
 11. Family history of substance abuse
 12. Family history of suicide

■ ETIOLOGY OF MOOD DISORDERS

- Genetic/Biologic origins (Levinson, 2005; Sadock & Sadock, 2007; Stahl, 2008; Wong, Arcos-Burgos, & Licinio, 2008)
 1. Data consistently demonstrate high concordance rates among first-degree relatives of people with unipolar depression and Bipolar Disorder and among monozygotic versus dizygotic twins—the more family members affected with a mood disorder, the more likely other first-degree family members will be affected.
- 2. Recent genetics studies have focused on identifying specific susceptibility genes for mood disorders. Linkage studies suggest the involvement of several specific genes (from <http://www.ncbi.nlm.nih.gov/sites/entrez?db=Gene>)
 - a. Depression—chromosomes 2, 5, 11, and 17 have been implicated.
 - (1) SLC6A4 (also known as: 5HTT, 5-HTTLPR, SERT) on chromosome 5—Encodes protein that transports serotonin. The encoded protein terminates the action of serotonin and recycles it. A repeat length polymorphism in the promoter of this gene has been shown to affect the rate of serotonin uptake and may play a role in depressive symptoms.
 - (2) BDNF (brain-derived neurotrophic factor) on chromosome 11—may play a role in the regulation of stress response and in the biology of mood disorders.
 - b. Mania—chromosomes 5, 10, 11, and 13 have been implicated.
 - (1) DAOA (D-amino acid oxidase activator) on chromosome 13—polymorphisms in this gene have been implicated in susceptibility to Schizophrenia and Bipolar Affective Disorder, possibly due to decreased levels of D-serine and decreased NMDA receptor functioning.
 - (2) BDNF (see depression, 2.c above)
- 3. Neurotransmitter hypotheses
 - a. Imbalances in nerve cells whose neurotransmitters are biogenic amines (e.g., serotonin (5 HT), norepinephrine (NE), and dopamine (D)); and other related modulating neurohormones, acetylcholine and gamma acetyl buteric acid (GABA); the feedback between messenger hormones and target organs suggest many types of defective neuroendocrine secretion
 - b. Overactivity of the limbic hypothalamic-pituitary-adrenal axis (LHPA) leading to hypercortisolism
- 4. Circadian rhythm hypothesis
 - a. A disturbance in regulation of biologic rhythms that synchronize body functions is congruent with rhythmical cyclical nature of mood disorders.
 - b. Depressed individuals may be in a chronic state of sleep satiety (arousal) leading to REM sleep abnormalities.

- Acetylcholine may be involved in shortened REM latency in depression (phase advance of circadian rhythms) leading to advances in cortisol secretion (which normally surges in early morning to prepare for wakefulness).
- c. Depressed individuals may dispense earlier with central nervous system (CNS) programs that promote vegetative functions or overcome the restraints of arousal systems sooner than nondepressed individuals.
 - d. The phase delay hypothesis posits that for individuals with seasonal affective disorder (SAD), circadian rhythms occur at a later time relative to sleep onset and temperature, and predicts an antidepressant response to morning photo-therapy. This shifts the onset of melatonin production and secretion to an earlier time in the evening, which results in a correction of the disrupted relationship between sleep, temperature, and circadian rhythms.
 - e. Bipolar patients in the manic phase may have phase shifting, loss of patterning, and disorders of amplitude.

■ DIAGNOSTIC STUDIES/TESTS

- General recommendation—General medical evaluation with standard laboratory tests to rule out medical cause(s) of mood symptoms, as well as thyroid function tests (some thyroid illness is present in 8% of patients with depressive disorders), and toxicology screening (when substance-related effects are known/suspected); there are no definitive tests for mood disorders. While the clinical utility of the following tests is unknown, they have received attention in the literature:
 1. The dexamethasone suppression test (DMST) has been suggested as a useful test for depression; limited support for clinical use of this test has been reported. Underlying premise: dexamethasone is an exogenous steroid that suppresses blood levels of cortisol. Based on the premise that many depressed patients exhibit hypersecretion of cortisol, a single (11 p.m.) dose of cortisol does not depress late afternoon cortisol levels. If the postdexamethasone cortisol level is 5 mg/mL, then it has escaped suppression, and support is added for a diagnosis of biologic depression.
 2. Thyrotropin releasing hormone (TRH) stimulation test and corticotropin-releasing hormone (CRH) are thought to be useful in

differentiating unipolar from bipolar disorders and mania from Schizophrenia.

3. Urinary MHPG—A major metabolite of norepinephrine (NE) is 3-methoxy 4-hydroxyphenylglycol (MHPG); because this metabolite crosses the blood-brain barrier, its CNS activity can be estimated by measuring MHPG elimination in urine (peripheral MHPG is also secreted in urine); proposed that patients with low MHPG have less norepinephrine to metabolize and would respond to antidepressants that block norepinephrine reuptake; patients with normal or high NE levels may have a serotonin deficient depression and may respond to drugs that block serotonin reuptake.
4. Sleep EEG (REM latency measurement)—sleep EEGs indicate that depressed patients spend less time in the more refreshing slow-wave phases of sleep and have a shorter pre-REM phase (decreased REM latency) of 2-30 minutes versus 90 minutes.

■ SCREENING INSTRUMENTS

- Patient self-report questionnaires
 1. Center for Epidemiological Studies—Depression Scale (CES-D)
 2. Beck Depression Inventory-II (BDI-II)
 3. Zung Self-Rating Depression Scale (ZSRDS)
 4. Geriatric Depression Scale (GDS)
 5. Mood Disorders Questionnaire (MDQ)
 6. General Health Questionnaire (GHQ)
- Clinician-completed rating scales
 1. Hamilton Rating Scale for Depression (HAM-D, HRSD)
 2. Montgomery-Asberg Depression Rating Scale (MADRS)
 3. Schedule for Affective Disorders and Schizophrenia (SADS)
 4. Inventory for Depressive-Symptomatology-Clinician Rated (IDS-C)
 5. Symptom Checklist-90 Revised (SCL-90-R)
 6. Young Mania Rating Scale (YMRS)
- Nursing diagnoses—several of the 2009-2011 NANDA International (2009) nursing diagnoses can be applied to mood disorders, including:
 1. Fatigue
 2. Insomnia
 3. Sleep Pattern, disturbed
 4. Anxiety
 5. Coping, ineffective
 6. Hopelessness

7. Powerlessness
8. Self-Esteem, chronic low
9. Sorrow, chronic
10. Neglect, self
11. Sensory Perception, disturbed
12. Suicide, risk for
13. Self-Mutilation, risk for
14. Self-Mutilation
15. Role Performance, ineffective
16. Health Behavior, risk-prone
17. Knowledge, deficient (specify)
18. Health Management, ineffective self

■ INTERVENTIONS

- Biochemical interventions
 1. Antidepressant drugs (NOTE: Evaluate personal and family history of Bipolar Disorder prior to initiating treatment and monitor suicidality of all patients)
 - a. Selective serotonin reuptake inhibitors (SSRIs) (See **Table 7-2**), norepinephrine dopamine reuptake inhibitors (NDRIs) dual serotonin, and norepinephrine reuptake inhibitors (SNRIs) (See **Table 7-3**) are considered to be first-line agents in treating depression.

■ **Table 7-2** Selective Serotonin Reuptake Inhibitors (SSRI)

Generic Name	Trade Name(s)	Oral Dosage Range	Maximum Daily Dose	Comments
Citalopram	Celexa	20 to 60 mg/day	60 mg/day	Few drug interactions (thus a good augmenting agent) Recommended SSRI for post-MI depression History of seizure, use with caution
Escitalopram	Lexapro	10 to 20 mg daily	20 mg/day	Few drug interactions (thus a good augmenting agent) May be better tolerated than any other antidepressant History of seizure, use with caution
Fluoxetine	Prozac Prozac Weekly Sarafem	20 to 60 mg/day 90 mg/week	80 mg/day	First SSRI Long half-life Initiate other antidepressants up to 5 weeks after discontinuation
Fluvoxamine	Luvox CR	100 to 200 mg/day	300 mg/day	Luvox—immediate release form removed from US market due to severe liver toxicity No warning for hepatotoxicity for controlled-release form Significant withdrawal effects Avoid abrupt discontinuation Initiate other antidepressants up to 2 weeks after discontinuation
Paroxetine	Paxil Paxil CR Pexeva	20 to 40 mg/day	50 mg/day	Significant withdrawal effects Avoid abrupt discontinuation Initiate other antidepressants up to 2 weeks after discontinuation Paxil CR dosing: 25 to 62.5 mg in am
Sertraline	Zoloft	50 to 200 mg/day	200 mg/day	Significant withdrawal effects—avoid abrupt discontinuation Initiate other antidepressants up to 2 weeks after discontinuation

■ **Table 7-3** NDRI, SNRI, & Other Common Antidepressants

Generic Name	Trade Name(s)	Class	Oral Dosage Range	Maximum Daily Dose	Comments
Bupropion	Wellbutrin	NDRI	200 to 450 mg/day in divided doses	450mg/day	History of seizures—use with caution Zyban used for smoking cessation
	Wellbutrin SR (sustained-release)		200 to 450 mg/day in divided doses	400 mg/day	
	Wellbutrin XL (extended-release)		150 to 450 mg/day in single dose	450 mg/day	
	Zyban		150 mg/day in divided doses	300 mg/day	
Duloxetine	Cymbalta	SNRI	40 to 60 mg/day in 1 to 2 doses	120 mg in divided doses over 60 mg	History of seizures—use with caution
Venlafaxine	Effexor, Effexor XR	SNRI	75 to 250 mg/day	375 mg/day	Usually start with 37.5 mg dose increasing by 75 mg as tolerated
Nefazodone	Serzone (brand not in US)	SARI	100 to 600 mg/day	600 mg/day	Risk of hepatotoxicity—monitor LFTs
Trazodone	Desyrel	SARI	50 to 400 mg/day in divided dose	600 mg/day	Also used for insomnia (25 to 50 mg @ bedtime, increased as tolerated)
Mirtazapine	Remeron	Other	15 to 45 mg daily	45 mg daily	Dual serotonin & norepinephrine actions

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

- b. Tricyclic antidepressants (TCAs) (See **Table 7-4**) and monoamine oxidase inhibitors (MAOIs) are considered second-line agents.
- c. MAOIs—inhibit the action of monoamine oxidase, an enzyme that metabolizes neurohormones responsible for stimulating physical and mental activity (serotonin, norepinephrine, and epinephrine); usually used when client is unresponsive to non-MAOI antidepressants (See **Table 7-5**).
 - (1) Side/Adverse effects of MAOIs
 - (a) Most common effects: constipation, anorexia, nausea, vomiting, dry mouth, urinary retention, skin rash, transient impotence, drowsiness, headache, dizziness, orthostatic hypotension
 - (b) Occasional stimulant effect (insomnia, restlessness, anxiety)
 - (c) Hypomania in patients with Bipolar Disorder (35%)
 - (d) Parasthesias (tingling at periphery, electric-shock-like sensations)
 - (e) Hypertensive crisis (See **Tables 7-6 & 7-7**)
2. Mood stabilizers—antimanic medications—See **Table 7-8**
 - a. Lithium—WARNING: Toxic levels are near therapeutic levels—need to monitor closely for signs of toxicity (tremor, ataxia, diarrhea, vomiting, sedation)
 - (1) Obtain blood levels drawn
 - (a) 7 days after tx begins (12 hours after last dose)
 - (b) 2× weekly × 2 weeks

■ **Table 7-4** Common Tricyclic Antidepressants

Generic Name	Common Trade Name	Oral Dosage Range	Maximum Daily Dose	Comments
Amoxapine	Asendin	200 to 300 mg/day	600 mg/day	TCAs block transporter site for norepinephrine & serotonin Significant side effects: —Anticholinergic side effects (dry mouth, blurred vision, constipation, urinary hesitancy) —Sedation —Orthostatic hypotension Significant drug interactions Do not use if cardiac condition exists May be lethal in overdose
Amitriptyline	Elavil	50 to 150 mg @ bedtime	300 mg /day divide doses over 75 mg	
Clomipramine	Anafranil	100 to 200 mg/day	250 mg/day	
Desipramine	Norpramin	100 to 200 mg/day	300 mg/day	
Doxepin	Sinequan	75 to 150 mg/day	300 mg/day	
Imipramine	Tofranil	50 to 100 mg/day	300 mg/day	
Nortriptyline	Pamelor	75 to 150 mg/day in divided doses	300 mg/day	

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

■ **Table 7-5** Monoamine Oxidase Inhibitors (MAOIs)

Generic Name	Trade Name(s)	Class	Dosage Range	Maximum Daily Dose	Comments
Isocarboxazid	Marplan	MAOI	20 to 60 mg/day PO in divided dose	60 mg/day	Avoid use with: —Tyramine-rich products —SSRIs
Phenelzine	Nardil	MAOI	45 to 90 mg/day PO in divided dose	90 mg/day	Significant side effects: —Anticholinergic effects —Orthostatic hypotension
Selegiline	Eldepryl	MAO B inhibitor	10 mg daily PO	10 mg daily	Hepatic and hematologic dysfunction (monitor blood counts & LFTs) EMSAM—no diet restrictions with ≤ 12 mg transdermal patch
	EMSAM (transdermal)	Selective MAOI	6 to 12 mg/day	12 mg/day	
Tranlycypromine	Parnate	MAOI	30 mg/day PO in divided dose	60 mg/day	

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

■ **Table 7-6** Signs & Symptoms of Hypertensive Crisis and Nursing Interventions

Signs and Symptoms	Nursing Intervention
<i>Warning Signs</i>	
Increased blood pressure	Hold next MAOI dose
Palpitations	Do not lie client in supine or prone position (elevated BP in head)
Frequent headaches	
<i>Symptoms of Hypertensive Crisis</i>	
Sudden elevation of blood pressure	Monitor vital signs
Explosive headache (occipital radiating frontally)	Chlorpromazine 100 mg IM (blocks norepinephrine, repeat if necessary)
Palpitations; chest pain	Phentolamine slowly administered in 5 mg IV doses (binds with norepinephrine receptor sites, blocking norepinephrine)
Sweating	Manage fever with external cooling techniques
Fever	Assess intake of tyramine-containing foods
Nausea; vomiting	
Dilated pupils	
Photophobia	
Neck stiffness	
Nosebleed	
Intracranial bleeding	

Moller, M. (1998). Mood disorders. In C. Houseman (Ed.). *Psychiatric certification review guide for the generalist and clinical Specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.). Potomac, MD: Health Leadership Associates, Inc.

- (c) 1 × weekly × 2 weeks
- (d) q 3 months × 6 months
- (e) q 6 months thereafter
- (2) Therapeutic range—0.6–1.4 mEq/L for adults; 0.6–0.8 mEq/L in geriatric clients or those with medical illness
- (3) Lithium toxicity—usually dose related—See **Table 7-9**
- (4) Significant side effects—See **Table 7-10**
- b. Anticonvulsants
 - (1) Depakote is approved for first-line treatment for mood stabilization in Bipolar Disorder
 - (a) When lithium is contraindicated or ineffective
 - (b) For rapid cyclers (> 4 episodes/year)
 - (c) For prevention of recurrence
 - (2) Mode of action
 - (a) Structurally related to tricyclic antidepressants
 - (b) Anticonvulsant activity mediated through a “peripheral” type benzodiazepine receptor
- (c) Effective in inhibiting seizures kindled from repeated stimulation of limbic structures
- (d) GABA antagonist activity
- (3) Administration
 - (a) Fourteen days before peak effect
 - (b) Dose guided by plasma levels
 - (c) Complete laboratory tests prior to beginning therapy
 - i. CBC
 - ii. Liver function tests
 - iii. Serum electrolytes
 - iv. EKG
- (4) Blood tests q 2 weeks × 3 months; q 3 months thereafter to monitor hematopoietic suppression and hyponatremia
- (5) Reinforcement of teaching after each treatment
- 3. Additional considerations regarding pharmacotherapy
 - a. Assess suicidality and presence of manic or psychotic symptoms at each contact/visit.
 - b. Monitor clients treated with antidepressants for signs of overstimulation of serotonin receptors causing Serotonin

■ Table 7-7 Dietary Restrictions for Patients Taking MAOIs

Food and Beverages to Avoid	Safe Food, Beverages, and Medication
Cheese, especially aged or matured (Cheddar, Mozzarella, Parmesan, Gruyre, Stilton, Brie, Swiss, blue, Camembert)	Cottage Cheese
Fermented or aged protein (salami, mortadella, sausage, bologna, pepperoni)	Farmer's Cheese
Pickled or smoked fish	Cheese Whiz
Beer, red wine, Sherry, Cognac, liqueurs	Ricotta
Yeast or protein extracts (Marmite, Oxo, Bovril)	Havarti
Broad bean pods	Boursin
Beef or chicken liver	Fresh fruits
Yogurt	Bread products raised with yeast (bread)
Sauerkraut	
Overripe fruit	
Foods/Beverages to Be Consumed in Moderation	
Chocolate	
Sour cream	
Avocado	
Clear spirits and white wine	
Soy sauce	
Caffeine drinks	
Medications to Avoid	Safe Medications
Cold medications	Aspirin, Tylenol
Nasal and sinus decongestants	Pure steroid asthma inhalants
Allergy and hay fever remedies	Codeine
Narcotics, especially meperidine	Plain Robitussin or Terpin-hydrate with codeine
Inhalants for asthma	All laxatives
Local anesthetics with epinephrine	All antibiotics
Weight-reducing pills	Antihistamines

Moller, M. (1998). Mood disorders. In C. Houseman (Ed.). *Psychiatric certification review guide for the generalist and clinical specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.) Ed. Potomac, MD: Health Leadership Associates.

■ **Table 7-8** FDA Approved Medications Used in Treating Bipolar Disorder

Generic Name	Trade Name(s)	Oral Dosage Range	Maximum Dose	Monitoring & Other Comments
Aripiprazole	Abilify	15 to 30 mg/day	30 mg/day	Increased suicide risk Available in disintegrating tablet form
Carbamazepine	Tegretol, Tegretol XR, Equetro	400 to 1200 mg/day in divided doses	1200 mg/day	Serum level (4–12 mcg/ml) Monitor serum level, LFTs, for signs of bleeding/bruising
Lamotrigine	Lamictal	50 to 200 mg/day	200 mg daily	Risk of serious rash Increased suicide risk May cause photosensitivity
Lithium	Eskalith, Cibalith, Lithane, Lithobid	900 to 1200 mg/day in divided doses	1800 mg/day	Serum level (0.6–1.2 mEq/L) Monitor serum level and toxicity (See Table 7-10)
Olanzapine	Zyprexa	10 to 20 mg/day	20 mg/day	Increased suicide risk Monitor weight
Olanzapine & Fluoxetine (combination)	Symbyax	olanzapine/fluoxetine 6 mg/25 mg to 12 mg/50 mg	18 mg/75 mg/day	Increased suicide risk Monitor weight Avoid abrupt discontinuation
Oxcarbazepine	Trileptal	600 to 2400 mg/day in divided dose	2400 mg/day	Hyponatremia risk—monitor fluid and Na May decrease efficacy of oral contraceptives
Quetiapine	Seroquel, Seroquel XR	300 to 800 mg/day (may divide dose)	800 mg/day	Increased suicide risk Monitor for cataracts
Valproate/Valproic Acid/Divalproex Sodium	Depakene, Depakote, Depakote ER, Depakote Sprinkles	750 to 1500 mg/day Acute mania: dose = 250 to 1000 mg	60mg/kg/day	Serum level (target: 50–125mg/ml) Monitor serum level, LFTs, platelet, coagulation Liver toxicity (malaise, facial edema, anorexia, jaundice) & suicidality
Ziprasidone	Geodon	80 to 160 mg in divided dose	160 mg/day	IM form (10–20 mg, max. 40 mg/day), discontinue IM dose within 3 days

(Keltner et al., 2007; Sadock & Sadock, 2007; Stahl, 2009)

■ **Table 7-9** Lithium Toxicity & Related Treatment*Mild*

At lithium levels of 1.5–2 mEq/L—occasionally occurs at normal levels

Develops gradually over several days

Symptoms—ataxia, coarse tremor, confusion, diarrhea, drowsiness, fasciculation, slurred speech

Treatment

Hold all lithium doses

Obtain lithium blood level

Check vital signs

Patient education

Moderate to Severe

At lithium levels > 2 mEq/L

Gradual or sudden onset

Symptoms—muscle tremor, hyperreflexia, pulse irregularities, hyper or hypotension, EKG changes, visual or tactile hallucinations, oliguria, or anuria, seizures, coma, death

Treatment—rapid assessment of clinical signs and symptoms of lithium toxicity

Hold all lithium doses

Monitor vital signs and LOC

Protect airway and provide standby oxygen

Obtain lithium level stat; BUN, creatinine, urinalysis; CBC; monitor electrolytes EKG; monitor cardiac states

Limit lithium absorption; provide an emetic—N–G suctioning may be appropriate

Vigorously hydrate 5 to 6 L/day IV—indwelling catheter; monitor intake and output; ROM; deep breathing

Maintain bed rest

Moller, M. (1998). Mood disorders. In C. Houseman (Ed.). *Psychiatric certification review guide for the generalist and clinical specialist in adult, child, and adolescent psychiatric and mental health nursing* (2nd ed.) Potomac, MD: Health Leadership Associates, Inc.

■ **Table 7-10** Lithium Side Effects & Nursing Interventions

Side Effect Symptom	Nursing Intervention
<p>Polyuria, with possible progression to Type II diabetes</p> <p>Urine output is large in volume and so dilute that it may be colorless.</p>	<p>Reassure client that increased urination is common and benign.</p>
<p>Client may complain of urinating so frequently that it interferes with activities of daily living, including sleep.</p>	<p>Urine volume may diminish if the physician reduces the lithium dose or changes to a slow-release form or a single daily dosage. When severe, the physician usually orders 24-hour urine volume. If volume is greater than 3 L, a further renal workup is usually requested. When severe, polyuria is often treated by the physician with a thiazide or potassium-sparing diuretic (taking care to reduce the lithium dose). Lithium is contraindicated for clients with renal dysfunction.</p>
<p>Increased thirst</p>	<p>Recommend that clients quench their thirst and maintain a fairly stable intake of liquids from day to day. The best thirst quencher is water or a low-calorie beverage that will not cause weight gain when taken in large amounts. Gum or hard candies may help moisten the mouth.</p>

(continues)

■ **Table 7-10** Lithium Side Effects & Nursing Interventions (*continued*)

Side Effect Symptom	Nursing Intervention
Tremor—a fine tremor that worsens with intentional movements. It can make writing, drinking hot beverages, and many other motor tasks difficult.	Reassure that this is benign and may be temporary. In some clients it is persistent. The physician may order a reduction in dose, more frequent doses, or a change to a slow-release form. When the tremor is severe or incapacitating, the physician may treat it with a beta blocker, usually propranolol (Inderal). Recommend that the client reduce or eliminate caffeine-containing beverages.
Nausea, abdominal discomfort, diarrhea, or soft stools	Reassure that this is benign and usually temporary. Recommend that the client take lithium with meals, a glass of milk, or a snack. If symptoms persists, the physician may change to another lithium preparation.
Muscle weakness or fatigue	Reassure that this is benign and usually temporary. Since this is not a very common side effect of lithium, ascertain whether it is being caused by another medication being taken by the client. Encourage the client to remain active and get regular physical exercise. If symptom persists, the physician may reduce the dose, order more frequent divided doses, change to slow-release, or reduce the dose and more gradually increase to the present dose level.
Edema of the feet or other body parts	Reassure that this is benign and may be temporary. A moderate salt restriction may reduce the edema. If moderate salt restriction is undertaken, the serum lithium level usually rises somewhat. It then becomes necessary to monitor for signs of toxicity and keep the physician informed in case it becomes necessary to reduce the lithium dose.
Hypothyroidism (5%)	Explain that this is reversible and treatable. The physician usually orders thyroid hormone replacement, such as levothyroxine (Synthroid) or desiccated thyroid.
Weight gain (60%)	Explain that this is fairly common and benign. Moderate calorie restriction and increased exercise usually help. Advise against fluid restriction or sodium restriction unless undertaken with knowledge of the physician and nurse, since either intervention can cause the serum lithium level to rise.
Hair thinning or loss	Explain that this may be temporary. Since hair loss can be a symptom of hypothyroidism, inform the physician so that thyroid function can be checked. If hair does not return, lithium is usually stopped so that hair can regrow. During periods of hair loss, encourage the client to consider wearing a wig.
Benign, reversible granulocytosis	Explain that this is benign. This side effect is the basis for its use as a treatment in some granulocytopenic conditions.
Decreased libido	Suggest timing sexual activity to not coincide with peak action time of medication. Explore strategies for continuing relationship intimacy.

Syndrome (SS)—a potentially fatal phenomenon usually resulting from drug-drug interactions (severe risk when SSRIs are combined with MAOIs, lithium, tryptophan, St. John's wort) (Keltner et al., 2007; Sadock & Sadock, 2007)

- (1) Most frequent signs and symptoms of SS are:
 - (a) Mental status changes such as confusion or hypomania
 - (b) Agitation or restlessness
 - (c) Myoclonis
 - (d) Hyperthermia
 - (e) Diaphoresis
 - (f) Chills
 - (g) Abdominal cramping, diarrhea, nausea
 - (h) Headache
 - (i) Tremor
 - (j) Ataxia or incoordination
 - (k) Hyperreflexia
 - (2) Treatment interventions for SS consist of removing the offending agent(s) and prompt treatment of all associated symptoms, which may include nitroglycerine, cyproheptadine, benzodiazepines, anticonvulsants, cooling blankets, mechanical ventilation, and paralyzing agents (Sadock & Sadock, 2007).
 - (3) Note also that abrupt discontinuation of SSRIs can lead to SSRI withdrawal, also called Discontinuation Syndrome (DS)—rare with fluoxetine.
 - (a) Signs and symptoms of DS include dizziness, weakness, flu-like symptoms, headache, anxiety, cognitive dulling, and recurrence of depressive symptoms (rebound depression)
 - (b) To avoid DS slowly taper most SSRIs when discontinuing
- Electroconvulsive therapy (Sadock & Sadock, 2007)
 1. Mechanism of action—Much of the research has focused on changes in neurotransmitter receptors and second-messenger systems—every neurotransmitter system is affected, but like antidepressants, a series of ECTs leads to downregulation of post-synaptic beta-adrenergic receptors.
 2. Indications
 - a. Most common indication for ECT is Major Depressive Disorder (MDD).
 - b. Emergency therapy for suicidal or hyperactive clients who are in physical danger is indicated.
 - c. Clients are unresponsive to or cannot tolerate medications.
 - d. Manic episodes—avoid with lithium treatment.
 - e. Schizophrenia—used for acute (marked positive symptoms, catatonia, or affective symptoms that are likely to respond to ECT), not chronic, symptoms of Schizophrenia.
 3. Treatment (following pretreatment evaluation)
 - a. 6–12 treatments on alternate days
 - b. Atropine sulfate administered for vagolytic effect 30–60 minutes prior to treatment
 - c. Short-acting barbiturate (Brevital Sodium) administered IV to induce anesthesia
 - d. Succinylcholine (Anectine) administered IV as muscle relaxant after anesthetic
 - e. 100% O₂ administered 1–2 min. to prepare for apneic period from muscle relaxant and convulsion
 - f. Client positioned in supine position; mouth gag inserted; jaw supported as needed
 - g. Electrodes applied unilaterally (less amnesia) at nondominant side temple or bilaterally (more amnesia) at temples
 - h. Fingers and toes observed for twitching
 - i. O₂ administered by bag breathing when twitching stops until spontaneous respiration resumes
 - j. Patent airway maintained; client positioned on side
 - k. Vital signs monitored until stable
 - l. Patient begins to respond in 10–15 minutes.
 4. Side effects
 - a. Anoxia during seizure
 - b. Memory loss—temporary—most return to baseline within 6 months; approximately 75% of ECT patients indicate this as the worst adverse effect
 - c. Headache
 - d. Marked confusion in about 10% of ECR patients
 - e. Cardiac arrhythmias
 - f. Mortality: 1:10,000 patients
 5. Nursing intervention
 - a. Complete physical assessment including EKG, EEG, X-rays of spine and chest.
 - b. Provide opportunity to express feelings about ECT.
 - c. Assess client's response.
 - d. Client education guidelines
 - (1) Assess patient and family anxiety level and ability to understand.

- (2) Individualize amount of information shared (i.e., treatment, post-ECT confusion, memory loss, etc.).
 - (3) Provide time to discuss concerns and answer questions.
 - (4) Instruct accompanying adult in dealing with the following post-ECT effects:
 - (a) Orienting to time, place, and person
 - (b) Headache
 - (c) Nausea
- Other brain stimulation interventions (Sadock & Sadock, 2007)
 1. Repeated transcranial magnetic stimulation—a noninvasive procedure that stimulates cells of the cerebral cortex
 2. Vagal nerve stimulation—stimulation of the left vagus nerve through a multiprogrammable bipolar pulse generator implanted in the left chest wall
 3. Deep brain stimulation—involves creating a small hole in the skull into which small wire is passed into the selected brain regions; the wire is attached to a pacemaker device implanted in the chest wall and the pace maker is used to stimulate the selected brain region.
 4. Psychosurgery—involved surgery to modify areas of the brain; goal is to reduce symptoms of severely ill patients who have not responded to less invasive treatment interventions.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Psychoanalytic theory
 - a. Object loss hypothesis—Infants experiencing loss of the maternal love object in infancy experience separation anxiety and grief related to loss of the primary love object; early loss is thought to predispose the adult to respond abnormally to losses that occur later in life, becoming depressed significantly more often than those not experiencing such early losses.
 - b. Aggression-turned-inward hypothesis—depression is proposed to be a turning inward of the aggressive instinct that is not directed at the appropriate object, with accompanying feelings of guilt.
 - (1) This process is initiated by loss of an object toward whom a person feels love and hate (ambivalence).
 - (2) The person is unable to express the angry feelings because they are thought to be irrational or inappropriate and are unacceptable to the superego.
 - (3) The person may develop a pattern of containing angry/aggressive feelings and directing them inward against the self leading to self-hatred.
 - (4) Suicide is viewed as a strike against the hated and loved object as well as the self; manic episode is viewed as a defense against depression.
 - Interpersonal interventions
 1. Objectives
 - a. Insuring safety with reduced potential for self-harm
 - b. Increasing appropriate expression of thoughts and feelings
 - c. Increasing self-esteem and social interaction
 2. Facilitating the expression of feelings
 - a. Acknowledge client pain and despair.
 - b. Reinforce that depression is self-limiting.
 - c. Convey hope for future.
 - d. Do not give false reassurance.
 - e. Engage in active listening.
 - f. Demonstrate acceptance of thoughts and feelings.
 - g. Facilitate expression of positive and negative thoughts and feelings.
 - h. Assist client in identifying strategies for expressing and coping with negative feelings (anger, guilt, aggressiveness, etc.).
 - i. Provide objective feedback and positive reinforcement.
 - j. Increase self-esteem.
 - (1) Schedule regular sessions with client.
 - (2) Accept negativism without judgment.
 - (3) Minimize time focused on real or perceived failures.
 - (4) Focus on identifying strengths and accomplishments.
 - (5) Collaborate with client in identifying factors maintaining low self-esteem.
 - Cognitive interventions
 1. Theoretical foundations
 - a. Depression is a cognitive problem originating from disturbed thinking in which the depression-prone person explains an adverse event as a personal shortcoming.
 - b. Developmental experiences sensitize certain people and make them vulnerable to depression. The constellation of negative thoughts that characterizes depression remains dormant until a person becomes depressed. When depression occurs after a life stressor, the dormant cognitive set

- appears; negative cognitive processes replace objective thinking.
- c. Cognitive elements of depression
 - (1) Cognitive triad—the person’s negative view of self, the world and the future, which is a distortion of reality
 - (2) Silent assumptions—irrational beliefs or rules that significantly affect the depressed person’s cognitive, affective, and behavior patterns
 - (3) Logical errors—faulty information processing and errors in thinking that maintain the person’s belief in the validity of his/her negative concept despite contradictory evidence
- 2. Objectives
 - a. Increasing client’s sense of control over his/her goals/behavior
 - b. Increasing self-esteem
 - c. Assisting client in modifying negative expectations
- 3. Guidelines
 - a. Assist in exploring feelings to elicit patient’s view of problem(s).
 - b. Assist client in identifying negative thoughts.
 - c. Accept client perceptions, not conclusions.
 - d. Teach thought interruption or substitution.
 - e. Encourage client to increase realistic thinking by appraising personal assets, strengths, accomplishments, and opportunities.
 - f. Encourage formulation of realistic versus unrealistic goals.
- Behavioral interventions
 1. Objectives
 - (1) Activating clients in a realistic goal-directed way
 - (2) Developing alternative problem-solving and coping strategies
 - (3) Increasing self-esteem
 - (4) Instilling hope
 - (5) Increasing client responsibility for change
 - (6) Gradual redirection of self-preoccupation to interests in outside world
 2. Guidelines
 - a. Assess client strengths and weaknesses and personal and environmental factors that maintain depression.
 - b. Work with client to develop a structured daily program of activities that:
 - (1) Considers probability of succeeding.
 - (2) Considers attention span, distractibility and motivation.
 - (3) Contains realistic goals and expectations.
 - (4) Provides opportunities for performance-based positive reinforcement.
 - c. Involve clients in the following activities:
 - (1) Assertiveness training
 - (2) Role playing
 - (3) Social skills training
 - (4) Stress management
 - (5) Relaxation exercises
 - (6) Meditation
 - (7) Physical fitness/exercise
 - d. Increase client’s present versus past or future orientation.
- Hopelessness theory of depression (learned helplessness)
 1. Based on attribution theory—a chain of perceived negative life events are hypothesized to be the “occasion setter” for people to become hopeless and depressed.
 2. Depression consists of four classes of deficits: motivational, cognitive, self-esteem, and affective.
 3. Three types of influences determine whether a person will become hopeless, and, in turn depressed, when negative life events are experienced:
 - a. When highly desired outcomes are believed improbable or when highly aversive outcomes are perceived probable, and the person anticipates that no response in his or her repertoire will positively affect the outcome (helplessness), depression occurs.
 - b. When negative life events are attributed to stable versus unstable and global versus specific causes, and are viewed as important, helplessness, low self-esteem, and depression ensue.
 - c. Inferred negative consequences are most likely to lead to depression. The consequence is viewed as important, not remediable, likely to change, and affecting many areas of life. When inferred characteristics about the self (self-worth, abilities, desirability, etc.) are negative and will interfere with attainment of important outcomes, helplessness and depression may ensue.
 4. Improvement of depression is contingent upon one’s perceived control and mastery of their environment.

- Family dynamics/ Family therapy
 1. Developmental experiences within the family system (abuse, conflict, divorce, death) can be antecedents of depression.
 - a. Nodal events (significant exits and entries of people, places, objects, activities, and roles in a family system), especially those perceived as undesirable, can precipitate depression, especially when an event generates stress or anxiety not openly dealt with in the family system.
 - b. Multiple nodal events occurring within a brief period may escalate the likelihood of stress (cluster stress) and depression.
 - c. Anniversary reactions (affective responses around anniversary of nodal event), which reactivate feelings associated with original nodal event, can take form of depression, suicidal thoughts, gestures, attempts, and other stress-related symptoms.
 - d. Family precursors of mood disorders include early developmental family experiences related to strong nurturing in early childhood followed by cutting off of nurturing supplies in early childhood, coupled with unrealistic expectations, unquestioning acceptance of parental values, and frustrated efforts to obtain family approval and love. Underlying resentment toward parents may erupt briefly, followed by quiet and fear of rejection. Manic episode masks guilt, loss, and rejection. Depressive episode represents internalization of disappointment, loss, and perceived failure.
 2. Objectives
 - a. Increasing functional family interaction patterns
 - b. Increasing family effectiveness in coping with grief, loss, stress
 3. Family education, including:
 - c. Community resources (medical, social, vocational, support groups)
 - d. Positive support and knowledge to anticipate and avoid problems
 4. Refer to or conduct family therapy sessions.
 5. Conduct family intervention when suicide is attempted or completed.
 - a. Explore family response to stress.
 - b. Explore family relationships re: isolation, scapegoating, estrangement.
 - c. Explore family communication patterns.
 - d. Promote grief rituals and customs.
 - e. Facilitate open expression of feelings (guilt, anger, sadness, helplessness, etc.).
- Group approaches
 1. Devise a structured plan of therapeutic activities that considers client's level of depression or mania.
 2. Encourage attendance at group sessions and activities.
 3. Accept nonverbal participation.
 4. Set limits on disruptive behavior.
 5. Positively reinforce appropriate participation.
 6. Encourage sharing of common feelings, thoughts, behaviors, life experiences among clients.
 7. Promote problem solving within group.
 8. Promote modification of dysfunctional expectations of self and others.
 9. Teach stress management strategies.
 10. Instruct and model social skills.
 11. Use role playing and rehearsal of social interactions.
 12. Encourage initiation of socialization in an expanded social environment.
- Milieu interventions
 1. Objectives
 - a. Maintaining client safety
 - b. Decreasing manipulation
 - c. Increasing self-responsibility
 2. Intervention guidelines
 - a. Engage client in developing functional coping strategies.
 - b. Utilize stress management strategies.
 - (1) Exercise
 - (2) Relaxation training
 - (3) Meditation
 - (4) Nutritional diet
 - (5) Adequate sleep
 - c. Teach abilities to differentiate normal mood response and stress from illness symptoms.
- Community resources
 1. Interventions
 - a. Discharge from inpatient setting.
 - b. Collaborate with team for discharge planning to include:
 - (1) Appropriate living arrangements
 - (a) Family
 - (b) Solo
 - (c) Halfway house
 - (d) Group home
 - (2) Employment/vocational planning
 - (3) Referral to psychoeducation programs
 - (a) Vocational rehabilitation
 - (b) Social skills training
 - (c) Mental health education programs

- (4) Referral to day treatment programs
- (5) Referral to support/self help groups
 - (a) National Alliance for the Mentally Ill (NAMI)
 - (b) Manic-Depressive and Depressive Association
 - (c) Recovery, Inc.
2. Professional involvement in advocacy groups, community and professional organizations, self-help groups, political coalitions lobbying for mental health resources and rights

■ QUESTIONS

Select the best answer

1. Susan Z. age 20, was at a bar in the town where she went to college. Always an outgoing, life-of-the-party type, Susan became loud and abusive to people at the bar, jumped on the bar and began doing a strip dance, singing loudly, knocking over everything in sight. The police were called and at the station house, Susan loudly rambled on about how all the women in her family were life-of-the-party types. The community mental health nurse interviewing Susan understands that:
 - a. Bipolar Disorder does not have a higher rate in families with relatives who have the disorder
 - b. Bipolar Disorder does have a higher rate in families with relatives who have the disorder
 - c. Bipolar disorder is inherited
 - d. Bipolar disorder is not recurring
2. People at highest risk for suicide are:
 - a. Married, white males younger than 60
 - b. Single, white males older than 60
 - c. Black males
 - d. Males younger than 24 and older than 50
3. What percentage of the annual suicides is associated with depression?
 - a. 20%
 - b. 30%
 - c. 50%
 - d. 80%
4. Mr. B. has experienced depressed mood and difficulty sleeping over the past 6 weeks. He reports having no appetite and has lost 15 pounds during this time. Mr. B. describes a loss of interest in most of the activities he used to find pleasurable and a diminished ability to concentrate. Although this is the first time he has felt this way, Mr. B. states that he frequently thinks about taking his life. The advanced practice PMH nurse would probably give him which of the following diagnoses?
 - a. Bipolar Disorder, depressed
 - b. Major Depression, recurrent
 - c. Major Depression
 - d. Seasonal Affective Disorder
5. Mrs. C., age 42, calls the Mental Health Center with the following complaint: "I've been taking venlafaxine, 75 mg bid for depression, and now I can't sleep, am running around getting all distracted, and talking a mile a minute." The advanced practice PMH nurse must rule out:
 - a. The emergence of hypomania
 - b. Non-compliance with venlafaxine dosing
 - c. No relationship of symptoms with venlafaxine
 - d. The need for electroconvulsive therapy
6. In addition to assessment for specific signs and symptoms of Major Depressive Disorder, it is essential for the advanced practice PMH nurse to assess the patient's _____ in planning appropriate treatment interventions.
 - a. prior episodes of unipolar depression or Bipolar Disorder
 - b. risk for suicide
 - c. concurrent substance abuse
 - d. non-psychiatric physical health problems
7. A priority feature of the assessment process with the depressed patient is:
 - a. Assessment of family history
 - b. Assessment of suicide risk
 - c. Assessment of concurrent substance abuse
 - d. Assessment of stressful life events
8. When assessing the depressed patient, a frequently used patient self-report questionnaire is:
 - a. The Beck Depression Inventory
 - b. Hamilton Rating Scale for Depression
 - c. Schedule for Affective Disorders and Schizophrenia
 - d. Minnesota Multiphasic Personality Inventory
9. An experimental laboratory test to assess levels of norepinephrine in depressed patients prior to initiating pharmacotherapy is:
 - a. CBC test
 - b. Urinary MHPG test
 - c. TRH stimulation test
 - d. Dexamethasone suppression test

10. Which laboratory test is proposed to differentiate unipolar depression from Bipolar Disorder?
- Urinary MHPG test
 - Dexamethasone suppression test
 - TRH and CRH stimulation test
 - SMAC test
11. At an appointment with the psychiatric and mental health advanced practice nurse in private practice, Edward K. reports that for the past 3 or 4 years he has become depressed in October after golf season is finished, begins to feel better in April, and feels totally normal and happy again by May. He says to the nurse, "Maybe I need other meaningful things in my life." The advanced practice nurse would probably give him which of the following diagnoses?
- Major Depression, recurrent
 - Major Depression
 - Bereavement
 - Seasonal Affective Disorder
12. Marcia S., age 53, describes herself as being depressed for as long as she can remember. She describes it as "living under a gray cloud." Marcia describes waking up 3 weeks ago feeling like the gray cloud had turned black. She feels sad, hopeless, worthless, guilty about something she cannot identify, and pessimistic about things getting better for her. The nurse would probably give her which of the following diagnoses?
- Dysthymia
 - Double depression
 - Depression, recurrent type
 - Depression, melancholic type
13. Karen K. called the office of the advanced practice PMH nurse in private practice saying she had to have an appointment now or she was going to fall apart. During the assessment interview, Karen described herself as becoming increasingly depressed following the birth of her first child 9 months ago in April. At first she felt blue, then increasingly despondent, sleeping a lot, hardly able to get out of a chair, crying all the time. She is now fearful that she might hurt the baby if she doesn't get some help. The advanced practice nurse would probably give her which diagnosis?
- Major Depression
 - Major Depression, melancholic type
 - Major Depression, psychotic type
 - Major Depression, postpartum type
14. Carl W., 60 years old, has been hospitalized on a medical unit for various aches and pains he has been experiencing for several weeks. He feels depressed, tense, and unable to sleep at night. In talking to the nurse, he reveals that his wife died 8 months ago, and he has not adjusted to the loss. To maximize the opportunity to determine the extent of Mr. W.'s bereavement versus depression, the nurse should:
- Ask the internist for a psychiatric consultation for Mr. W. as soon as possible
 - Continue the discussion about his wife's death
 - Explore his ambivalence toward his wife
 - Inform the head nurse about Mr. W.'s feelings
15. D., age 33, is brought to the local hospital by her husband, who tells the nurse that she has been involved in a whirlwind of activity that began several months ago when she quit her job to write the "Great American Novel." At the same time, she began painting her house. When he tried to get her to slow down, her activity just increased; she took little time to sleep or eat, and began spending huge amounts of money. Her husband brought her to the hospital following a call from the bank informing him that she had just tried to cash a check for \$500,000. On admission, D. is agitated, speaking loudly and challenging the nurse.
- The nurse would probably give D. which of the following diagnoses?
- Bipolar Disorder, depressed phase
 - Bipolar Disorder, manic phase
 - Bipolar Disorder, hypomanic phase
 - Bipolar Disorder, recurrent type
16. Two days ago, G. arrived on the psychiatric unit in a manic episode, exhibiting extreme excitement, disorientation, incoherent speech, agitation, frantic, aimless physical activity, and grandiose delusions. Which assessment finding is most characteristic of this stage of mania?
- Expansive mood
 - Depressed mood
 - Hypersomnia
 - Low self-esteem
17. Jason King, age 55, is admitted to the psychiatric unit of the general hospital. His wife states that he has gradually become withdrawn over the last month, refusing to bathe or change clothes, eating little, failing to go to work and sleeping only 3 to 4 hours per night. This evening

Mrs. King heard a shot from the basement and found Mr. King bleeding from a superficial chest wound. To assess Mr. King's current potential for suicide, the nurse should:

- a. Ask Mr. King why he feels like killing himself
 - b. Observe Mr. King for scars on his wrists or other signs of previous attempts
 - c. Ask Mrs. King about any previous suicide attempts or threats by Mr. King
 - d. Determine if there is a family history of suicide
18. To further assess Mr. King's suicide potential, the advanced practice PMH nurse should be particularly alert to his expression of:
- a. Frustration and impatience
 - b. Anger and resentment
 - c. Anxiety and loneliness
 - d. Helplessness and hopelessness
19. The neurotransmitter hypothesis proposes that depression occurs as a result of:
- a. Depletion of dopamine at the postsynaptic receptor site
 - b. Imbalance of norepinephrine at the postsynaptic receptor site
 - c. Disturbance in regulation of biologic rhythms
 - d. Shift in melatonin production and secretion
20. Genetic linkage studies suggest commonalities between mania and which of the following?
- a. Schizophrenia
 - b. Major Depressive Disorder
 - c. PTSD
 - d. Dissociative Identity Disorder
21. The circadian rhythm hypothesis proposes that people with unipolar depression may:
- a. Be in a chronic state of sleep satiety
 - b. Have chronic hypo-arousal
 - c. Have REM phase delay
 - d. Be in an acute state of hypersomnia
22. The circadian rhythm hypothesis proposes that people with unipolar depression may:
- a. Be in a chronic state of somnolence
 - b. Have a disturbance in regulation of biologic rhythms
 - c. Have circadian rhythms that occur at a time late for sleep onset
 - d. Be in a chronic state of under-arousal
23. Based on an understanding of the psychoanalytic theory of depression, the nurse can best help a patient develop more healthy coping mechanisms by:
- a. Promoting interpersonal relationships with peers
 - b. Allowing her to assume responsibility for her decisions
 - c. Promoting the external expression of anger
 - d. Setting realistic limits on her maladaptive behavior
24. When assessing a depressed person's premorbid personality characteristics, the nurse would expect that he/she demonstrated:
- a. Vulnerability to loss
 - b. Overmeticulousness
 - c. Stubbornness
 - d. Vulnerability to anger
25. Blanche, 26 years old, is admitted to the psychiatric unit with a diagnosis of Bipolar Disorder, manic episode. She is brought in by her husband, who states that she was fine until 3 days before admission. At that time she decided to plan a huge high school reunion and began calling all her classmates. Her speech became louder, more rapid, and insulting when the idea was not greeted with enthusiasm. Yesterday she went on a shopping spree and charged clothing worth \$7000. This morning she went into her husband's office and began reorganizing his files. She became quite agitated, and her husband brought her to the emergency room.
- In assessing Blanche, the nurse is aware that the manic episode is in reality an:
- a. Attempt to block unconscious feelings of depression
 - b. Incorrect interpretation of environmental stimuli
 - c. Exaggerated response to an elating situation
 - d. Uncontrolled acting out of uncensored id drives
26. Laurie M., age 32, is married and is a very successful attorney. She and her husband have a Victorian house they have restored. They ski, play tennis, and have an active social life. Yet Laurie reports feeling depressed all the time. She perceives herself as "never measuring up." Despite having friends, she thinks they are only nice to her because they like her husband. She never enjoys the sports she does, because she never performs as well as she thinks she should. According to cognitive theory, Laurie's symptoms are most likely related to:

- a. Logical errors
b. Negative feedback
c. Developmental trauma
d. Distorted self-concept
27. Laurie's cognitive, affective, and behavior patterns are maintained by irrational beliefs and rules called:
- a. Logical errors
b. Silent assumptions
c. Cognitive distortions
d. Developmental trauma
28. Ted H., age 26, dropped out of college once, failed out twice, and currently works nights as a janitor in a factory. Both Ted and his family regard him as the family disappointment. Ted calls the mental health clinic because he feels depressed and very worried that he is going to lose his job. He states that his company is laying people off, and despite good evaluations, he knows that he will, as usual, be one of the unlucky who get fired.
- According to the Hopelessness Theory of Depression, the psychiatric and mental health advanced practice nurse understands that Ted's symptoms are most likely to occur when negative life events are perceived to be:
- a. Stable, global, important
b. Unstable, global, important
c. Stable, specific, important
d. Unstable, global, important
29. Ted's ability to affect the outcome of potentially negative life events, like losing his job, is perceived by him to be:
- a. Nonexistent
b. Low
c. Moderate
d. High
30. Fran S., age 57, is brought to the hospital Emergency Department by her daughter. She sits crying in a chair saying, "How much can a person take? I cannot take anymore." Her daughter reports that Mrs. S.'s husband was killed in a car accident 3 years ago, and her 80-year-old mother was diagnosed with Alzheimers last year. Six months ago, her son revealed that he is homosexual and last week told the family that he has been HIV positive for 3 years and was just diagnosed as having Kaposi's sarcoma. Since that time, Fran has been mute other than when she is crying and muttering. She refuses to eat, bathe, or change her clothes. She has not slept more than 3 hours a night and says she just wants to crawl under a cover and not come out.
- The psychiatric and mental health advanced practice nurse understands that Fran's depression may be precipitated by:
- a. Cluster stress events
b. Anniversary reaction
c. Stress reaction
d. Lack of social support
31. If Fran S. began to feel depressed around the time of year when her husband was killed, this would be called a(n):
- a. Nodal event
b. Stress reaction
c. Anniversary reaction
d. Life cycle stressor
32. Bipolar patients frequently report family relationship patterns that consist of:
- a. Open communication patterns
b. Realistic expectations
c. Closed communication patterns
d. Unrealistic expectations
33. When a manic patient exhibits extreme excitement, disorientation, frantic, aimless physical activity, and grandiose delusions, which nursing diagnostic category would hold the highest priority?
- a. Coping, ineffective
b. Hopelessness
c. Violence, risk for self-directed
d. Identity, disturbed personal
34. Carl W., age 70, is hospitalized for depression. His wife died 1 year ago. He has felt sad and tense ever since. He has lost 40 pounds this year, has difficulty getting up in the morning, has missed numerous days of work and says to the nurse, "What's the use of talking? I'd rather be dead. I can't go on without my wife."
- The psychiatric and mental health nurse makes the nursing diagnosis of complicated grieving associated with the loss of his wife. She makes this nursing diagnosis because of Mr. W.'s:
- a. Prolonged period of grief and mourning after his wife's death
b. Difficulty expressing his loss
c. Inability to talk about his loss
d. Inability to sleep and symptoms of depression
35. Which of the following is not an initial objective of pharmacological intervention in unipolar depression or Bipolar Disorder?

- a. Symptom reduction
 - b. Improved function
 - c. Recurrence prevention
 - d. Seizure prevention
36. The role of the nurse in pharmacological interventions that facilitates postdischarge compliance with the medication regimen is:
- a. Collection of assessment data
 - b. Coordination of treatment modalities
 - c. Monitoring of side effects
 - d. Patient education
37. M., a depressed patient, is started on imipramine (Tofranil), 75 mg orally at bedtime. The nurse should tell the patient that:
- a. The medication may be habit forming, so it will be discontinued as soon as she feels better.
 - b. The medication has no serious side effects.
 - c. She should avoid eating such foods as aged cheese, yogurt, and red wine while taking the medication.
 - d. The medication may initially cause some tiredness, which should become less bothersome over time.
38. M., a depressed patient, will be started on a tricyclic antidepressant. The psychiatric and mental health advanced practice nurse understands that this type of medication:
- a. Blocks the transporter site for norepinephrine and serotonin
 - b. Increases reuptake of serotonin and norepinephrine
 - c. Increases metabolism of neurotransmitters
 - d. Regulates the frontal cortex where norepinephrine is made
39. D., a severely depressed patient, has not responded to tricyclic antidepressants. Prior to beginning ECT, a decision is made to initiate a trial of another antidepressant. The drug family of choice would be:
- a. Heterocyclics
 - b. Monoamine oxidase inhibitors (MAOIs)
 - c. Selective Serotonin Reuptake Inhibitors (SSRIs)
 - d. Lithium
40. The physician orders tranylcypromine sulfate (Parnate) for D. The nurse would be aware that D. understood the teaching about the drug when the patient states, "While taking the medicine, I should avoid eating":
- a. Fish
 - b. Red meat
 - c. Citrus fruit
 - d. Processed cheese
41. The nurse should teach a depressed patient on MAOIs that failure to adhere to dietary restrictions can result in:
- a. Hyperglycemic episodes
 - b. Bradycardia
 - c. Hypertensive crisis
 - d. Syncope
42. A psychiatric and mental health advanced practice nurse orders lithium carbonate, 300 mg four times a day and chlorpromazine, 100 mg four times a day for a manic patient who has just been admitted to the inpatient psychiatric unit exhibiting extreme excitement, disorientation, frantic, aimless activity, and grandiose delusions. Which statement best explains the reason for ordering chlorpromazine?
- a. A lower dose of lithium can be given.
 - b. Chlorpromazine helps control the manic symptoms until the lithium takes effect.
 - c. Joint administration makes both drugs more effective.
 - d. Joint administration decreases the risk of lithium toxicity.
43. The physician plans to order lithium carbonate for a manic patient. Before beginning the lithium treatment regimen, the nurse performs a physical assessment. She is aware that lithium is contraindicated when a patient exhibits dysfunction of the:
- a. Renal system
 - b. Reproductive system
 - c. Endocrine system
 - d. Respiratory system
44. Early signs of lithium toxicity include:
- a. Coarse tremors, ataxia, drowsiness, diarrhea
 - b. Ataxia, confusion, and seizures
 - c. Elevated white blood cell count and orthostatic hypotension
 - d. Restlessness, shuffling gait, and involuntary muscle movements
45. One week after a manic patient begins taking lithium, this nurse notes that his serum lithium level is 1 mEq/liter. How should the nurse respond?
- a. Call the physician immediately to report the laboratory results.
 - b. Observe the patient closely for signs of lithium toxicity.

- c. Withhold the next dose and repeat the blood work.
d. Continue administering the medication as ordered.
46. A first-line pharmacologic treatment modality for mood stabilization of Bipolar Disorder is:
- Clonazepam
 - Risperidone
 - Valproate
 - Serentil
47. Two weeks after a manic patient begins taking carbamazepine (Tegretol), the nurse notes that her serum Tegretol level is 14 mg/1. How should the psychiatric and mental health advanced practice nurse respond?
- Call the physician immediately to report the laboratory results.
 - Observe the patient closely for signs of toxicity.
 - Withhold the next dose and notify the physician.
 - Continue administering the medication as ordered.
48. M., a patient with severe depression, does not respond to several trials of antidepressant medications. At a team conference, a decision is made to initiate a series of electroconvulsive therapy (ECT) treatments. When should nursing intervention begin?
- As soon as the patient and family are presented with this treatment alternative
 - The night before ECT is scheduled
 - Immediately after ECT is administered
 - When the patient returns to the unit after ECT therapy
49. The interdisciplinary team is considering electroconvulsive therapy (ECT) treatments for M., a patient with severe depression. The psychiatric and mental health advanced practice nurse knows that which of the following are not appropriate indications for ECT as a treatment approach:
- Emergency therapy for suicidal patients
 - Patients who are unresponsive to antidepressants
 - Use during time lag between initiation of pharmacotherapy and onset of effectiveness
 - Effectiveness in treatment of relatives
50. The most distressing side effect of ECT is:
- Memory loss
 - Ataxia
 - Hypotension
 - Hyponatremia
51. The most serious side effect of ECT is:
- Memory loss
 - Cardiac arrhythmias
 - Hypotension
 - Agitation
52. The most effective approach to meeting a manic patient's hydration and nutrition needs would be to:
- Leave finger foods and liquids in her room and let her eat and drink as she moves about
 - Bring her to the dining room and encourage her to sit and eat with calm, quiet companions
 - Explain mealtime routines and allow her to make her own decisions about eating
 - Provide essential nutrition through high-calorie tube feedings
53. A depressed patient has difficulty sleeping at night. She reports feeling fatigued and unrefreshed. The nurse should NOT encourage the patient to:
- Limit intake of caffeinated drinks
 - Take sedatives hs
 - Take daytime naps
 - Receive back rubs
54. The nursing staff request a consultation with the psychiatric and mental health advanced practice nurse about a manic patient who demonstrates resistive behavior in relation to hygiene activities. He refuses to bathe, brush his teeth, or change his clothes. The advanced practice PMH nurse suggests which of the following interventions?
- Matter of factly assist with hygiene activities.
 - Ignore the behavior.
 - Confront the patient about his behavior.
 - Suggest that his medication be augmented with a neuroleptic.
55. Andrew M., age 42, is brought to the psychiatric unit by his parents and a sister who states, "He's just not himself since his wife died 2 years ago. He has no interests and doesn't care for himself any more, just sitting alone when he's not working. The nurse discusses the plan of care with Andrew. The nurse recognizes that it would be most helpful to:

- a. Involve him in outdoor group games each day
 - b. Encourage him to do relaxation exercises
 - c. Encourage him to talk about and plan for the future
 - d. Talk with him about his wife and the details of her death
56. Andrew attends group therapy in which the psychiatric and mental health advanced practice nurse is the leader. During one session, another client talks about his wife leaving and his feeling of abandonment. When the members are leaving the session, the APN-PMH notices that tears are running down Andrew's face. Considering his problems, the APN-PMH should:
- a. Ask the group members to return and discuss Andrew's feelings
 - b. Observe Andrew's behavior carefully over the next few hours
 - c. Go to Andrew's room and ask him to discuss his thoughts and feelings
 - d. Ask another patient to stay and spend time talking with Andrew
57. In planning activities for Mr. R., a depressed patient, the nurse finds him very resistive and complaining about his inadequacies and worthlessness. The best approach by the nurse would be to:
- a. Involve Mr. R. in activities in which he will be assured of success
 - b. Listen to Mr. R. and delay the planned activity for another time
 - c. Schedule activities that Mr. R. can complete independently
 - d. Encourage Mr. R. to select an activity in which he has some interest
58. Which of the following responses reflects a cognitive approach to dealing with low self-esteem?
- a. "For each negative trait you list about yourself, I will ask you to give me a positive trait."
 - b. "Can you recall six positive things about yourself?"
 - c. "What do you think interferes with your ability to view yourself in a positive manner?"
 - d. "What do you think would enable you to see yourself in a positive way?"
59. D., age 33, was brought to the hospital by her husband following a call from the bank informing him that she had just tried to cash a check for \$500,000 in an account that had a \$5 balance. D.'s husband states that she has hardly slept or eaten in the past 2 weeks. On admission, D. is agitated, speaking loudly and challenging the nurse. Which approach would be most therapeutic in working with D.?
- a. Teaching the patient about banking procedures
 - b. Confronting the patient about her inappropriate behavior
 - c. Kindly but firmly guiding the patient into such activities as bathing and eating
 - d. Showing the patient that she is in a controlled environment
60. When developing a care plan for a manic client, which of the following are NOT important to consider when designing behavioral interventions:
- a. Attention span
 - b. Distractibility
 - c. Unit resources
 - d. Medication supply
61. Ms. W. is admitted to the psychiatric unit with a diagnosis of severe depression. One morning, Ms. W. says to the nurse, "God is punishing me for my past sins." The nurse's best response is:
- a. "God is punishing you for your sins, Ms. W.?"
 - b. "Why do you think that, Ms. W.?"
 - c. "You really seem upset about this."
 - d. "What sins would he be punishing you for?"
62. Ms. W. tells the nurse that she has an unhappy marriage and has had several affairs. Although she feels that her husband ignores her, she blames herself for having had these affairs. The most appropriate response to assist Ms. W. in exploring her thoughts and feelings is:
- a. "Help me to understand how these affairs are all your fault?"
 - b. "Tell me why the affairs are your fault."
 - c. "It sounds like your husband ignores you. Who could blame you for having an affair?"
 - d. "Tell me about your husband."
63. James R., a manic patient, is approaching discharge. He is to be discharged on lithium carbonate. In the family teaching plan for discharge, the nurse should stress the importance of:
- a. Watching his diet to avoid aged cheese, yogurt, and caffeinated beverages
 - b. Taking the pills with milk

- c. Having a CBC done once a month
d. Having his blood levels checked as ordered
64. The psychiatric and mental health advanced practice nurse is meeting with a group of recurrent bipolar patients and their families. A key preventive intervention designed to maintain family function is:
- Recognition of relapse signs and symptoms
 - Referral for family therapy
 - Referral to NAMI
 - Recognition of early signs of lithium toxicity
65. Mrs. K. is admitted to the psychiatric unit following a suicide attempt. Mrs. K. does not answer any of the nurses' questions. To assess Mrs. K.'s current potential for suicide, the nurse should:
- Ask Mrs. K. why she feels like killing herself
 - Observe Mrs. K. for scars on her wrists or other signs of previous attempts
 - Ask Mr. K. about any previous suicide attempts or threats by Mrs. K.
 - Determine if there is a family history of suicide
66. In teaching an orientation group about nursing care of the suicidal patient, the psychiatric and mental health advanced practice nurse teaches that the suicidal risk for a depressed patient is often greatest:
- When the depression is most severe
 - Before any kind of somatic treatment is started
 - When the patient begins to express anger
 - When the patient makes a sudden and dramatic improvement
67. A manic patient is assigned to a private room that is somewhat removed from the nurse's station. The primary reason for this room assignment is to:
- Decrease environmental stimuli
 - Prevent the patient's excessive activity from disturbing others
 - Deter the patient from disturbing the nurses
 - Provide the patient with a quiet environment for thinking about his problems
68. On the unit, a manic patient is elated and sarcastic. She is constantly cursing and using foul language. She has the other clients on the units terrified. The psychiatric and mental health advanced practice nurse, who has been asked to consult in the management of this patient, advises the staff to:
- Demand that she stop what she is doing
 - Firmly tell her that her behavior is unacceptable
 - Ask her what is bothering her
 - Increase her medication or have additional medication ordered
69. Mr. M., a 50-year-old man who has been treated for double-depression during the past two years, states to the psychiatric and mental health advanced practice nurse "They've tried every medicine, nothing works, even the ones you can't eat cheese with." In reviewing his history, the APN-PMH notes the distinct absence of which of the essential laboratory tests that may explain his lack of response to pharmacological agents:
- Blood gases
 - Cardiac enzymes
 - Free thyroxine
 - White blood cell count
70. T. R., a 46-year-old woman, is admitted to your inpatient psychiatric unit after a suicide attempt. She has a history of multiple psychiatric hospitalizations due to depression with similar presentations. The following symptoms are also present: anhedonia, decreased sleep, difficulty concentrating, low energy, hopelessness, and decreased appetite. The appropriate DSM diagnosis for the clinical condition described is:
- Major Depressive Disorder, single episode
 - Major Depressive Disorder, recurrent
 - Dysthymic Disorder
 - Borderline Personality Disorder
- Case for 71 & 72:
- B. V., a 48-year-old male recovering from an acute myocardial infarction (MI), develops depressive symptoms: decreased energy, anhedonia, poor appetite.
71. The most likely diagnosis is:
- Bipolar Disorder, most recent episode depressed
 - Major Depressive Disorder, single episode
 - Major Depressive Disorder, recurrent
 - Mood Disorder Due to MI, with depressive features
72. The best pharmacologic treatment option for B. V. is:
- Citalopram
 - Imipramine
 - Bupropion
 - Venlafaxine

■ ANSWERS

- | | |
|--------------|--------------|
| 1. b | 37. d |
| 2. b | 38. a |
| 3. c | 39. b |
| 4. c | 40. d |
| 5. a | 41. c |
| 6. b | 42. b |
| 7. b | 43. a |
| 8. a | 44. a |
| 9. b | 45. d |
| 10. c | 46. c |
| 11. d | 47. c |
| 12. a | 48. a |
| 13. d | 49. d |
| 14. b | 50. a |
| 15. b | 51. b |
| 16. a | 52. a |
| 17. c | 53. c |
| 18. d | 54. a |
| 19. b | 55. d |
| 20. a | 56. c |
| 21. a | 57. a |
| 22. b | 58. a |
| 23. c | 59. c |
| 24. a | 60. d |
| 25. a | 61. c |
| 26. a | 62. a |
| 27. b | 63. d |
| 28. a | 64. a |
| 29. a | 65. c |
| 30. a | 66. d |
| 31. c | 67. a |
| 32. d | 68. b |
| 33. c | 69. c |
| 34. d | 70. b |
| 35. d | 71. d |
| 36. d | 72. a |

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Behavioral Syndromes and Disorders of Adult Personality

■ EATING DISORDERS

Fear of obesity and the pursuit of thinness represent the driving force in both Anorexia and Bulimia Nervosa, two of the most common eating disorders (Stuart & Sundeen, 1995). There is also consideration of including a diagnosis of obesity (body mass index/BMI > 30) in the next revision of the DSM (Devlin, 2007; Volkow, & O'Brien, 2007).

Anorexia Nervosa (AN)

- Definition (American Psychiatric Association [APA], 2000; Sadock & Sadock, 2007)—a severe preoccupation with food and refusal to maintain a weight within the normal range for age and height. AN is divided into two predominate types:
 1. Binge-eating/purging type—characterized by intermittent episodes of rigorous/strict dieting and episode of binge-eating (eating more than intended, but not enormous amounts) or purging (most often self-induced vomiting and may include overuse of laxatives, and/or diuretics or emetics)
 2. Restricting type—characterized by avoiding the intake of food as well as no evidence of binge-eating or purging behavior—usually trying to consume less than 300 calories per day and no fat grams, may be compulsively overactive
- Signs and symptoms (APA, 2000, 2006; Keltner, Schwecke, Bostrom, 2007; Sadock & Sadock, 2007)
 1. Refusal to eat
 2. Intense fear of gaining weight or becoming fat
 3. Weight less than 85% of expected weight
 4. Distorted body image
 5. At least three consecutive missed menstrual periods
 6. Excessive exercising
 7. Preoccupation with food
 8. Bodily changes
 - a. Emaciated appearance
 - b. Lanugo growth on face, extremities and trunk
 - c. Bradycardia, hypotension, hypothermia are common
 - d. Delayed gastric motility
 - e. Dry skin, dry and falling hair
 - f. Dental decay
- Laboratory & other diagnostic tests (APA, 2006; Sadock & Sadock, 2007)
 1. Recommended laboratory tests for all eating disordered patients:
 - a. CBC, including differential
 - b. Blood chemistry studies
 - c. Serum electrolytes
 - d. BUN
 - e. Serum creatinine (interpretations must incorporate assessments of weight)
 - f. TSH test; if indicated, free T4, T3
 - g. Erythrocyte sedimentation rate
 - h. Aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase
 - i. Urinalysis
 2. Additional testing may be warranted, including an electrocardiogram for severely

- malnourished patients, radiologic tests for GI bleeding, etc.
- 3. Screening tests (APA, 2006)
 - a. Clinician-administered
 - (1) Eating Disorder Examination (EDE)
 - (2) Yale-Brown-Cornell Eating Disorder Scale (YBC-EDS)
 - b. Self-report
 - (1) Diagnostic Survey for Eating Disorders (DSED)
 - (2) Bulimia Test—Revised (BULIT-R)
 - (3) Eating Attitudes Test (EAT)
 - (4) Eating Disorder Examination—Questionnaire (EDE-Q)
 - (5) Eating Disorders Inventory-2 (EDI-2)
 - (6) Eating Disorders Questionnaire (EDQ)
 - (7) Questionnaire on Eating and Weight Patterns (QEWP)
- Mental status variations (Keltner, Schwecke, Bostrom, 2007; Sadock & Sadock, 2007)
 - 1. Mood and affect
 - a. Dysphoric mood with crying spells
 - b. Emotionally lability
 - c. Anxiety
 - d. Low self-esteem
 - 2. Sleep disturbance (insomnia or hypersomnia)
 - 3. Thought processes
 - a. Distorted body image
 - b. Delusional thinking about body size
 - c. Concrete thinking
 - d. Overpowering fear of losing control
 - e. Hypochondriasis
 - f. Obsession with food and cooking
 - g. Decreased concentration
 - 4. Appearance—emaciated
 - 5. Defense mechanisms
 - a. Repression
 - b. Regression
 - c. Denial
 - d. Manipulation—untruthful about food intake and methods of losing weight
 - 6. Impaired judgment related to food
 - 7. Impaired insight
 - a. Intellectualization
 - b. Perfectionistic attitude
 - 8. Behavior
 - a. Ritualistic
 - b. Compulsive
- Mental status variations (Keltner, Schwecke, Bostrom, 2007; Sadock & Sadock, 2007)
 - 1. Judgment and insight
 - a. Recognition that eating behavior is abnormal
 - b. Problems with impulse control (stealing, drug and/or alcohol abuse, self-mutilation, suicide attempt)
 - c. Manipulative and untruthful behavior
 - d. Difficulty identifying and dealing with emotions
 - 2. Thought processes
 - a. Overly concerned with body shape and weight
 - b. Obsessional ideas
 - 3. Mood—depressed (feels sad and lonely, empty and isolated, with self-criticism and guilt feelings)
 - 4. Orientation—lethargy and confusion due to extreme dehydration caused by self-induced vomiting and excessive use of laxatives
- 3. Dieting/fasting or excessive exercise to control weight
- 4. Weight usually within normal range
- 5. Dehydration, electrolyte imbalance
- 6. Gastric acid in vomitus contributing to erosion of tooth enamel
- 7. Psychoactive substance abuse/dependence
- 8. Perceived inability to control bingeing
- 9. Average of at least 2 binges a week for at least 3 months
- 10. Depressed mood and self-deprecatory thoughts following binges
- 11. Exaggerated concern about body shape and weight
- 12. Enlargement of face and cheeks due to swelling of salivary glands
- 13. Changes in EKG—cardiac arrhythmias leading to renal problems

Information Common to Anorexia and Bulimia

- Differential diagnosis
 - 1. Depressive disorders
 - a. Absence of distorted body image
 - b. Absence of intense fear of obesity
 - c. True loss of appetite
 - 2. Obsessive-Compulsive Disorder
 - 3. Schizophrenic disorders
 - a. Bizarre eating patterns present without eating disorder syndrome or concern with the caloric content of food
 - b. Refusal to eat

Bulimia Nervosa

- Signs and symptoms (APA, 2000, 2006)
 - 1. Recurrent episodes of binge eating
 - 2. Self-induced vomiting or abuse of laxatives/diuretics

4. Somatization Disorder
 - a. Absence of fear of becoming overweight
 - b. Amenorrhea for 3 months or more is unusual
 5. Medical illnesses
 - a. Hyperthyroidism
 - b. Neoplasms
 - c. Anemia
 - d. Diabetes mellitus
 - e. Crohn's disease
 - f. Neurological diseases
 6. Borderline Personality Disorder
- Nursing diagnoses (NANDA, 2009)
 1. Body Image, disturbed
 2. Fluid Volume, risk for deficient
 3. Nutrition—less than body requirements, imbalance
 4. Nutrition—more than body requirements, imbalanced
 5. Nutrition—risk for more than body requirements, imbalanced
 6. Anxiety (moderate to severe)
 - Genetic/Biological origins
 1. Decreased hypothalamic norepinephrine activation
 2. Dysfunction of lateral hypothalamus
 3. Abnormal dexamethasone suppression test findings
 4. Low serum serotonin level (Bulimia Nervosa)
 5. Hereditary predisposition
 6. Excess endorphins shutting down the feeding system and inhibiting release, thus initiating amenorrhea
 7. Chronic deficit of endorphins initiating feeding to stimulate this down-regulated system
 - Biochemical interventions (APA, 2006; Sadock & Sadock, 2007; Stahl, 2008)
 1. There are no medications yielding efficacious results in treating Anorexia Nervosa. There is limited evidence of success with cyproheptadine (Periactin) and amitriptyline (Elavil). There is additional evidence for effectiveness of medications used to address associated symptoms of depression, anxiety, and agitation. In Anorexia Nervosa, patients can be concerned about the side effect of weight gain associated with any medication; this topic must be addressed sensitively.
 2. Antidepressants have been effective in addressing symptoms of Bulimia Nervosa. SSRIs (specifically fluoxetine) have the highest empirical support and lowest side effect profile for these patients.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Unresolved conflicts during childhood
 - b. Inconsistent parental response to child's needs
 - c. Disturbance of self-esteem
 - d. Food serving as a means to express feelings
 - e. Separation, individuation, and control issues (Anorexia Nervosa)
 - f. Independence/dependence struggle between woman and parent(s)
 - g. Avoidance of sexuality
 2. Psychotherapeutic interventions (NOTE: Hospitalization for medical stabilization and restoration of nutritional state (dehydration, starvation, electrolyte imbalance) may be required.) (APA, 2006; Sadock & Sadock 2007)
 - a. Objectives
 - (1) Addressing eating disordered behavior (restoration to a healthy weight, and elimination of binge/purge behaviors); helping client reestablish normal eating behavior, avoid excessive exercise, avoid self-induced vomiting or laxative abuse
 - (2) Treating any physical complications and associated psychiatric conditions
 - (3) Enhancing patient's motivation to cooperate in the restoration of healthy eating patterns and participation in treatment
 - (4) Educating patient regarding healthy nutrition and eating patterns
 - (5) Helping patient to reassess and change core dysfunctional cognitions, attitudes, motives, conflicts, and feelings related to the eating disorder
 - (6) Enlisting family support and providing family counseling and therapy where appropriate
 - (7) Helping to develop a plan to prevent relapse
 - b. Individual psychotherapy (insight-oriented therapy)
 - (1) Establish realistic thinking process.
 - (2) Increase self-esteem.
 - (3) Establish a healthy sense of control and autonomy.
 - (4) Deal with underlying psychological conflicts.
 3. Cognitive/Behavior therapy (very effective in treating Bulimia Nervosa—most effective when combined with SSRI (fluoxetine))
 - a. Establish contract
 - b. Describe expected behaviors

- c. Eliminate power struggle
 - d. Initiate consistency from staff to coordinate treatment
 - e. Positive reinforcement
 - f. Informational feedback
 - g. Progressive desensitization focusing on feelings prior to an episode of binge eating
4. Relaxation techniques
- Family dynamics/Family therapy
 1. Overly strict environment and disagreement concerning discipline
 2. Chaotic, conflictual environment with marital discord and hostility
 3. Power and control issues
 4. High value placed on perfectionism
 5. Parental criticism that promotes perfectionistic and obsessive behavior in child
 6. Feelings of helplessness and ambivalence
 7. Perceived loss of control in life
 8. Family unable to resolve problems that arise with the family
 9. Need for “sick” member to enable the other family members to communicate with each other
 10. Less understanding and nurturant and more belittling, blaming, rejecting, and neglectful
 11. Sexual abuse
 12. Family therapy
 - a. Educate family about the disorder.
 - b. Support family as they deal with guilt and stigma of having member with disorder.
 - c. Focus on fostering open, healthy interaction patterns.
 - Group approaches
 1. Types
 - a. Supportive
 - b. Self-help
 - c. Small group therapy
 - d. Support group for parents
 - e. Outpatient
 2. Group functions
 - a. Fostering self-esteem
 - b. Gaining insight
 - c. Sharing concerns
 - d. Providing constructive support from peers
 - Milieu interventions (Keltner, Schwecke, Bostrom, 2007)
 1. Provide for safety and physical needs.
 2. Closely observe with appropriate interventions for avoidance behaviors (hiding food in napkin to discard later, intentionally spilling food while eating).

3. Counteract effects of starvation by promoting weight gain and restoring normal nutritional balance.
 4. Include dietitian in treatment plan.
 5. Encourage client to share feelings with staff.
 6. Maintain consistency of responses among staff members.
 7. Document intake and output.
 8. Involve dietitian in treatment planning and teaching of proper nutrition.
 9. Reduce focus on food or eating with client once protocol established; art and other expressive therapies may be useful in helping client express feelings.
 10. Use behavioral reinforcement.
 11. Provide group interaction with peers.
 12. Address adolescent development issues.
 13. In hospital, give client opportunity to be responsible for own weight gain and reward for conforming to treatment regimen.
 14. Encourage behavioral diaries.
 15. Teach to recognize cues for hunger and satiation.
 16. Limit exercising in treatment.
 17. Avoid keeping food records, weighing frequently, constantly counting calories, cooking for others, and reading recipes.
- Community resources
 1. Eating disorder groups
 2. Family support groups
 3. Twelve-step programs

■ SEXUAL AND GENDER IDENTITY DISORDERS

Paraphilias (Sadock & Sadock, 2007)

- Definition—repetitive or preferred sexual fantasies or behaviors that involve giving or receiving pain, or activity with a nonconsenting partner, to experience full sexual arousal and satisfaction (Wilson & Kneisl, 1996). Paraphilias include the following subcategories:
 1. Fetishism—use of clothing or other nonliving object as source of sexual arousal (not clothing of opposite sex—see transvestic fetishism)
 2. Exhibitionism—exposure of genitals to unsuspecting stranger
 3. Frotteurism—body contact with strangers in public places—usually involves the rubbing of the clothed body of a stranger with male genitalia
 4. Pedophilia—sexual contact with prepubescent child
 5. Sexual masochism—receiving physical/mental pain from sexual partner

6. Sexual sadism—inflicting physical/mental pain on sexual partner
 7. Transvestic fetishism—recurrent cross-dressing by heterosexual male
 8. Voyeurism—watching others undressing/engaged in sexual activity
- Differential diagnosis
 1. Rule out nonpathogenic sexual experimentation.
 2. Rule out public urination.
 3. Rule out exposure as prelude to sexual activity with child.
 4. Rule out poor judgment due to:
 - a. Mental retardation
 - b. Organic personality syndrome
 - c. Alcohol intoxication
 - d. Schizophrenia
 - Mental status variations
 1. Inadequate social skills
 2. Depressed mood and anxiety accompanying the behaviors
 3. Poor judgment and impulse control
 - Genetic/Biologic origins
 1. Limbic system or temporal lobe abnormalities
 2. Abnormal levels of androgens
 - Biochemical interventions
 1. Antiandrogenics—medroxyprogesterone (depo-Provera)—5 to 10mg/day induces a reversible chemical castration.
 2. Serotonergic agents (SSRIs) have been used with limited success.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Unresolved Oedipus complex leading to identification with opposite gender parent or object for libido cathexis
 - b. Castration anxiety
 2. Psychotherapeutic interventions
 - a. Psychodynamic psychotherapy
 - (1) Explore thoughts, feelings, and behavior that precede paraphiliac behavior in order to control occurrences.
 - (2) Eliminate anxiety or depression that accompanies behavior.
 - b. Behavior therapy
 - (1) Systematic desensitization
 - (2) Aversive techniques
 - (3) Assertiveness training
 - c. Combination of psychodynamic and behavioral techniques

- Milieu interventions—nurse's role is primarily associated with prevention of problems, which focuses on the development of adaptive coping strategies to deal with stressful life events.

Gender Identity Disorder

- Definition—persistent discomfort with one's assigned gender and a feeling that it is inappropriate or inaccurate (Sugar, 1995)
- Signs and symptoms—DSM-IV-TR Criteria (APA, 2000)
 1. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
 - a. In children, manifested by at least four of the following:
 - (1) Repeatedly stated desire to be, or insistence that he or she is, the other sex
 - (2) In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
 - (3) Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
 - (4) Intense desire to participate in the stereotypical games and pastimes of the other sex
 - (5) Strong preference for playmates of the other sex
 - b. In adolescents and adults, manifested by symptoms such as:
 - (1) Stated desire to be the other sex
 - (2) Frequent passing as the other sex
 - (3) Desire to live or be treated as the other sex
 - (4) The conviction that one has the typical feelings and reactions of the other sex
 2. Persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex
 - a. In children, manifested by any of the following:
 - (1) In boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis
 - (2) In boys, aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities
 - (3) In girls, rejection of urinating in a sitting position or assertion that she does not want to grow breasts or

- menstruate, or marked aversion toward normative feminine clothing
 - b. In adolescents and adults, manifested by symptoms such as preoccupation with getting rid of one's primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to alter physical sexual characteristics to simulate the other sex) or belief that one was born the wrong sex
 - 3. Not concurrent with a physical intersex condition (e.g., androgen insensitivity syndrome or congenital hyperplasia)
 - 4. Clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Differential diagnosis
 1. Schizophrenia—clients rarely develop delusion that focuses on sex change; may have hallucinations or ideas of reference.
 2. Late adolescents who are uncomfortable with own bodies but feel guilty because of attraction to members of own sex. May feel homosexuality is worse than transsexualism and want sex reassignment to lead normal heterosexual lives.
 3. Nonconformity to stereotypical sex role behavior—cross-gender wishes due to nonconforming
 4. Transvestic fetishism—cross-dressing behavior for sexual excitement
 - Mental status variations
 1. Dysphoric mood
 2. Anxiety
 - Genetic/Biologic origins
 1. Prenatal estrogen and androgen levels
 2. Chromosomal abnormalities
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. In boys
 - (1) Physical or psychological loss of the mother that results in separation anxiety in the child
 - (2) Severe disruption or distortion in mother-son relationship that results in the mother's withdrawal, which leads to separation anxiety and feminine behavior
 - (3) Feminine behavior and/or identification caused by excessive closeness to mother
 - b. In girls—Mother lacks self-esteem as a woman and derogates femininity as inferior. Mother rejects girl who turns to father who nurtures and protects from the aggressive mother.
 - c. In both boys and girls—separation threats and behavior as defense against separation
 2. Psychotherapeutic interventions
 - a. Psychotherapy
 - (1) Assist to individuate from mother.
 - (2) Aid in developing diverse perceptions of women and femaleness.
 - (3) Work through loss of the attachment figure.
 - b. Behavioral therapy
 - (1) Systematically arrange that rewards follow sex-appropriate behaviors.
 - (2) Target behaviors, such as selection of toys and dress-up play, exclusive affiliation with opposite sex, and mannerism.
 - (3) Enhance behavior deficiencies such as poor athletic ability.
 - (4) Focus on overt sex-type behaviors rather than gender identity or gender dysphoria.
 - (5) Provide social attention or social reinforcement.
 - (6) Encourage self-monitoring procedures.
 - Family dynamics
 1. Strong interest in opposite-gender role behavior and weak reinforcement of normative gender-role behavior by parents
 2. Extreme physical and psychological closeness with son by the mother
 - a. Parental encouragement of cross-gender behavior—mothers of feminine boys themselves had gender identity conflicts as children that led them to devalue men and masculinity
 - b. Father as physically absent or psychologically peripheral—no counterforce to pathogenic mother-son relationship

■ SEXUAL DYSFUNCTIONS

- Definitions (APA, 2000)
 1. Male Erectile Disorder—persistent or recurrent inability to maintain an erection until completion of sexual activity
 2. Female Sexual Arousal Disorder—persistent or recurrent inability to attain or maintain an adequate lubrication-swelling response of sexual

- excitement until completion of the sexual activity
3. Dyspareunia—pain before, during, and after sexual intercourse
 4. Vaginismus—recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse
 5. Orgasmic Disorder—persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase
 6. Premature Ejaculation—persistent or recurrent ejaculation with minimal sexual stimulation before, upon, or shortly after penetration and before the person wishes it
 7. Hypoactive Sexual Desire Disorder—persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity
 8. Sexual Aversion Disorder—persistent or recurrent extreme aversion to and avoidance of all (or almost all), genital sexual contact with a sexual partner
- Differential diagnosis
 1. Central nervous system tumors
 2. Mood disorder
 3. Rape trauma syndrome
 4. Neuroendocrine disorders
 5. Penile, prostate, or testicular cancer
 6. End-stage renal disease
 - Mental status variations—affect may be sad, depressed, or anxious
 - Nursing diagnoses (NANDA, 2009)
 1. Sexual Dysfunction
 2. Sexuality Pattern, ineffective
 - Genetic/Biologic origins
 1. Decreased levels of serum testosterone
 2. Elevated levels of prolactin
 3. Physical changes due to:
 - a. Surgery, aging, or trauma
 - b. Drug abuse or medication side effects
 - c. Neurological disorders
 - d. Infection and poor hygiene
 - Biochemical interventions—the primary medications used in treating erectile dysfunction are the PDE-5 inhibitors—sildenafil (Viagra); vardenafil (Levitra) and tadalafil (Cialis).
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Religious orthodoxy
 - b. Gender identity or sexual preference
 - c. Sexual phobias
 - d. Depression
 - e. Fear of becoming pregnant
 - f. Traumatic sexual experiences in childhood
 - g. Negative conditioning that sex is dirty
 - 2. Psychotherapeutic interventions
 - a. Cognitive therapy—changing maladaptive beliefs
 - b. Psychodynamic therapy—resolving intrapsychic conflicts
 - c. Behavioral therapy
 - (1) Systematic desensitization
 - (2) Sensate focus exercises
 - (3) Masturbatory training
 - (4) “Squeeze” technique for premature ejaculation
 - d. Marital/sex therapy to treat dysfunctions of sexual response cycle
 - e. Hypnotherapy
 - Family therapy—Couples/Marital therapy
 1. Homework assignments or exercises
 2. Observing and responding to homework
 - Group approaches
 1. Discussion of problems and concerns
 2. Homework for individual and couple exploration
 3. Group support and reassurance
 - Milieu interventions
 1. Use nondirective approach in completing assessment.
 2. Use language that is understandable to the client.
 3. Convey attitude of warmth, openness, honesty, and objectivity.
 4. Remain nonjudgmental.
 - Community resources
 1. Sex Addicts Anonymous
 2. American Association of Sex Educators, Counselors, and Therapists (AASECT)

■ SLEEP DISORDERS

Primary Insomnia

- Definition—the inability to initiate or maintain adequate sleep not due to any other cause (e.g., psychiatric illness, medical illness, or drug use)
- Differential diagnosis
 1. Physical conditions
 2. Medication—withdrawal from CNS stimulants
 3. Dysthymia—mood disturbance
 4. Cyclothymia—insomnia due to hypomania

- 5. Normal aging—changes in sleep pattern
 - 6. Psychiatric disorder
 - 7. Constant pain
 - 8. Obstructive lung disease
 - 9. Neurological diseases
- Mental status variations
 1. Anxiety
 2. Depression
 3. Appearance of fatigue (e.g., sleepy, dark circles under eyes)
 4. Difficulty concentrating
- Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective
 2. Fatigue
 3. Insomnia
 4. Sleep Deprivation
 5. Sleep Pattern, disturbed
 6. Walking, impaired
- Genetic/Biologic origins
 1. Two primary neurotransmitters involved in the sleep/wake cycle
 - a. Histamines
 - b. GABA
 2. Increased autonomic activity
 3. Increased physiologic activation as evidenced by increased heart rate, core body temperature, skin conductance
 4. Increased levels of stress
 5. Other psychopathology
 - a. Mood disorders
 - b. Psychoactive Substance-Abuse Disorder
 6. Physical disorders that cause pain/discomfort, such as arthritis, angina
 7. Hormonal disturbances
 8. Lifestyle that includes frequent changes or irregular sleep-wake patterns
 9. Febrile illness in childhood associated with sleep terror disorder and sleep walking disorder
- Biochemical interventions (selection of agent depends upon the specific sleep problems) (Stahl, 2008)
 1. Sleep-onset-only problem first-line agents:
 - a. Zolpidem (Ambien)—10 mg PO at bedtime for 7 to 10 days; or Ambien CR—12.5 mg PO at bedtime
 - b. Eszopiclone (Lunesta)—1 to 3 mg PO at bedtime
 - c. Zalplon (Sonata)—10 mg PO at bedtime for 7 to 10 days
 - d. Ramelteon (Rozerem)—8 mg PO at bedtime
- 2. First-line options for sleep onset and sleep maintenance problems:
 - a. Zolpidem CR (Ambien CR)—12.5 mg PO at bedtime
 - b. Eszopiclone (Lunesta)—1 to 3 mg PO at bedtime
- 3. Second-line treatment options include:
 - a. Benzodiazepines
 - (1) Triazolam—0.125 to 0.25 mg PO at bedtime
 - (2) Temazepam—15 to 30 mg PO at bedtime
 - (3) Estazolam—1 to 2 mg PO at bedtime
 - (4) Flurazepam—15 to 30 mg PO at bedtime for 7 to 10 days
 - (5) Quazepam—15 to 30 mg PO at bedtime
 - b. Trazodone—25 to 50 mg PO at bedtime, may need to increase to 50 to 100 mg (or full antidepressant dose) PO at bedtime
 - c. Antihistamine (diphenhydramine)—25 to 50 mg PO at bedtime; hydroxyzine—50 to 100 mg PO at bedtime
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Higher levels of depressed mood and anxiety than normal individuals
 - b. Increased cognitive activity for clients without medical or psychiatric disorder other than anxiety caused by stress
 2. Psychotherapeutic interventions (Williams, Karacan, Moore & Hirshkowitz, 1995)
 - a. Sleep hygiene training
 - b. Stimulus control instructions
 - c. Sleep restriction
 - d. Chronotherapy
 - e. Bright light therapy
 - f. Relaxation, meditation, biofeedback
 - g. Cognitive therapy
 - (1) Alter view of sleep problem
 - (2) Paradoxical intention with thought stopping and identification of irrational beliefs about sleep
- Family dynamics/Family therapy—none described
- Group approaches
 1. Self-hypnosis
 2. Autogenic training
 3. Sharing concerns
 4. Gaining insight
- Milieu interventions
 1. Decrease caffeine and alcohol intake during afternoon and evening.

2. Increase exercise during morning and afternoon.
 3. Encourage use of relaxation techniques.
 4. Discourage daytime naps.
 5. Encourage expression of emotion that might affect sleep.
 6. Eliminate or diminish environmental factors that may disturb sleep.
 7. Encourage client to get out of bed for alternative activities when unable to fall asleep.
- Community resources
 1. Stress management training
 2. Biofeedback training
 3. Yoga classes

Other Sleep Disorders

- Definitions only are provided for the following sleep disorders (APA, 2000):
 1. Narcolepsy—excessive daytime sleepiness and abnormal manifestations of REM sleep
 2. Breathing-related Sleep Disorder—sleep disturbance due to sleep-related breathing difficulties (e.g., sleep apnea or central alveolar hypoventilation syndrome)
 3. Circadian Rhythm Sleep Disorder (Sleep-Wake Schedule Disorder)—sleep disruption due to mismatch between the sleep-wake schedule required by a person's environment and his/her circadian sleep-wake pattern
 4. Sleep Terror Disorder—recurrent episodes of abrupt awakening from sleep without dream recall
 5. Sleepwalking Disorder—repeated episodes of arising from bed during sleep and walking about
 6. Primary Hypersomnia—excessive sleepiness that results in impairment in social, occupational, or other important areas of functioning

■ IMPULSE CONTROL DISORDERS

- Definitions—characterized by the failure to resist an impulse, drive or temptation to perform some act that is harmful to the individual or others. There is increasing tension or arousal before committing the act and pleasure, gratification, or relief during the act (Sadock & Sadock, 2007).

Intermittent Explosive Disorder

- Definition—those individuals who have discrete episodes of losing control of aggressive impulses resulting in serious assault or the destruction of property

- Differential diagnosis
 1. Psychotic disorders—violent behavior may result in response to delusions and hallucinations, and there is gross impairment of reality testing.
 2. Organic mental disorder—violent behavior results from confusion or medical condition.
 3. Antisocial or Borderline Personality Disorder—aggressiveness and impulsivity are part of the client's character and are present between outbursts.
 4. Conduct Disorder—presents with a repetitive and resistant pattern of behavior as opposed to an episodic pattern.
 5. Intoxication with or effects of a psychoactive substance (anabolic steroids) is present.
 6. Bipolar Disorder—manic behavior is present.
- Mental status variations
 1. Uncontrolled anger
 2. Impulsivity
 3. Poor judgment
 4. Emotional instability
 5. Paranoia
- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Low cerebrospinal fluid levels of 5-H1AA
 2. Inhibition of serotonin synthesis or antagonizing effects of serotonin
 3. Hormonal disturbance (increased testosterone)
 4. Prenatal trauma, infantile seizures, head trauma, encephalitis, and hyperactivity
 5. Disordered brain physiology in the limbic system
 6. Hereditary predisposition
- Biochemical interventions—mixed results with the following agents (Sadock & Sadock, 2007):
 1. Lithium—300 mg tid—qid
 2. Carbamazepine—200 mg bid with food
 3. Oxazepam—10 to 30 mg tid or qid
 4. Propranolol—60 to 640 mg/day
- Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective
 2. Violence, [actual/] risk for other-directed
 - a. Nursing interventions
 - (1) Convey an accepting attitude toward the client.
 - (2) Maintain low level of stimuli in client's environment (low lighting, few people, simple decor, low noise level).
 - (3) Help client recognize the signs that tension is increasing and ways in which violence can be averted.

- (4) Explain to client that should explosive behavior occur, staff will intervene in whatever way is required (e.g., tranquilizing medication, restraints, isolation) to protect the client and others.
- (5) Help client identify the true object of his/her hostility.
- b. Outcome criteria
 - (1) Client will not cause harm to self or others.
 - (2) Client will be able to verbalize the symptoms of increasing tension.
 - (3) Client will be able to verbalize strategies to avoid becoming violent.
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins—early frustration, oppression and hostility as predisposing factors
 2. Psychotherapeutic interventions (Keltner, Schwecke, & Bostrom, 2007):
 - a. Cognitive and Behavioral therapies
 - b. Social skills training
 - c. Problem solving
 - d. Relaxation exercises
 - e. Stress management
- Family dynamics/Family therapy
 1. Early chaotic and violent family environment with heavy drinking, by one or both parents
 2. Parental brutality, child abuse, and emotional and physical unavailability of a father figure
 3. Family therapy can be helpful when client is adolescent or young adult.
- Group approaches
 1. Fostering group loyalty
 2. Peer pressure to reinforce expectations and provide confrontation
- Milieu interventions
 1. Provide structured outlets for the energy of anger.
 2. Encourage physical activity that allows large muscle involvement (e.g., jogging, swimming, weight lifting).
 3. Ensure a safe and therapeutic environment.
 4. Teach appropriate expression of anger.
 5. Reduce sources of undue anxiety or high levels of anxiety to prevent angry outbursts.
- Community resources—mental health centers

Other Impulse Control Disorders

- Definitions only are provided for the following impulse control disorders (Sadock & Sadock, 2007):

1. Pathological Gambling—chronic and progressive failure to resist impulses to gamble and gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits
2. Kleptomania—recurrent inability to resist the impulse to steal objects not needed for personal use or their monetary value; without premeditation and little thought of legal consequences
3. Pyromania—deliberate and purposeful fire setting on more than one occasion; tension or an affective arousal before setting the fires; and intense pleasure, gratification, or relief when setting the fires or seeing the fires burn
4. Trichotillomania—recurrent failure to resist impulses to pull out one's own hair; onset usually occurring before age 17 and affecting females more often than males

■ PERSONALITY DISORDERS—CODED ON AXIS II OF THE DSM-IV-TR MULTIAXIAL CLASSIFICATION SYSTEM

- Definition—An enduring pattern of perceiving, relating to, and thinking about the environment and oneself to the extent that it leads to inflexible and maladaptive behavior, and either significant functional impairment or subjective distress. In the DSM-IV-TR, personality disorders are clustered into three categories:
 1. Cluster A—subtypes are: schizoid, schizotypal, and paranoid. Cluster A personality disorders are characterized by odd and aloof features.
 2. Cluster B—subtypes are: antisocial, borderline, histrionic, narcissistic. Cluster B personality disorders are characterized by impulsive, dramatic, and erratic features.
 3. Cluster C—subtypes are: obsessive-compulsive, avoidant, and dependent. Cluster C personality disorders are characterized by anxious and fearful features. (APA, 2000; Sadock & Sadock, 2007)

Cluster A Personality Disorders

Schizoid Personality Disorder

- Definition—diagnosed in patients who display a lifelong pattern of social withdrawal; often described as eccentric.
- Differential diagnosis
 1. Schizotypal Personality Disorder—cognitive and perceptual distortions
 2. Paranoid Personality Disorder—suspiciousness and paranoid ideation

3. Avoidant Personality Disorder—social isolation but a strong desire for relationships with others
4. Obsessive-Compulsive Personality Disorder—social detachment due to excessive devotion to work and difficulty expressing emotions rather than lack of desire or capacity for intimacy

Schizotypal Personality Disorder

- Definition—Individuals are strikingly odd or strange, even to laypersons; magical thinking, peculiar ideas, ideas of reference illusions, and derealization are part of their everyday world.
- Differential diagnosis
 1. Schizophrenia—has enduring psychosis
 2. Paranoid and Schizoid Personality Disorders—cognitive and perceptual distortion, marked eccentricity or oddness and profound social discomfort
 3. Avoidant Personality Disorder—desiring relationships
 4. Borderline—engagement in social isolation as a result of having intentionally driven others away

Paranoid Personality Disorder

- Definition—characterized by long-standing suspiciousness and mistrust of people in general
- Differential diagnosis
 1. Paranoid Schizophrenia—persistent psychotic symptoms (hallucinations and bizarre delusions)
 2. Delusional Disorder, paranoid type—prominent and persistent delusions of persecution
 3. Schizotypal Personality Disorder—cognitive and perceptual distortions

Information Common to Cluster A Personality Disorders

- Nursing diagnoses (NANDA, 2009)
 1. Coping, defensive related to guardedness and secretiveness
 2. Social Interaction, impaired
 3. Social Isolation
- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Hereditary—Cluster A (paranoid, schizotypal, schizoid)—family history of psychiatric disorders such as alcoholism, drug addiction, or Schizophrenia
 2. Schizotypal—more often with first-degree biologic relatives diagnosed with Schizophrenia
 3. Imbalance in dopamine and serotonin neurotransmitter of persons with Schizotypal Personality Disorder

4. Low levels of platelet monoamine oxidase (MAO) observed in some individuals with Schizotypal Disorder.

- Biochemical interventions—There are no empirically supported medications used to treat personality disorders. The following medications have been used to treat anxiety, depression, agitation, and psychotic-like symptoms (Sadock & Sadock, 2007):
 1. MAOIs have been used with limited success—social anxiety, social phobia, and depressive symptoms.
 2. Navane—schizotypal; decreases illusions, ideas of reference, obsessive symptoms and Phobic Disorder.
 3. Antipsychotics (haloperidol)—in small doses for brief periods can be used for paranoid thinking, anxiety, and hostility.
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Schizoid Personality Disorder—grossly inadequate, cold, or neglectful early parenting that creates expectation that the relationship would not be gratifying and leads to subsequent defensive withdrawal from others
 - b. Paranoid—recipient of irrational and overwhelming parental rage may lead to an identification with that rage and its projection onto others
 2. Psychotherapeutic interventions
 - a. Psychotherapy—treatment of choice, focusing on the client's feelings rather than intellectualized thoughts
 - b. Cognitive therapy—to address faulty thinking
- Family dynamics—Cluster A (paranoid, schizotypal, schizoid)—subjected to parental antagonism by serving as scapegoats for displaced parental aggression
- Group approaches
 1. Schizoid Personality Disorder—to increase comfort in social situations
 2. Paranoid Personality Disorder—may not be good due to excessive suspiciousness

Cluster B Personality Disorders

Antisocial Personality Disorder

- Signs and symptoms
 1. More common in men
 2. History of irresponsibility and impulsiveness

3. Lacks remorse for actions
 4. Exploits and manipulates others
 5. Self-centered
 6. Anger that leads to hostile outbursts
- Differential diagnosis
 1. Conduct Disorder—if person younger than 18 years with characteristic features present
 2. Psychoactive substance abuse—episodic behavior associated with alcohol/drug intake
 3. Mental retardation—may exhibit remorse due to actions or behavior
 4. Schizophrenia—presence of prolonged psychotic episodes
 5. Manic episode—mood changes
 6. Cyclothymic Disorder—periods with hypomanic symptoms and depressive symptoms
 7. Borderline Personality Disorder—fear of abandonment, substance abuse
 - Diagnostic studies/tests
 1. Neurological work-up
 2. ECG
 - Mental status variations
 1. Absence of anxiety or depression
 2. Suicide threats and somatic preoccupation
 3. Absence of delusions or other signs of irrational thinking
 4. Highly manipulative and untrustworthy
 5. Lacking in remorse
 6. Compulsive recklessness
 7. Impulsivity
 - Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Hereditary predisposition—associated with substance-use disorders (alcohol).
 2. Low cortical arousal and reduced level of inhibitory anxiety may play a role.
 - Biochemical interventions (Sadock & Sadock, 2007)—used to address anger, rage, and depressive symptoms, but use with caution due to frequent comorbid substance-use disorder.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins—arrest in normal psychological development with failure to integrate ambivalent feelings originally aroused against the primary caretaker
 2. Psychotherapeutic interventions
 - a. Confrontation of inappropriate behavior
 - b. Individual psychotherapy
 - c. Structured living with supervision
 - d. Outpatient supportive therapy
 - Family dynamics
 1. Chaotic home environment
 2. Parental deprivation during the first 5 years of life
 3. Presence of intermittent appearance of inconsistent, impulsive parents
 4. Traumatic abandonment experiences
 5. Physical and sexual abuse
 - Group approaches
 1. Help client assume responsibility for behaviors.
 2. Confront inappropriate and manipulative behaviors.
 3. Allow client to receive parenting not previously received.
 4. Allow client to tolerate feelings of emptiness, depression, and anxiety.
 5. Develop socially appropriate behavioral responses.
 - Community resources
 1. Alcoholics Anonymous
 2. Emotions Anonymous
 3. Narcotics Anonymous
- Borderline Personality Disorder (Sadock & Sadock, 2007)***
- Signs and symptoms
 1. Two-thirds of those diagnosed are female.
 2. Self-mutilation, labile mood (mood swings)
 3. Impulsivity
 4. Outbursts of intense anger and rage
 5. Unstable relationships due to intolerance for being alone
 6. Identity diffusion (lack of consistent sense of self)
 7. Chronic emptiness, boredom
 8. Depression
 9. Frantic efforts to avoid real or imagined abandonment
 10. Micropsychotic episodes (brief psychotic episodes)
 - Differential diagnosis
 1. Cyclothymia—presence of hypomania
 2. Schizophrenia—presence of prolonged psychotic episodes, thought disorder or other signs
 3. Paranoid personalities—extreme suspiciousness
 4. Schizotypes—showing marked peculiarities of thinking, strange ideation, and recurrent ideas of reference
 - Mental status variations
 1. Affect—mood swings, anxiety, depression

2. Thought processes
 - a. Difficulty concentrating
 - b. Suicidal gestures and attempts
 3. Insight lacking—poor judgment
 4. Defense mechanisms
 - a. Manipulation
 - b. Splitting
 - c. Projection
 - d. Denial
 - e. Rationalization
 - f. Idealization
 - g. Devaluation
 5. Memory—recent memory disturbance
- Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective
 2. Violence, [actual/] risk for other-directed
 3. Violence, [actual/] risk for self-directed
 4. Role Performance, ineffective
 5. Social Interaction, impaired
 - Genetic/Biologic origins (Sadock & Sadock, 2007)—related to history of mood disorders, alcoholism, and somatization disorders among family members
 - Biochemical interventions—useful in treating specific personality features that interfere with functioning
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Inconsistent and unpredictable parenting
 - b. Unmet need for love
 - c. Separation/individuation phase not accomplished
 2. Psychotherapeutic interventions (Sadock & Sadock, 2007)
 - a. Reality oriented therapy favored over in-depth unconscious interpretations
 - b. Long-term psychotherapy with supportive modifications to develop trust
 - c. Behavioral therapy—with limit setting (mutually agreed upon limits)
 - d. Dialectic Behavior therapy—has shown efficacious results, particularly among patients with parasuicidal behavior, such as cutting (See Chapter 3)
 - Family dynamics
 1. Parent may be critical and rejecting, or
 2. Parent may be suffocating and smothering and interferes with optimal progression of attachment-separation sequences.

- Milieu interventions
 1. Staff develops self-awareness to avoid negative countertransference.
 2. Establish trusting relationship with client.
 3. Institute safety precautions.
 4. Provide structured supportive and consistent environment.
 5. Apply behavioral limits judiciously.
 6. Assist client in taking responsibility for consequences of actions.
 7. Assist the client in identifying feelings and in learning how to express them in a socially acceptable manner.
 8. Enhance client's self-esteem and sense of self-worth.
- Community resources
 1. Day hospital programs
 2. Halfway houses

Histrionic Personality Disorder

- Definition—characterized by colorful, dramatic, extroverted behavior in excitable, emotional persons; accompanying their flamboyant presentation, however, is often an inability to maintain deep, long-lasting attachments.
- Differential diagnosis
 1. Borderline Personality Disorder—may have rapidly shifting emotions and less capacity for ambivalence
 2. Borderline and Antisocial Personality Disorder—may crave excitement and become frustrated by delayed gratification; more likely to behave impulsively and violate the rights of others
 3. Narcissistic Personality Disorder—craves attention but wants to be admired for superiority rather than weakness or being dependent
 4. Manic and hypomanic states—episodic in nature and present with other classic symptoms of mania or hypomania
 - a. Persons with histrionic personality disorder are often not aware of their own true feelings—clarification of feelings and emotions in psychotherapy can be useful
 - b. Adjunctive pharmacologic interventions
 5. Origins—fixation at the phallic phase leads to seeking sexual involvement with opposite-sex parent and leads to a conflictual relationship with the same-sex parent

Narcissistic Personality Disorder

- Definition—characterized by a heightened sense of self-importance and grandiose feelings that they are unique in some way (APA, 2000; Sadock & Sadock, 2007).

- Differential diagnosis
 1. Other personality disorders—absence of grandiosity
 2. Borderline personality—unstable self-image, self-destructiveness, impulsivity and abandonment fears
 3. Antisocial—insensitive and exploitive, exhibiting impulsivity and more materialistic
 4. Schizotypal and paranoid—suspiciousness, social withdrawal and alienation
 5. Manic or hypomanic episodes—presence of grandiosity
- Genetic/Biologic origins—related to history of mood disorders, alcoholism, and somatization disorders among family members
- Biochemical interventions
 1. Lithium—used for mood swings
 2. Antidepressants (serotonergic) likely most useful
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins—Narcissistic Personality Disorder—results from ongoing childhood experiences of having fears, failures, dependence, or other signs of vulnerability that is responded to with criticism, disdain, or neglect
 2. Psychotherapeutic interventions
 - a. Behavioral therapy—no evidence of success.
 - b. Group therapy may be most effective.

Cluster C Personality Disorders

Avoidant Personality Disorder

- Definition—Persons show extreme sensitivity to rejection, which may lead to a socially withdrawn life; behavior is due to shyness rather than desire to be asocial.
- Differential diagnosis
 1. Schizoid Personality Disorder—social isolation due to interpersonal indifference, insensitivity to social interactions, lacking in self-consciousness and indifferent to criticism
 2. Dependent Personality Disorder—strong desire for relationships, low self-confidence and interpersonal insecurity, but more secure when relating to and clinging to others; fear of interpersonal loss
 3. Social Phobia—prominent anxiety in social setting, consisting only of fear of performing in social setting

Dependent Personality Disorder

- Definition—persons with the disorder subordinate their own needs to those of others, get others to assume responsibility for major areas in their lives, lack of confidence, and may experience intense discomfort when alone for more than a brief period of time
- Differential diagnosis
 1. Borderline Personality Disorder—intense attachments, needing others to alleviate a sense of emptiness or to provide them with a sense of identity
 2. Avoidant Personality Disorder—so strongly fearful of hurt and rejection that they will withdraw from relationships, not as likely to cling to others
 3. Histrionic Personality Disorder—excessive need for reassurances and approval motivated by a need for praise and desire to be the center of attention

Obsessive-Compulsive Personality Disorder (OCPD)

- Definition—characterized by emotional constriction, orderliness, perseverance, stubbornness, and indecisiveness—unlike other personality disorders, those with OCPD are aware of their suffering and seek treatment on their own.
- Differential diagnosis
 1. Narcissistic Personality Disorder—attempting to be perfect primarily as a means of sustaining their grandiosity rather than avoiding mistakes; not as critical of self as they are of others
 2. Antisocial Personality Disorder
 3. Dependent Personality Disorder—indecisiveness due to need for help and reassurance rather than to a self-inflicted fear of being inaccurate
 4. Obsessive-Compulsive Disorder—characterized by repetitive unwanted thoughts and ritualistic behaviors rather than personality traits

Information Common to Cluster C Personality Disorders

- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Obsessive-Compulsive Personality Disorder found with basal ganglia and frontal cortex dysfunctions.
 2. Children with high innate submissiveness and low activity and persistence may elicit parental responses that promote Dependent Personality Disorder.

3. High anxiety in Avoidant Personality Disorder found due to increased cortisol and sympathetic arousal.
 4. Avoidant Personality Disorder—genetically based, temperamental predisposition to social avoidance or an inability to perform flexibly in new situations.
- Biochemical interventions—used to treat anxiety, depression, and psychotic-like symptoms
 1. Clonazepam (Klonopin), clomipramine (Anafranil), and SSRIs have been useful in reducing symptoms associated with OCPD.
 2. No evidence of significant role in treatment of avoidant or dependant personality disorders. Treating associated features (anxiety, depression) has been successful, however.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Obsessive-Compulsive Personality Disorder—develops from excessive parental disapproval and control, which may cause the child to stifle emotional expression (especially anger), and focus on the details of childhood tasks, attempting to be perfect as a way to win the approval of critical, over-controlling, and perhaps obsessional parents.
 - b. Dependent Personality Disorder—develops from under-indulgence and ongoing reinforcement patterns during the oral stage; family environments inhibit expression of feelings and exhibit high control; excessive dependence may represent a reaction formation against the expression of hostility or assertiveness; cultural and social factors contribute to excessive dependence in women and minorities
 - c. Avoidant Personality Disorder—children who are rejected, belittled, and censured by their parents may develop feelings of self-depreciation and social alienation.
 2. Psychotherapeutic interventions
 - a. Psychotherapy—treatment of choice: focus on the client's feelings rather than intellectualized thoughts
 - b. Cognitive therapy—to address faulty thinking
 - c. Behavioral therapy
 - d. Assertiveness training—maybe useful in OCPD
 - Family dynamics—Cluster C (avoidant, passive-aggressive, dependent, obsessive-compulsive

disorders)—families are over-controlling; child expected to live up to impossible standards and then condemned when fails.

- Nursing diagnoses (NANDA, 2009)
 1. Coping, defensive
 2. Social Interaction, impaired
 3. Fear
- Group approaches
 1. Dependent Personality Disorder—encourage autonomy and increase social self-confidence
 2. Avoidant Personality Disorder—social skills training
 3. Obsessive-Compulsive Personality Disorder—focus on current life situations and confrontation
- Community resources
 1. Obsessive-Compulsive Disorder support group
 2. Assertiveness training groups and seminars

Other Personality Considerations:

- Depressive Personality Disorder—characterized by chronic unhappiness and life-long anhedonia, pessimism, and self-doubting (Sadock & Sadock, 2007). Psychological origins—disturbance of early object relations that lead to an excessively severe superego, the inhibited expression of aggression, and excessive dependence on the love and acceptance of others.
- Passive-Aggressive Personality Disorder—characterized by procrastination, stubbornness, inefficiency, covert obstructionism (Sadock & Sadock, 2007). Psychological origins—contradictory and inconsistent training methods are major factors.
- Interventions—Psychotherapy is the treatment of choice for Depressive Personality Disorder, limited success with Passive-Aggressive Personality Disorder. Biochemical approaches used to treat anxiety, depression, and psychotic-like symptoms are indicated. No evidence of significant role in treatment of Dependent Personality Disorder, and Passive-Aggressive Personality Disorder.

■ QUESTIONS

Select the best answer

1. Which of the following characteristics is most typical of bulimia?

- a. Unsuccessful efforts to control weight normally
 - b. Persistent over-concern with body shape and weight combined with periods of strict dieting
 - c. Self-induced vomiting alternating with periods of normal eating
 - d. Episodes of binge eating and self-induced vomiting or other severe weight control methods
2. The psychiatric and mental health advanced practice nurse is giving an inservice on Bulimia Nervosa. Which of the following would be valid information to present? Families with a member with Bulimia Nervosa are:
 - a. Rigid and inflexible
 - b. Chaotic
 - c. Overprotective
 - d. Abusive
 3. In order to assess a client's eating patterns, which of the following might the nurse use?
 - a. "Do you often feel fat?"
 - b. "Who plans the family meals?"
 - c. "What do you eat in a typical day?"
 - d. "What do you think about your present weight?"
 4. Based on the client's response to the question above, what nursing diagnosis is most likely? Nutrition, imbalanced: less than body requirement related to:
 - a. Abuse of laxative as evidenced by electrolyte imbalances
 - b. Physical exertion in excess of energy produced through caloric intake as evidenced by weight loss
 - c. Self-induced vomiting as evidenced by swollen glands
 - d. Refusal to eat as evidenced by loss of 15% of body weight
 5. When the advanced practice PMH nurse engages the family of a client with a diagnosis of Anorexia Nervosa in family therapy, what type of family dynamics might she/he expect to see?
 - a. Overly strict and disagreement about discipline
 - b. Overprotective, abusive, rigid
 - c. Impulsive, rigid, perfectionistic
 - d. Controlling, impulsive, abusive
 6. Which of the following would NOT be an area for milieu management of Bulimia Nervosa?
 - a. Maintain behavioral diary.
 - b. Promote exercise.
 - c. Promote expression of feelings.
 - d. Develop adaptive coping.
 7. While conducting an initial assessment, the nurse gathered the following sexual history; pain before, during, and after sexual intercourse. Which of the following nursing diagnoses would be most appropriate for the data described?
 - a. Transvestic fetishism
 - b. Sexual Arousal Disorder
 - c. Sexual Dysfunction
 - d. Altered Sexuality Patterns
 8. According to the premise of Cognitive therapy, which of the following would represent an example of cognitive restructuring in the treatment of the client with a Sexual Dysfunction?
 - a. Maintaining a diary of all stressful events
 - b. Asking someone else to validate negative thoughts
 - c. Identifying irrational thoughts and counter them with rational explanations
 - d. Practicing affirmations
 9. In psychosocial development models, the term "gender identity" refers to the:
 - a. Personal perception of being male or female
 - b. Outward expression of socially accepted masculine or feminine traits
 - c. Sexual classification assigned at birth
 - d. Congruence of hormone levels and sexual behavior
 10. Which of the following is true about a person with Paraphilia?
 - a. Paraphilia is a sexual dysfunction.
 - b. Persons with Paraphilia do not have normal sexual habits.
 - c. Erotic pleasure is received from the activity.
 - d. The Paraphilia tends to be obsessional in nature.
 11. The first intervention in assessment at the initiation of sex therapy is:
 - a. Clarification of each member's perceptions of the other
 - b. Exploration of each member's beliefs about sexuality
 - c. Separate assessments to enhance free expression
 - d. Assessment of the couple's communication patterns

12. The nurse is assessing a client's sexual problem. In order to assess the client's feelings and attitudes about sex, the nurse might ask:
- The client's beliefs about alternative sexuality
 - How the client's religion views sex
 - For a description of the client's earliest sexual experiences
 - The client's perception of his/her parent's relationship
13. As the nurse plans treatment for a sexual problem, it is important to focus the interventions toward:
- The couple
 - The identified client
 - Each member individually
 - The partner
14. The primary intervention by the nurse in sex therapy is:
- Activities for the couple
 - Homework assignments
 - Communication clarification
 - Values clarification
15. Which of the following mental status variations would the nurse expect to see in a patient with a medical diagnosis of Gender Identity Disorder?
- Dysphoric mood
 - Poor insight
 - Hallucinations
 - Memory loss
16. Which of the following is a manifestation of Gender Identity Disorder?
- Fetishism
 - Cross-dressing
 - Sexual sadism
 - Masochism
17. Mr. Cartwright tells the nurse that his sexual functioning is normal when his wife wears gold pumps. He states, "Without the gold pumps. I'm not interested in sex." The advanced practice PMH nurse assesses this as:
- Pedophilia
 - Exhibitionism
 - Voyeurism
 - Fetishism
18. Which of the following would be best to use when the nurse assesses a client's sexual functioning?
- "Have you recently experienced a change in your self-esteem?"
 - "Has anything such as illness, pregnancy, or a health problem interfered with your role as a wife/husband?"
 - "Has anything such as a heart attack or surgery changed the way you feel about yourself as a man/woman?"
 - "Has anything such as surgery or disease changed your body's ability to function sexually?"
19. A new nurse tells the psychiatric and mental health advanced practice nurse "I'm unsure about my role when clients bring up sexual problems." The psychiatric and mental health advanced practice nurse should give clarification by saying:
- "All nurses qualify as sexual counselors because of their knowledge about biopsychosocial aspects of sexuality throughout the life cycle."
 - "All nurses should be able to screen for Sexual Dysfunction and give limited information about sexual feelings, behaviors, and myths."
 - "All nurses should defer questions about sex to other health care professionals because of their limited knowledge."
 - "All nurses who are interested in Sexual Dysfunction can provide sex therapy for individuals and couples."
20. The nurse is caring for a client who presents with a medical diagnosis of Antisocial Personality Disorder. Which of the following nursing diagnoses would be most appropriate?
- Ineffective Family Coping
 - Social Interaction, impaired
 - Anxiety
 - Altered Sensory Perception
21. Joan, who has a history of conflictual relationships, expresses the desire for friends but acts in alienating ways with people who befriend her. Which of the following would be an important nursing intervention for Joan?
- Help her find friends who are patient and extra caring.
 - Establish a therapeutic relationship in which role-modeling and role-playing may occur.
 - Accept her as she is, because she can't change.
 - Point out her difficulties in relationships and suggested areas for improvement.

22. Mr. Grady constantly bends rules to meet his needs and then gets angry when other patients and staff confront him on his behavior. He threatens patients and manipulates staff to get what he wants. Which is the best nursing approach to use with Mr. Grady?
- Administer p.r.n. medication every time Mr. Bradley does not follow the rules.
 - Ignore his behavior and privately tell the other patients to let Mr. Grady switch the television channels as much as he wants.
 - Encourage the other staff to take turns watching Mr. Grady.
 - Set firm limits for Mr. Grady and be consistent in addressing behaviors and enforcing unit rules.
23. The affect most commonly found in the client with Borderline Personality Disorder is one of:
- Happiness and elation
 - Apathy and flatness
 - Sadness and depression
 - Anger and hostility
24. The action by the nurse that would be most appropriate when Mr. Smith states, "I'm no good, I'm better off dead." would be:
- Stating, "I will stay with you until you are less depressed."
 - Stating, "I think you are a good person who should think about living."
 - Alerting all staff to provide 24-hour observation of the client
 - Removing all articles that may be potentially dangerous
25. Limit setting is an intervention strategy to be utilized with which of the following behaviors?
- Manipulation
 - Repression
 - Reaction formation
 - Projection
26. Conrad, 29 years old, is admitted for psychiatric observation after being arrested for breaking windows in the home of his former girlfriend, who refuses to see him. His history reveals abuse as a child by a punitive stepfather, torturing family pets, and one arrest for disorderly conduct. Which nursing diagnosis should be considered?
- Social interaction, impaired
 - Altered thought processes
 - High risk for trauma
 - Violence, risk for other-directed
27. Under which of the following circumstances is restraint appropriate?
- To encourage adherence to unit rules
 - To control difficult interpersonal situations
 - To establish the consequence of behaviors
 - To prevent harm to self and others
28. Which of the following mental status variations would the nurse expect to see in a client with a diagnosis of Borderline Personality Disorder?
- Euphoria
 - Good insight and judgment
 - Mood lability
 - Hallucinations
29. While you are caring for Jennifer, she tells you that she's afraid her husband will leave her because she has no interest in sex anymore. There is no medical or chemical reason for her decreased libido. Jennifer asks the nurse if anything can be done about her lack of interest in sex. The most appropriate referral by the nurse for this client is:
- Marriage counselor
 - Psychiatrist
 - Psychoanalyst
 - Sex therapist
30. The psychiatric advanced practice nurse is asked to assess a 24-year-old female who reports that she is unable to have intercourse because of involuntary contractions of her vagina. The appropriate term is:
- Arousal disorder
 - Dyspareunia
 - Orgasmic dysfunction
 - Vaginismus
31. The nurse is evaluating the outcome of measures to promote sleep. Which of the following would indicate that these measures have been successful?
- Client is able to sleep at least 4 hours each night.
 - Client states he felt rested the next day.
 - Client accepts minor interruptions to sleep as normal.
 - Client is able to verbalize anxieties.
32. The sleeping disorder that can be described as excessive daytime sleepiness is which of the following disorders?
- Sleep Terror Disorder
 - Primary Hypersomnia
 - Circadian Rhythm Sleep Disorder
 - Narcolepsy

33. The nurse is admitting a client with a diagnosis of Primary Insomnia. Which of the following assessment findings would be essential to confirm the diagnosis?
- Inability to obtain sleep not due to any other cause
 - Inability to obtain sleep due to a medical disorder
 - Disturbance of sleep-wake cycle
 - Excessive daytime sleepiness
34. You are the psychiatric clinical specialist on a sleep disorder unit. Which of the following is the key aspect of a psychotherapeutic intervention program?
- Verbalizing feelings
 - Gaining insight
 - Thought stopping
 - Sleep hygiene training
35. Which of the following nursing diagnoses is most appropriate for a client with a sleep disorder?
- Perceptual Disturbances
 - Impaired Thought Processes
 - Sleep pattern, disturbed
 - Ineffective Family Coping
36. Which of the following would NOT be an example of milieu interventions for Primary Insomnia?
- Decrease alcohol and caffeine intake during afternoon and evening.
 - Thought stopping.
 - Discourage daytime naps.
 - Increase exercise during morning and afternoon.
37. Which of the following phenomena would most likely accompany a diagnosis of Primary Insomnia?
- Medication withdrawal
 - Situational/Environmental changes
 - Normal aging
 - Mood disorders
38. The clinical specialist is implementing a behavior modification plan with a client with a diagnosis of Pathological Gambling. Which of the following family dynamics might he/she expect to observe?
- Absent, inconsistent or harsh discipline
 - Chaotic and violent environment
 - Rigid and overprotective parents
 - Heavy drinking
39. Ferman, a 15-year-old female, has complained of an intense impulse to pull her hair out, followed by a sense of relief at having carried out the act. Which of the following medical diagnoses would be most appropriate for the psychiatric and mental health advanced practice nurse to make?
- Obsessive-Compulsive Personality Disorder
 - Tinea capitis
 - Trichotillomania
 - Autism
40. Which of the following would NOT be a mental status variation for the client with a diagnosis of Pathological Gambling?
- Anxiety
 - Impulsivity
 - Sadness
 - Poor insight
41. Johnson C. Smith is diagnosed with Pyromania. Which of the following behaviors would the nurse expect to observe in Mr. Smith?
- Aggressiveness
 - Sadness
 - Obsessive-compulsiveness
 - Intense pleasure when watching fires
42. John is pacing the hall near the nurses' station swearing loudly. An appropriate initial intervention for the nurse would be to say:
- "John, please quiet down."
 - "Hey, John, what's up?"
 - "John, you seem pretty upset. Tell me about it."
 - "John, you need to go to your room to get control of yourself."
43. Which of the following interventions is NOT appropriate for the nurse to use in the above situation?
- Telling the client that violence is not acceptable
 - Speaking in a loud, urgent tone of voice
 - Standing with arms relaxed at sides
 - Listening attentively to the client
44. It becomes necessary to give an intramuscular injection of psychotropic medication to a client who is becoming increasingly more aggressive. The client is in the television room. The nurse should:
- Enter the room; say, "Would you like to come to your room and take some medication your doctor has ordered for you?"

- b. Take three staff members with you to the room as a show of solidarity and say, "Mr. Summer, please come to your room so I can give you some medication that will help you feel more comfortable."
- c. Take a male staff member to the television room and tell Mr. Summer, "Mr. Summer, you can come to your room willingly to take your shot or Mr. Crinshaw and I will take you there."
- d. Enter the television room; place Mr. Summer in a basket hold and say, "I'm going to take you to your room to give you an injection of medication to calm you."
45. Following an incident in which staff intervention was required to control a client's aggressive behavior, which of the following data would be *least* important to the staff's evaluation of the intervention?
- a. The client's behavior preceding and during the incident
- b. Intervention techniques used
- c. The environment
- d. The staff's views about theories of the etiology of aggression
46. Based on the client's potential for violence toward others and inability to cope with anger, which short-term goal would be most appropriate? The client will:
- a. Acknowledge his angry feelings
- b. Describe situations that provoke angry feelings
- c. List how he's handled his anger in the past
- d. Practice expressing anger
47. The impulse control disorder that is characterized as the deliberate and purposeful setting of fires is which of the following?
- a. Pyromania
- b. Kleptomania
- c. Trichotillomania
- d. Intermittent explosive disorder
48. The impulse control disorder that is characterized as the inability to resist the impulse to steal objects is which one of the following
- a. Pyromania
- b. Kleptomania
- c. Trichotillomania
- d. Intermittent explosive disorder
49. Some reports support the use of _____ in treating symptoms of Anorexia Nervosa.
- a. Cyproheptadine
- b. Amitriptyline

- c. Atomoxetine
- d. Both a and b are correct

50. Dialectical Behavior therapy is particularly effective in treating persons with:
- a. Borderline Personality Disorder
- b. Antisocial Personality Disorder
- c. Paraphilias
- d. Bulimia Nervosa

ANSWERS

- | | |
|-------|-------|
| 1. d | 26. d |
| 2. b | 27. d |
| 3. c | 28. c |
| 4. d | 29. d |
| 5. a | 30. d |
| 6. b | 31. c |
| 7. c | 32. d |
| 8. c | 33. a |
| 9. a | 34. d |
| 10. c | 35. c |
| 11. d | 36. b |
| 12. b | 37. b |
| 13. a | 38. a |
| 14. c | 39. c |
| 15. a | 40. c |
| 16. b | 41. d |
| 17. d | 42. c |
| 18. d | 43. b |
| 19. b | 44. b |
| 20. b | 45. d |
| 21. b | 46. b |
| 22. d | 47. a |
| 23. c | 48. b |
| 24. c | 49. d |
| 25. a | 50. a |

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Cognitive Mental Disorders and Geropsychiatric Nursing

■ COGNITIVE DISORDERS

- Overview (Sadock & Sadock, 2007)—Cognition involves memory, orientation, judgment, language, the ability to engage in interpersonal relationships and problem solving, and performing actions and abstractions (proverb interpretation). Cognitive disorders are associated with or caused by disturbance in the physiological functioning of brain tissue—structural, hormonal, biochemical, electrical, etc.—which causes cognitive deficits; ranges along continuum from acute (Delirium) to chronic (Dementia of the Alzheimer's type).

Delirium

- Definition—A transient (short-term), reversible, state of confusion, resulting from a gross disruption in brain physiology and developing from a wide variety of factors (Lipowski, 1992); although symptoms are similar in their disturbance of consciousness and cognition, the delirium disorders are differentiated on etiology (Delirium Due to a General Medical Condition, Substance-Induced Delirium, Delirium Due to Multiple Etiologies, and Delirium Not Otherwise Specified) (American Psychiatric Association [APA], 2000); can progress to permanent dementia if identifying causes are not diagnosed and treated.
- Signs and symptoms (APA, 2000; Sadock & Sadock 2007)
 1. Disturbance of consciousness
 2. Change in cognition (memory deficit)

3. Disturbance in sleep-wake cycle and level of psychomotor activity
4. Disorientation to time, place, or persons
5. Reduced ability to focus, shift, or maintain attention
6. Disorganization of thinking (may manifest as irrelevant, rambling, or incoherent speech)
7. Perceptual disturbances resulting in illusions and hallucinations;
8. Emotional disturbances constituting lability of affect
9. Transient, occurs abruptly, and fluctuates throughout the day

- Differential diagnosis
 1. Schizophrenia—due to perceptual, affective, and behavioral similarities
 2. Other psychotic disorders
 3. Dementia—onset of delirium is abrupt and duration is shorter than with ementia (hours to weeks/delirium vs months to years/dementia) (Breitner & Welsh, 1995; Lipowski, 1992). Attention fluctuates in delirium (preserved in dementia) (Sadock & Sadock, 2007)
 4. Depression—sluggishness and depressed affect when delirious
 5. Anxiety disorders—due to affective and behavioral similarities
- Diagnostic studies/tests—identify underlying causes using the following methods:
 1. Complete physical examination
 2. Complete neurological workup (including electroencephalogram (EEG))

3. Complete battery of laboratory tests including but not limited to: blood chemistries, CBC, serologic tests for syphilis, HIV antibody test, urinalysis, blood and urine drug screen, and thyroid profile
 4. Additional testing, when indicated, includes: B12 levels, CT scan, and MRI (Sadock & Sadock, 2007)
 5. Use of screening instruments such as:
 - a. Delirium Rating Scale (Trzepacz, Baker, & Greenhouse, 1988)
 - b. Intensive Care Delirium Screening Checklist (Bergeron, Dubois, Dumont, Dial, & Skrobik, 2001)
- Mental status variations (Keltner, Schwecke, & Bostrom, 2007; Sadock & Sadock, 2007)
 1. Fluctuating consciousness/cognitive impairment with lucid intervals
 2. Inability to maintain attention or engage in goal-directed behavior; difficulty following questions upon examination; client may perseverate in response to earlier questions
 3. Disorganization of thought—difficulty maintaining coherent stream of thought, easily distracted; speech rambling, inconsequential, or illogical; faulty reasoning and lack of goal-directed behavior
 4. Perceptual disturbances—illusions, hallucinations, delusions may be present, but generally poorly organized; can suffer acute paranoid delusions accompanied by fear, anxiety, attempts to escape or destructive rage episodes
 5. Impairment in the level of consciousness—client falls asleep during the interview
 6. Disturbed sleep-wake cycle—hypervigilant during the night and sleeps during the day
 7. Abnormally increased or decreased psychomotor activity; may pick at the bed linen or be sluggish, resembling catatonia-like movements; three clinical patterns possible (Lipowski, 1992):
 - a. Hypoalert—hypoactive client who is lethargic and drowsy
 - b. Hyperalert—hyperactive client who is restless and agitated
 - c. Mixed variant—shifting between lethargy and agitation
 8. Disorientation (place, time, and/or person)—disorientation to place and time is very common; however, disorientation to person is rare
 9. Memory impairment—usually short-term memory impairment and both anterograde (memory for events just prior to onset of delirium) and retrograde (memory for events just after the episode) amnesia present
 10. Appears bewildered, and may be anxious and frightened
 - Nursing diagnoses—several of the 2009–2011 NANDA International (2009) nursing diagnoses can be applied to delirium, including:
 1. Insomnia
 2. Behavior, risk-prone health
 3. Coping, ineffective
 4. Self-Care Deficit, bathing
 5. Self-Care Deficit, dressing
 6. Confusion, acute
 7. Memory, impaired
 8. Sensory Perception, disturbed (specify)
 9. Social Interaction, impaired
 - Biologic origins—delirium can be attributed to a wide range of physical disorders ranging from metabolic disturbances to withdrawal from substances such as alcohol or sedative-hypnotic agents (APA, 2000).
 1. Risk factors associated with delirium (Sadock & Sadock, 2007)
 - a. Severity of illness—the more severe the illness, the more likely delirium will occur.
 - b. Age and gender—more common in males; the older the patient, the more likely delirium will occur; persons older than age 70 are most vulnerable.
 - c. Cognitive impairment or preexisting brain damage/disease (tumors, traumatic brain injury, dementia)—approximately 25% to 50% of patients diagnosed with Dementia have been found to have Delirium superimposed upon the Dementia.
 - d. Diabetes
 - e. Hearing or visual impairment
 - f. Malnutrition
 - g. Systemic infection
 - h. Substance-use disorder (alcohol, nicotine, or narcotics)
 2. The following are common causes of Delirium (Keltner, Schwecke, & Bostrom, 2007; Sadock & Sadock, 2007):
 - a. General surgical procedures and pneumonia are associated with Delirium
 - b. Substance-related intoxication, withdrawal, or toxicity—alcohol, medications (particularly those with anticholinergic properties, such as benztropine), or other substances have been implicated in Delirium.
 - c. Certain drugs have been implicated in the development of Delirium, particularly in older persons. Drugs that can cause delirium include anticholinergics, antihistamines, antidepressants (tertiary TCAs), GI agents (e.g., cimetidine/Tagamet), and low potency antipsychotics (Videbeck, 2006).

- d. Systemic illness (such as infection, trauma, heart failure, malnourishment)—urinary infection is a common culprit in the development of delirium in older or catheterized patients.
 - e. Hepatic functioning that decreases with normal aging; drugs have been shown to have a longer half-life and decreased plasma clearance. Drugs that require a high rate of hepatic extraction should be used judiciously (e.g., major tranquilizers, tricyclic antidepressants, and antiarrhythmic agents (Ferrini & Ferrini, 1992).
- Biochemical interventions—goals of any intervention are to treat the underlying cause, and to provide physical, sensory, and environmental support.
 1. Treatment of the underlying cause(s) (Sadock & Sadock, 2007):
 - a. Restore adequate fluid and electrolyte balance, nutrition, and vitamin supply (Lipowski, 1992; St. Pierre, 1996).
 - b. Eliminate medication(s) suspected of affecting mental status.
 - c. Treat toxicity as indicated—if toxicity from anticholinergics is suspected, the use of physostigmine reverses the delirium for 15 to 30 minutes following a 1 to 2 mg intravenous dose (repeated doses may be needed).
 - d. Treat withdrawal from substances.
 - (1) Alcohol withdrawal delirium develops after recent cessation or reduction of alcohol consumption.
 - (2) Benzodiazepines are the first-line treatment choice for delirium associated with substance-related withdrawal (lorazepam (Ativan) initially 0.25 to 0.5 mg PO/IM/IV, every 6 to 8 hours—caution when liver damage is present) (Meagher & Leonard, 2008).
 - (2) May need to replace thiamine and other vitamins to prevent permanent organic disorder due to deficiency.
 2. Treat psychosis when present.
 - a. Haloperidol—most commonly used sedative because of low anticholinergic side effects, quick sedation, and low incidence of orthostatic hypotension (Tune & Ross, 1994; Lipowski, 1992); potential for extrapyramidal symptoms such as “cogwheel” rigidity in joints (can be seen in flexing and extending the elbow) and excessive salivation, and dystonic reactions such as torticollis (extreme turning of head to one side with the inability to correct posture). Administer an intramuscular dose of 2 to 6 mg of haloperidol, repeated in hourly intervals if patient remains agitated. Switch to oral dose when calm (a daily divided dose of 5 to 40 mg PO may be needed in patients with delirium).
 - b. Droperidol (has a more rapid onset of sedation than haloperidol)—monitoring of the electrocardiogram is advised with this alternative.
 - c. Atypical antipsychotic agents may be useful (avoid ziprasidone (Geodon) due to activating effects).
 - 3. Treat insomnia when present.
 - a. Short- or intermediate-acting benzodiazepines (e.g., lorazepam, 1 to 2 mg PO at bedtime) are considered to be first-line agents in treating insomnia in delirious patients.
 - 4. Avoid barbiturates and long-acting benzodiazepines unless they are being used to treat the underlying cause of delirium, such as alcohol withdrawal or seizures.
- Psychosocial approaches
 1. Attend to the client’s concerns and fears, which may be expressed in the hallucinations and/or delusions (Lipowski, 1992).
 2. Reorient the client to reality, especially when illusions are present.
 3. Reduce fear and anxiety by providing a calm reassuring manner, assuring the client that you will be sure he is safe.
 4. Explain all procedures to minimize anxiety.
 5. If client is extremely agitated, the use of physical restraints is not recommended since they may increase fear and agitation along with increasing the risk of problems associated with immobility. The use of “sitters” or enlisting the family’s help is more efficacious.
 - Family dynamics/Family therapy
 1. Involve the family in assessment, planning, intervention, and evaluation of the nursing care plan.
 2. Family can provide useful information as to the client’s premorbid cognitive status, the possible causative factor of the delirium, history of the client and other critical data.
 3. Family can assist in planning psychosocial interventions that are likely to be most successful.
 4. Family can assist in interventions by helping to orient and reassure the client.
 5. Family needs to be provided with information and reassurance along with referral information for use postdelirium.

- 6. Family members may exhibit grief reactions such as anger, hostility, bargaining, depression, guilt, avoidance, denial, and ambivalence (Barry, 1996).
- Group approaches—for delirious clients, group intervention is contraindicated.
- Milieu interventions
 1. Aimed at providing safety, support, and structure
 2. Environmental interventions help reestablish orientation by placing clock, calendar, and familiar belongings in the client's room.
 3. Encourage family visits to assist patient with orientation.
 4. Correct any sensory deficit that the patient may have by having eyeglasses or hearing aid made available and within close reach.
 5. Place the client in a room with windows to help orient to day and night.
 6. Keep outside, distracting noises to a minimum and keep a low light on at night.
 7. Reduce, but don't eliminate stimulation, as sensory deprivation also contributes to delirium.
- Community resources—not indicated during the acute episode, but may be useful as a referral resource based on the following factors:
 1. Etiology of the delirium (i.e., Alcoholics Anonymous; Narcotics Anonymous; social support such as senior center, case management, or home health services)
 2. Need for the client and/or family to resolve the emotional trauma associated with the acute episode of delirium through participation in individual, group, or family counseling/therapy
- b. Cerebrovascular disease—in particular, stroke and cerebral blood flow problems
- c. Cerebral oxygenation problems
- d. Infectious diseases of, or affecting, the central nervous system—syphilis, AIDS
- e. Brain trauma
- f. Toxins
- g. Metabolic disturbances
- h. Hypoglycemia, diabetes
- i. Normal pressure hydrocephalus
- j. Degenerative neurologic diseases
- k. Drugs & toxins (e.g., alcohol, anticholinergics, heavy metals, carbon monoxide)
- Signs and symptoms
 1. Criteria for the diagnosis of a dementia based on clinical examination
 - a. Presence of cognitive deficit (APA, 2000; Keltner et al., 2007)
 - (1) Memory impairment (required for DSM-IV-TR diagnosis of dementia)
 - (a) Impairment in ability to learn new information
 - (b) Forgetting previously learned information
 - i. Often both forms are present.
 - ii. In later stages, extreme memory impairment is evidenced in inability to recall most or all information (e.g., family member's identity, own birthday, and sometimes their own name).
 - (2) In addition to memory deficits, the following may be present (at least one is necessary for DS-IV-TR diagnosis of Dementia):
 - (a) Deterioration of language function (aphasia), evidenced by difficulty in recalling names of persons or objects may be present. In advanced stages, individual may be mute, or demonstrate echolalia (repeating what is heard) or palilalia (repeating a sound or word over and over again).
 - (b) Difficulty in carrying out motor function, despite intact motor abilities (apraxia) may be present. May contribute to difficulties in drawing, cooking, activities of daily living.
 - (c) The inability to recognize or identify objects by name—although sensory abilities are intact (agnosia)—may be present (e.g.,

Dementia

- Definition—Development of multiple cognitive deficits affecting at least three of the following mental activities: memory, language, visuospatial skills, personality, or emotional state, and executive function; the decline in cognitive functioning causes significant impairment in social or occupational functioning, representing a significant decline from a previous level of functioning; does not routinely occur during the course of a delirium (except Vascular Dementia), and are judged to be related to a causative factor. In most cases dementias are irreversible (APA, 2000, 2007; Flood & Buckwalter, 2009).
 1. Etiology (Sadock & Sadock, 2007)
 - a. Hereditary factors

cannot recognize by touch alone, a wristwatch, keys, or pencil when placed in hands).

- (d) A disturbance in executive functioning may be present—as evidenced by impaired abstract thinking, difficulty in shifting from one mental activity to another, and problems in performing serial motor skills.
 - b. Information from patient's family, friends, and employers
 - c. Report of change in personality of a person older than age 40 suggests consideration of Dementia.
 - d. Other information suggesting Dementia includes change in intellectual ability, forgetfulness, efforts to conceal cognitive deficits.
2. Criteria for severity of Dementia
 - a. Mild—work or social activities are significantly impaired, however the capacity for independent living, adequate personal hygiene, and reasonable judgment remain intact.
 - b. Moderate—independent living is hazardous, and some degree of supervision is necessary.
 - c. Severe—activities of daily living are so impaired that continual supervision is required, (e.g., unable to maintain minimal personal hygiene; largely incoherent or mute).
- Differential diagnosis:
 1. Dementia of the Alzheimer's Type
 2. Vascular Dementia
 3. Dementia Due to HIV Disease
 4. Delirium
 5. Dementia Due to Parkinson's Disease
 6. Dementia Due to Huntington's Disease
 7. Dementia Due to Pick's Disease
 8. Dementia Due to Creutzfeldt-Jakob Disease
 9. Dementia Due to Other General Medical Conditions
 10. Dementia Due to Multiple Etiologies
 11. Substance-Induced Persisting Dementia
 12. Dementia Not Otherwise Specified
 13. Dementia Due to Head Trauma
 14. Schizophrenia
 15. Major Depressive Disorder
 16. Malingering and Factitious Disorder
 - Diagnostic studies/tests
 1. Battery of laboratory tests including, but not limited to: blood chemistries, CBC, serologic

tests for syphilis, HIV antibody test, urinalysis, blood and urine drug screen, B12 and folate level, and thyroid function tests

2. Screening instruments for cognitive functioning
 - a. Mini-Mental Status Exam—MMSE (Folstein, Folstein, & McHugh, 1975)
 - b. Clock Drawing Test—CDT (Shulman, Shedletsky, & Silver, 1986)
 - c. Mini-Cog (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000)
 - d. Alzheimer's Disease Assessment Scale (ADAS)
 - e. Behavioral Pathology in Alzheimer's Disease (BEHAVE-AD)
 - f. Blessed Dementia Scale (BLS-D)

Dementia of the Alzheimer's Type

- Definition—This type of dementia is characterized by a gradual and insidious onset and a generally progressive deteriorating course for which all other specific causes have been excluded by the history, physical examination, and laboratory tests (APA, 2000). It is the most prevalent of the dementias and can occur with the following variations:
 1. Senile or presenile onset, depending on whether after or before age 65
 2. Within senile and presenile variants, disease can be with delirium, with delusions, with depression, or uncomplicated.
- Signs and symptoms—characterized by multifaceted loss of intellectual abilities, such as memory, judgment, abstract thought, and other higher cortical functions; changes in personality and behavior, and significant decline and impairment in social and occupational functioning (APA, 2000)
- Differential diagnosis—exclusion of all alternative specific causes of Dementia by complete history, physical examination, and laboratory tests
 1. Benign forgetfulness—a common phenomenon among older adults
 2. Subdural hematoma
 3. Normal pressure hydrocephalus
 4. Brain tumors
 5. Parkinson's disease
 6. Vitamin B12 deficiency
 7. Hypothyroidism
 8. Delirium
 9. Acute psychotic episode
 10. Major depressive episode
 11. Multi-infarct dementia (See next section on Vascular Dementia)
 12. Medication interactions
 13. AIDS dementia complex (ADC)

- Mental status variations—manifestations include:
 1. Recent and remote memory deficits
 2. Short attention span and inability to concentrate
 3. Impairment in abstract thinking and judgment
 4. Other disturbances of higher cortical functioning, such as agnosia, apraxia, aphasia, and constructional difficulty
 5. Affective lability
 6. Perceptual disturbances such as hallucination
 7. Depressed mood
- Genetic/Biologic origins (APA, 2007; Sadock & Sadock, 2007)
 1. Precise cause(s) of Alzheimer's disease still unknown
 2. Hereditary factors
 - a. Familial patterns exist.
 - b. Genetic markers on chromosomes 1, 14, and 21 have been identified in early-onset (younger than age 60) Alzheimer's disease (AD)
 - c. An increased risk of late-onset AD has been associated with a variant of apolipoprotein E (APOE) found on chromosome 19; the risk is specifically associated with the allele APOE-e4 (APOE contains instructions for making the protein that carries cholesterol in the bloodstream) (Alzheimer's Disease Education & Referral (ADEAR) Center, 2008).
 - d. A number of biomarkers are currently under investigation. Of specific interest are *tau* and beta-amyloid proteins—two biomarkers in cerebrospinal fluid (APA, 2007). A recent National Institute on Aging (NIA) study found that participants with APOE-e4 genes, high levels of *tau* and low levels of beta-amyloid proteins were most likely to have mild AD, and testing for these biomarkers is currently underway (NIA, 2009).

Vascular Dementia (also known as multi-infarct dementia)

- Definition—direct consequence of cerebrovascular disease, characterized by the often abrupt onset of a stepwise deterioration in intellectual functioning that, early in the course, leaves some intellectual functions relatively intact (patchy deterioration) (APA, 2000)
- Signs and symptoms
 1. Symptoms of vascular dementia are largely the same as those found in AD.
 2. Multiple cognitive deficits manifested by memory impairment and disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting), aphasia, apraxia, and/or agnosia are present (APA, 2000).
- 3. Clinical or laboratory evidence in support of the diagnosis of vascular dementia includes:
 - a. Since the cause is cerebrovascular disease, focal neurologic signs and symptoms (e.g., exaggeration of deep tendon reflexes are an important diagnostic determinant)
 - b. History of stroke or other cerebrovascular insult; presence of carotid bruits is common
- 4. A stepwise deteriorating course with “patchy” distribution of deficits (affecting some functions, but not others) is present early in the course (APA, 2000).
- 5. Individual can present with delirium, delusions, or depression, gait abnormalities, weakness of an extremity. Different from other dementias, a diagnosis with the following specifiers is used for vascular dementia (APA, 2000, 2007):
 - a. With delirium
 - b. With delusions
 - c. With depressed mood
- Differential diagnosis (APA, 2000, 2007)
 1. General differential diagnosis of Dementia due to Other General Medical Conditions and Dementia of the Alzheimer's Type (See previous sections)
 2. Impairment due to single stroke
- Mental status variations—is differentiated from other primary dementias only by the fact that the cognitive manifestations may wax and wane, showing patchy or stepwise deterioration.
- Biologic origins—cerebrovascular diseases

Other Dementias

- Dementia Due to General Medical Condition (APA, 2000; Keltner et al., 2007; Sadock & Sadock, 2007)
 1. Dementia Due to HIV Disease—The presence of dementia in a client with a diagnosis of HIV or AIDS. Encephalopathy in HIV is associated with the type of dementia known as AIDS dementia complex (ADC) or HIV dementia and occurs in 14% of patients with HIV.
 2. Dementia Due to Pick's Disease—characterized by atrophy in the fronto-temporal regions of the brain (rather than parietal-temporal regions associated with Alzheimer's disease).
 3. Dementia Due to Traumatic Brain Injury—characterized by emotional lability, speech deficits/dysarthria (slurred, slow, and difficult to understand), and impulsivity—associated

- with boxer's "punch-drunk syndrome" and combat veterans who have experienced concussion and other serious head injuries
4. Dementia Due to Lewy Body Disease—characterized by hallucinations, parkinsonian features (resting tremor, bradykinesia, cogwheeling), and extrapyramidal symptoms; caused by Lewy inclusion bodies in cerebral cortex; attention rather than memory deficits evident early in illness; markedly adverse effects with antipsychotics.
 5. Dementia Due to B₁₂ Deficiency (reversible)—Pernicious anemia is the most common cause of B₁₂ deficiency. Dementias caused by this deficiency are rare—characterized by paresthesias of lower, then upper extremities resulting from neuronal demyelination. Other clinical manifestation of this dementia can include: mood and behavior changes, psychosis, and reflex changes (hypo- and hyper-reflexive). Biological intervention is Vitamin B₁₂ replacement therapy.
 6. Dementia Due to Normal Pressure Hydrocephalus (NPH) (reversible with early treatment)—NPH results when the flow of cerebrospinal fluid between the brain and spinal column is impaired. Clinical symptoms of NPH include urinary incontinence, gait apraxia, and dementia. The dementia associated with NPH effects one's ability to manage activities of daily living, and may result in personality dulling, lack of motivation, and limited judgment/insight. Memory loss occurs in later stages of the process and is followed by a progressive decline in cognitive functioning. Treatment involves surgical placement of a ventricular shunt in the brain and is most successful in reversing dementia in the early stages (Keltner et al., 2007).
13. Role Performance, ineffective
 14. Neglect, self
 15. Wandering [specify sporadic or continual]
 16. Health Management, ineffective self
 17. Coping, compromised family
- Biochemical interventions (APA, 2007; Flood & Buckwalter, 2009; Keltner et al., 2007; Stahl, 2008, 2009)
 1. After verifying a diagnosis of Dementia, blood pressure management at the higher end of the normal range is recommended for improving cognitive function in Vascular Dementia (ACE inhibitors and diuretics do not amplify cognitive impairment).
 2. Initial interventions depend on the etiologic factor causing the dementia and to treat the underlying cause of the disturbance (e.g., treat diabetes with insulin, hypothyroidism with thyroid replacement, thiamine deficiency with replacement, and iatrogenic disorders by eliminating the causative drug).
 3. In patients with Dementia, benzodiazepines may be used for anxiety; antidepressants for depressive symptoms, and antipsychotics for psychosis. Exercise caution when treating older patients. Avoid the use of pharmacologic agents with high anticholinergic actions.
 - a. "Sundowner syndrome" occurs when older patients are overly sedated—and in Dementia patients experiencing an adverse reaction to a psychoactive drug or with deprivation of external cues such as light and orienting cues (e.g., interpersonal contact, clock). This syndrome is characterized by drowsiness, confusion, ataxia, and accidental falls (Sadock & Sadock, 2007)
 - b. If biochemical intervention is indicated for control of agitation or hallucination associated with Dementia, drug treatment should be used cautiously (particularly in older patients), beginning with the lowest possible dose and tapering upward as needed. Haloperidol is the drug of choice for controlling agitation in dementias due to lower anticholinergic effects. Low dosage of 0.25 mg should be initiated. Side effects include dystonias (rigidity in joints and torticollis) and excessive salivation. Orthostatic blood pressures should be monitored and the client and his/her caregiver(s) should be taught the side effects.
 - c. In treating depression associated with, SSRIs are preferred over TCAs (due to the high anticholinergic and antiadrenergic

Information Common to all Dementias (unless stated otherwise)

- Nursing diagnoses—several of the 2009–2011 NANDA International (2009) nursing diagnoses can be applied to dementia, including:
 1. Behavior, risk-prone health
 2. Coping, ineffective
 3. Self-Care Deficit, bathing
 4. Self-Care Deficit, dressing
 5. Self-Care Deficit, toileting
 6. Confusion, acute
 7. Confusion, risk for acute
 8. Confusion, chronic
 9. Memory, impaired
 10. Social Interaction, impaired
 11. Caregiver Role Strain, risk for
 12. Insomnia

- properties of TCAs), and MAOIs (due to potential for serious interactions).
- d. Atypical antipsychotics have been used successfully in treating associated hallucinations and delusions, but recent evidence suggests a connection with increased risk of cardiovascular events and mortality in this population, as well as increased risk in the development of metabolic syndrome, thus very cautious use is advised.
 4. Thus far, the FDA has approved five medications (cholinesterase inhibitors) for treating Dementia of the Alzheimer's Type (other dementias are not listed). (See **Table 9-1**)
 5. Other treatment options include unproven interventions such as selegiline, statins, ginkgo biloba, folate preparations, and Vitamin E, which have limited support for their efficacy thus far;

agents showing some promise are lithium, and beta amyloid antagonists.

- Psychosocial approaches
 1. Base on careful nursing assessment of the patient.
 2. Goal of nursing care regardless of the setting is to help the client maintain the highest possible level of independence. Skill training can assist the client to reach his/her potential (Tappen, 1994).
 3. Use warm, caring, respectful approach.
 4. Use clear, simple, and direct communication.
 5. Keep tasks within the client's abilities, using sequencing and cuing (i.e., laying out the client's clothing in the order in which he/she needs to put it on)
 6. Avoid over- or under-stimulation.
 7. Provide for adequate rest and nutrition.

■ **Table 9-1** Cholinesterase Inhibitors Used in Treating Dementia*

Generic (Trade Name)	Approved Dementia Level	Usual Dose	Dosing Information	Comments
Donepezil (Aricept)	Mild, Moderate & Severe	5 to 10 mg PO in evening	Start at 5 mg; may increase to 10 mg in 4 to 6 weeks	First-line option; also available in disintegrating tablet form
Galantamine (Razadyne)	Mild to Moderate	16 to 24 mg PO daily	Immediate release: Initially 8 mg twice daily; may increase to 16 mg twice daily after 4 weeks; maximum 24-hr dose 32 mg	Second-line option; available in once-daily extended release form
Rivastigmine (Exelon)	Mild to Moderate	6 to 12 mg PO in two divided doses	Initially 1.5 mg PO twice daily; increase by 3 mg every 2 weeks; maximum 24-hr dose 12 mg	Second-line option; also available in transdermal form—dose: initially 4.6 mg/day; in 4 weeks increase to maximum dose of 9.5 mg/day
Tacrine (Cognex)	Mild to Moderate	20 to 40 mg PO four times daily	Initially 10 mg PO 4 times daily (qid) for 4 weeks; may increase by 10 mg qid increments every 4 weeks as needed; maximum 24-hr dose 160 mg	1st drug approved by FDA for treating Alzheimer's dementia; rarely used due to risk of reversible hepatic toxicity
Memantine (Namenda)	Moderate to Severe	10 mg PO twice daily	Initially 5 mg PO daily; may increase by 5 mg each week; maximum 24-hr dose 20 mg	Second-line option; recommended to divide doses over 5 mg, usually twice daily

*FDA Approval for Dementia of the Alzheimer's Type (APA, 2007; Stahl, 2008, 2009)

8. If the dementia is vascular, provide information to the client regarding managing risk factors associated with cardiovascular disease (diet, exercise, decreasing stress, medication, signs of impending stroke, etc.).
- Family dynamics/Family therapy
 1. Family needs to be included in the assessment as well as the intervention phase of treatment with cognitively impaired clients since they can provide much useful information regarding how to best care for their loved one.
 2. Family members are often the hidden victims of the illness, especially when the dementia is chronic rather than reversible.
 3. Family interventions always include providing support and education, and in some cases, such as when the dementia is due to substance abuse, counseling or therapy may be indicated.
 4. Family interventions also include assisting the family for anticipatory grief, which usually is a deep sadness that occurs before the anticipated future loss. Symptoms of anticipatory grief are depression, an increased preoccupation with the affected family member, an analysis of all the possible problems that may occur during the course of the disease, and anticipation how each family member will need to readjust to care for the affected family member (Barry, 1996). In addition to anticipatory grief, family members also may experience the bereavement stages proposed by Kubler-Ross (1969): denial, anger, bargaining, depression, and acceptance.
 - Group approaches—In selecting elder group participants, as with young adults, extreme paranoia and severe cognitive impairment is usually contraindicated for effective group work. Therefore, elders who are experiencing the latter stages of Alzheimer's disease or other dementias, tend not to benefit significantly from most of the following groups while those with mild cognitive impairment can and do benefit from group therapy:
 1. Reminiscence groups aim to increase self-esteem through positive affiliations and interactions with others (Ashton, 1993). These groups may be helpful for elders and individuals with mild cognitive disorders and depression.
 2. Cognitive-behavioral groups assist clients in correcting negative thoughts and attitudes, as well as maladaptive ways in which clients process information (Hitch, 1994). This type of group can be helpful to elders who suffer from mild cognitive impairment with superimposed depression or who have one of the previously mentioned disorders.
3. Educational groups seek to inform and emphasize learning and discussion instead of therapy (Neese & Abraham, 1992). For elders who have mild cognitive impairment and their families, educational groups addressing the various types of dementias are an excellent method to help alleviate the isolation that clients and families feel when faced with a chronic disorder.
 4. Validation groups developed by Feil (1989) are designed to benefit even severely impaired clients. The goals of validation are to stimulate communication in order to prevent withdrawal inward, to restore well-being, to facilitate the resolution of unresolved issues to prepare for death, and to reduce caregiver burnout by teaching empathy skills (Bleatheman & Morton, 1996; Fine & Rouse-Bane, 1995).
 5. Activity, movement, and sensory stimulation groups also enhance functioning in cognitively impaired older adults (Arno & Frank, 1994).
- Milieu interventions—are a critical factor in the treatment of both acute and chronic dementias, whether the client is at home or in an institution.
 1. Provide safety, structure, and support.
 2. Provide consistency of routine.
 3. Provide orientation and environmental cues.
 4. Explain procedures in clear, direct language to enhance understanding and allay anxiety.
 5. Provide for adequate rest, nutrition, and elimination.
 6. Disruptive behavior in demented clients often occurs in response to an environmental trigger. Therefore, it is important to assess and modify the environment (Whall, 1995). Disruptive behavior often occurs in response to perceived pain, need for control, need to feel safe, need for stimulation, and need to decrease stress.
 - Community resources
 1. Potential resources for clients and caregivers can be extensive depending on the etiology, duration, and level of cognitive and functional impairment associated with the dementia.
 2. Organizations related to organic factors causing the disorder would include Alcoholics Anonymous, The American Cancer Society, American Diabetes Association, American Lung Association, and the Alzheimer's Disease and Related Disorders Foundation.
 3. A wide array of community services are available to maintain the client and family,

including home health agencies, social services, outreach programs, homebound meals, church support, day care, respite care, hospice, nursing homes, and others.

■ GEROPSYCHIATRIC NURSING

- Overview (Kolanowski & Piven, 2006; Sadock & Sadock, 2007)—Old age is a natural phase of the life cycle, not a disease. A continuum of health in aging exists; ranging from those described as well-old to those described as sick-old. Well older individuals are maintaining daily functions and enjoying a time of integrity rather than despair (Eric Erikson—See Chapter 3). Conversely, the sick-old experience a variety of physical and mental disorders or combinations thereof. Within the next 20 years, the demands and opportunities for geropsychiatric nursing, in caring for well and sick older persons, will expand and grow exponentially. Issues regarding health maintenance, healthy lifestyle promotion, comorbid disorders (psychological and physical), long-term consequences of substance abuse and/or military conflict, cultural considerations and the effects of globalization/migration each contribute to future health care needs.
- Psychiatric examination of the older patient (Keltner, Schwecke, & Bostrom, 2007; Kolanowski & Piven, 2006; Sadock & Sadock, 2007)
 1. Nurses encountering older adults in any setting need to consider their physical, emotional, and social needs.
 2. In assessing older persons in a psychiatric setting, follow the same format as that used for younger adults.
 3. If evidence of cognitive impairment is presented, additional collateral information from family/caretaker is needed.
 4. In an approach with older clients, keep in mind the continuum of aging—taking into account whether the person is a well 75-year-old who volunteers at a local agency, or a frail 75-year-old residing in a nursing home.
 5. Psychiatric history should include:
 - a. Childhood/adolescent history and milestones
 - b. Family history
 - c. Marital/Civil union history
 - d. Sexual history—many well elders are sexually active well into advanced age
 - e. Abuse history and vulnerability for elder abuse
 6. Mental status variations
 - a. Patients older than 65 should be assessed for functional limitations that affect abilities/capacity for independent living (nutrition, dressing, grooming, toileting, etc.)
- Mental disorders & associated findings in old age (Keltner, Schwecke, & Bostrom, 2007; Kolanowski & Piven, 2006; Sadock & Sadock, 2007)
 1. Dementia disorders (See earlier sections of this chapter)—antipsychotic use contraindicated—related to increased risk of mortality due to cardiovascular or infectious events.
 2. Substance-related disorders
 - a. Long-term alcohol abuse can lead to infirmities such as cirrhosis, Wernicke's encephalopathy and Korsakoff's syndrome, malnutrition, effects of exposure (gangrene) and falls.
 - b. Sudden onset of delirium in older persons hospitalized for medical conditions is the most frequently recorded cause of alcohol withdrawal.
 3. Anxiety disorders—some anxiety disorders can occur for the first time after age 60.
 4. Schizophrenia—rarely diagnosed after age 65.
 5. Depressive disorders
 - a. Depressive disorders occur in about 15% of community-dwelling elders (home and nursing home residents).
 - b. Useful assessment instruments include the Geriatric Depression Scale (GDS).
 - c. Cognitive impairment with depression is referred to as pseudodementia (dementia syndrome of depression)—occurs in about 15% of depressed older patients.
 - d. Antidepressant use by adults older than 65 years increases risk of suicide. As with all patients, monitor closely for changes that indicate increased suicidality.
 - e. Increased suicide risk exists for persons older than 65 years—loneliness is the leading cause for suicide ideation.
 6. Other mental disorders
 - a. Sleep disorders—advanced age is a primary factor contributing to sleep disorders.
 - b. Pain disorders
 - (1) Comorbidity of medical and psychiatric conditions make pain a special condition among older adults.

- (2) Pain is associated with increased rates of depression, anxiety, delayed wound healing, reduced mobility, poor sleep and nutrition, reduced activity.
- Biochemical interventions (Keltner, Schwecke, & Bostrom, 2007; Kolanowski & Piven, 2006; Sadock & Sadock, 2007)
 1. A pretreatment medical evaluation is warranted, including electrocardiogram (ECG)
 - a. Age-related changes affect drug absorption, distribution, metabolism, and elimination.
 - (1) Delayed absorption of oral agents is more common in older adults.
 - (2) Multiple drugs competing for same enzyme can reduce hepatic metabolism.
 - (3) Creatinine clearance can be reduced despite normal serum creatinine levels.
 - (4) Reduced renal clearance might reduce dose requirements.
 - b. Include assessment of all medications used, as well as all over-the-counter and herbal compounds—25% of all prescribed drugs are written for individuals age 65 and older.
 2. Most psychotropics should be given in equally divided doses over a 24-hour period; once-daily dosing can cause intolerably rapid rise in drug blood levels.
 - a. Initial dosage is usually lower and adjustments made over time (“start low and go slow”)
 - b. First-line options for treating major mental disorders in younger adults are generally well tolerated at older age but in lower and more frequent doses, as previously described)
 - Psychotherapeutic interventions (Sadock & Sadock, 2007; Stevens & Kaas, 2008)
 1. The standard psychotherapies (individual, family & group) discussed in this text are efficacious for older adults as well.
 2. Psychotherapies with empirical support for use among older clients include cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), psychodynamic psychotherapy (PDP), and life review therapy—CBT, IPT, and PDP have been addressed elsewhere in this text (See Chapter 3 & specific disorders chapters for more details)
 3. Life review therapy
 - a. Reminiscence—characterized by review of meaningful and/or conflictual memories of past experiences
 - b. Life review therapy capitalizes on reminiscence behaviors through a conscious, deliberate process.
 - (1) Therapist may guide process by encouraging written/tape-recorded biographies/histories review of special events/milestones.
 - (2) Techniques include reunions with significant others, review of photos and other memorabilia.
 - (3) Useful in resolving conflicts, guilt/fear (unfinished business), reducing depression, enhancing self-esteem, increasing socialization, and acceptance of present reality.

■ QUESTIONS

Select the best answer

1. Ms. S, age 50, has been hospitalized for a cholecystectomy. Two days postoperatively she develops pneumonia. The nurse notes that Ms. S. does not know where she is and that she is picking at the bedclothes. What is the most likely diagnosis?
 - a. Hemorrhage
 - b. Sensory deprivation
 - c. Delirium
 - d. Urinary tract infection
2. Ms. S. is likely to be oriented to which of the following?
 - a. The time of day
 - b. The day of the week
 - c. Her daughter
 - d. The name of her medication
3. Which of the following is the hallmark indication of delirium?
 - a. Fluctuation of sensorium and limited attention span
 - b. Global cognitive impairment
 - c. Severe agitation
 - d. Dysphonia
4. What level of consciousness is Ms. S. likely to exhibit during delirium?
 - a. Alert and oriented
 - b. Hypervigilant
 - c. Fluctuating
 - d. Comatose

5. Ms. S. is likely to NOT exhibit what type of perceptual disturbance?
 - a. Poorly organized delusions
 - b. Hallucinations
 - c. Illusions
 - d. Well organized delusions
6. The onset of delirium is characterized by:
 - a. Onset occurring over several days
 - b. Abrupt onset
 - c. Occurrence within two days of exposure to a causative factor
 - d. Fluctuating onset
7. Ms. S. has an EEG. The findings are likely to show which feature?
 - a. Diffusely abnormal slowing
 - b. Normal
 - c. Focal points
 - d. Lower range of normal
8. Ms. S.'s nurse needs to write a care plan. Which is the major nursing diagnosis she would use?
 - a. Self-care Deficit
 - b. Confusion, acute
 - c. High Risk for Violence
 - d. Alteration in Role Performance
9. One of the ways in which delirium is differentiated from dementia is that delirium is:
 - a. Characterized by sundowning
 - b. A progressive deteriorating disease
 - c. Characterized by fluctuating level of consciousness
 - d. Chronic
10. Which of the following is NOT a risk factor for delirium?
 - a. Use of narcotics
 - b. Family dynamics
 - c. Systemic illness
 - d. Presence of dementia
11. Delirium is most common in which age group?
 - a. Age 10–20
 - b. Age 20–40
 - c. Age 40–60
 - d. Age 60–80
12. Which of the following physical disorders is least likely to cause delirium?
 - a. Hypertension
 - b. Substance abuse and withdrawal
 - c. Metabolic disorders
 - d. Systemic infections
13. Ms. S. was diagnosed with Delirium. What intervention is most critical?
 - a. Symptom management
 - b. Treating the underlying cause
 - c. Administering medication
 - d. Education of the patient
14. Which intervention would be the *second* most important?
 - a. Symptom management
 - b. Treating the underlying cause
 - c. Administering medication
 - d. Education of the patient
15. Which of the following drugs would be *least* likely to further complicate Ms. S.'s delirium?
 - a. Antibiotics
 - b. Antihistamines
 - c. Antihypertensives
 - d. Vitamin B_{12}
16. Mr. D. is a 65-year-old widowed white male. He is brought to the emergency room by his family because he has become agitated, disoriented, and has been hallucinating. Family reports that Mr. D. takes ranitidine for ulcer disease. What is the most likely cause of his symptoms?
 - a. His age
 - b. His ulcer disease
 - c. His medication
 - d. An undetected organic factor
17. The most important initial nursing intervention for Mr. D. is to:
 - a. Interview Mr. D. without his family present
 - b. Use chemical restraints to protect Mr. D
 - c. Provide the family with a list of support groups
 - d. Institute measures to clear the medication from Mr. D's body
18. Which of the following medications could the nurse anticipate for Mr. D.?
 - a. Chlordiazepoxide 25 mg po
 - b. Physostigmine 2mg IV
 - c. Chlorpromazine 100 mg IV
 - d. Diazepam 10 mg IV
19. In administering physostigmine, the nurse would be concerned about which of the following classes of medications potentiating the drug?
 - a. Antiemetics
 - b. Antianxiety
 - c. Antidepressants
 - d. Anticonvulsants

20. If Mr. D. continues to be agitated, what other pharmacological agent is the physician likely to order?
- Haloperidol
 - Chlorpromazine
 - Thioridazine
 - Lithium
21. The nurse would NOT anticipate which of the following side effects of haloperidol?
- Cogwheel rigidity
 - Excessive salivation
 - Dystonia
 - Orthostatic hypertension
22. Which individual intervention would the nurse NOT use in caring for Mr. D.?
- Reorienting Mr. D. to day, place, situation
 - Being attentive to Mr. D.'s fears
 - Telling Mr. D. that he needs to eat to get better
 - Offering fluids every 2 hours
23. Which of the following would NOT be an appropriate environmental intervention?
- Limiting family visits as these may be overstimulating
 - Providing orientation devices (clocks, calendars) in Mr. D.'s room
 - Keeping a low light on at night
 - Having Mr. D. wear his glasses during the day
24. Which of the following interventions is NOT indicated for Mr. D. at this time?
- Individual
 - Group
 - Family
 - Milieu
25. Which of the following is NOT a cognitive mental disorder?
- Affective disorders
 - Dementia of the Alzheimer's Type
 - Vascular Dementia
 - Delirium
26. Ms. T., who is 85, is unable to perform several of her ADLs due to her inability to conceptualize and complete tasks. Her level of dementia is:
- Mild
 - Moderate
 - Severe
 - Fluctuating
27. Ms. T.'s nurse notes that she has short-term memory loss. An example would be:
- Inability to remember what happened yesterday
 - Inability to remember current president
 - Inability to remember three objects after five minutes
 - Inability to remember an anniversary
28. A disorder of language is also noted. What would it be called?
- Agnosia
 - Anhedonia
 - Apraxia
 - Aphasia
29. Ms. B., a 68-year-old African American, has a B/P of 220/110. She has had several episodes of dizziness and temporary loss of consciousness. Her family notes that she has had difficulty remembering in the past few months. The most likely diagnosis would be:
- Dementia of the Alzheimer's type
 - Delirium
 - Vascular Dementia
 - Mood Disorder due to General Medical Condition
30. Mr. A. is an 82-year-old white married male. He has been diagnosed as having probable Dementia of the Alzheimer's type. He has withdrawn from his activities at the senior center but continues to perform his ADLs. The level of severity of his dementia could be characterized as:
- Mild
 - Moderate
 - Severe
 - Nonexistent
31. Which one of the following is NOT needed to make a diagnosis of Dementia?
- Impairment in short-term memory
 - Transient confusion
 - Impairment in long-term memory
 - Significant changes in social relationships
32. Which nursing diagnosis would be used for Mr. A.'s condition?
- Self-care deficit
 - Social isolation
 - Sensory/perceptual alterations
 - Memory, impaired

33. Various types of dementias will NOT have symptoms similar to which of the following?
- Acute psychotic episode
 - Delirium
 - Major depressive episode
 - Adjustment disorder
34. Which one of the following etiologic factors is NOT a factor in dementia?
- Heredity and degenerative neurologic disease
 - Cerebral vascular disease and normal pressure hydrocephalus
 - Lack of education, social isolation
 - Toxins and metabolic disturbances
35. Mr. W. is a 68-year-old widowed white male with a history of alcohol abuse. On interview he is able to remember in detail an incident that occurred 20 years ago but cannot remember 3 objects after 5 minutes on the mental status exam. He has no change in personality and his judgment is good. Mr. W.'s condition is probably caused by:
- A deficiency of thiamine
 - Heredity
 - Situational stress
 - A tumor
36. Ms. C. is a 70-year-old widowed female. Recently she has become very suspicious about her neighbor, whom she believes is an FBI agent. On a recent CT scan a right cerebral lesion was discovered. Her suspiciousness is most likely related to:
- Her neighborhood
 - Her family relationships
 - Her cerebral tumor
 - A grief reaction
37. Ms. C. is brought to the emergency room by the police after locking herself in her apartment and making threatening phone calls to her neighbor. The best initial nursing response to her is:
- Tell her not to worry, her neighbor is not an FBI agent
 - Take measures to allay her anxiety and protect her from harm
 - Agree that the FBI does intrude into our lives
 - Conduct a complete nursing assessment including physical examination
38. Of the following, which would NOT inform selection of nursing diagnoses for Ms. C.?
- Altered thought processes
 - Fear related to persecutory delusions
 - Risk for violence
 - Need for additional knowledge
39. Which is always associated with dementia?
- Ataxic gait
 - Impaired memory and judgment
 - Delusions
 - Affective disturbances
40. Alzheimer's disease is primarily characterized by:
- Progressive memory decline
 - Emotional distress
 - Dysphoria
 - Hallucinations
41. Assessment of Alzheimer's disease is best done by a:
- Physician
 - Nurse
 - Multidisciplinary team
 - Psychologist
42. Senile onset refers to:
- The development of the disease before age 65
 - The development of the disease after the person is determined to be senile
 - The disease occurring after age 65
 - The development of the disease before the person is determined to be senile
43. Mr. Y., an 80-year-old married male, has been diagnosed with Dementia of the Alzheimer's Type and placed on haloperidol, 10 mg at night, which is his only medication. He has become more agitated in the past week. His agitation is probably due to:
- His illness
 - A change in his environment
 - His medication
 - A urinary tract infection
44. Mr. Y.'s wife, to whom he has been married for 50 years, dies 2 years after he is first diagnosed with Dementia. Several months later he experiences weight loss, crying spells, and sleep disturbance. The most likely diagnosis would be:
- Dementia of the Alzheimer's Type with delusions

- b. Dementia of the Alzheimer's Type with depression
 c. Dementia of the Alzheimer's Type with delirium
 d. Dementia of the Alzheimer's Type with paranoia
45. Which affect would you NOT expect Mr. Y. to have?
 a. Sadness
 b. Hopelessness
 c. Euphoria
 d. Helplessness
46. Which type of hallucination would you NOT expect Mr. Y. to have?
 a. Tactile
 b. Visual
 c. Auditory
 d. Olfactory
47. Mr. Y. develops praxis. This includes:
 a. Simple delusions
 b. Confusion
 c. Inability to write
 d. Short attention span
48. Which of the following medications would NOT be used to treat Mr. Y.'s depression?
 a. Prozac
 b. Zoloft
 c. Trazodone
 d. Haldol
49. Which of the following is classified as a selective serotonin reuptake inhibitor (SSRI)?
 a. Trazodone
 b. Desipramine
 c. Fluoxetine
 d. Lithium
50. Alzheimer's disease is considered to result from:
 a. Aluminum intoxication
 b. Alcohol abuse
 c. Tumors
 d. Causes that are still unknown
51. Vascular Dementia is characterized by which of the following:
 a. Stepwise and patchy deterioration in intellectual functioning
 b. Global cognitive impairments
 c. Retrograde amnesia
 d. Headaches and fainting spells
52. Which of the following are not causes of delirium?
 a. Medications
 b. Metabolic and endocrine imbalances
 c. Sensory deprivation
 d. Infectious diseases
53. Which of the following is the most prevalent form of dementia?
 a. AIDS Dementia Complex
 b. Amnesic Disorder Due to a General Medical Condition
 c. Dementia of the Alzheimer's type
 d. Vascular Dementia
54. The *second* most prevalent dementia is:
 a. AIDS Dementia Complex
 b. Amnesic Disorder Due to a General Medical Condition
 c. Dementia of the Alzheimer's type
 d. Vascular Dementia
55. Ms. T. has dementia and resides in a nursing home. Which of the following individual interventions is NOT indicated to enhance her care?
 a. Provide balance between stimulation and rest.
 b. Provide structure and support.
 c. Provide clear and direct communication.
 d. Provide intensive group therapy.
56. Which of the following should be avoided in providing care to Ms. T.?
 a. The use of chemical and physical restraints
 b. Having family members visit
 c. Reminiscence groups, as they would be too stimulating
 d. Orientation measures
57. The nurse is considering starting a group for residents of Ms. T.'s nursing home who have mild cognitive impairment. Which type of group would be indicated?
 a. Reminiscence
 b. Jungian
 c. Psychoanalytic
 d. Gestalt
58. The primary purpose of cognitive-behavioral group interventions is to:
 a. Increase self-esteem through positive affiliations with others
 b. Correct negative thoughts and attitudes
 c. Provide information
 d. Explore unconscious motivations of behavior

59. Mr. B., two days postadmission for esophageal varices, develops delirium tremens. This state is most associated with which of the following conditions?
- Cocaine withdrawal
 - Parkinson's disease
 - Alcohol withdrawal
 - Hypoxia
60. Which of the following community resources would be most helpful to Mr. B.'s family?
- Alanon
 - Alzheimer's Disease and Related Disorders Foundation
 - American Heart Association
 - Mental Health Association
61. Validation is a method to:
- Limit communication
 - Restore well-being
 - Facilitate avoidance of unresolved issues
 - Teach sympathy skills
62. Dementia Due to HIV Disease is NOT called which of the following?
- AIDS Dementia Complex
 - HIV Vascular Dementia
 - HIV Encephalopathy
 - HIV Subcortical Dementia
63. In treating geropsychiatric patients, most psychotropics:
- Are best divided into equal doses over 24 hours
 - Are best in once-daily doses to reduce the incidence of medication errors
 - Are prescribed no differently than for younger adults
 - Are contraindicated due to effects of dementia
64. For patients older than 70 years, assessment of sexual activity is:
- Unimportant because few older than 70 are sexually active
 - Important because sexual activity continues well into advanced age
 - Irrelevant for persons in long-term care
 - Both a and c are correct
65. During the next 20 years, demands for expertise in geropsychiatric nursing is expected to:
- Decline
 - Remain the same
 - Grow slightly
 - Grow substantially

ANSWERS

- | | |
|-------|-------|
| 1. c | 34. c |
| 2. c | 35. a |
| 3. a | 36. c |
| 4. c | 37. b |
| 5. d | 38. d |
| 6. b | 39. b |
| 7. a | 40. a |
| 8. b | 41. c |
| 9. c | 42. c |
| 10. b | 43. c |
| 11. d | 44. b |
| 12. a | 45. c |
| 13. b | 46. a |
| 14. a | 47. c |
| 15. d | 48. d |
| 16. c | 49. c |
| 17. d | 50. d |
| 18. b | 51. a |
| 19. c | 52. c |
| 20. a | 53. c |
| 21. d | 54. d |
| 22. c | 55. d |
| 23. a | 56. a |
| 24. b | 57. a |
| 25. a | 58. b |
| 26. c | 59. c |
| 27. c | 60. a |
| 28. d | 61. b |
| 29. c | 62. b |
| 30. a | 63. a |
| 31. b | 64. b |
| 32. d | 65. d |
| 33. d | |

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Behavioral and Emotional Disorders of Childhood and Adolescence

■ CHILD AND ADOLESCENT PSYCHIATRIC MENTAL HEALTH NURSING

- Professional standards—Specialists in this area hold a master’s or doctoral degree addressing specific issues in child and adolescent psychiatric nursing and are certified as clinical nursing specialists in child and adolescent psychiatric nursing or family psychiatric and mental health nurse practitioners (FPMHNP) by the American Nurses Credentialing Center. They are recognized by their peers as Advanced Practice Registered Nurses.
 - Epidemiology
 1. Prevalence rates of mental disorders among children and adolescents (Bloom, & Cohen, 2009; Federal Interagency Forum on Child and Family Statistics, 2009; Keltner, Schwecke, & Bostrom, 2007)—20% of school-age children suffer significant mental health problems (8–12 million children and adolescents); of these, only 20% are receiving mental health services.
 2. Reports of child and adolescent health surveys from 2006 to 2008 (Bloom, & Cohen, 2009; Federal Interagency Forum on Child and Family Statistics, 2009) include the following facts:
 - a. The incidence of adolescent depression is 8.2% (highest incidence was among girls and those aged 16–17 years).
 - b. Youth who have had a major depressive episode (MDE) in the past year are at greater risk for suicide and are more likely than other youth to initiate alcohol and other substance use.
 - c. Among children ages 10–14, homicide and suicide were the third and fourth leading causes of death.
 - d. About 4.5 million children 3–17 years of age (7%) had Attention Deficit Hyperactivity Disorder (ADHD), with a 2:1 ratio for boys vs girls.
 - e. Attention-Deficit Disorder and Attention-Deficit/Hyperactivity Disorder (30%), and depression, anxiety, or other emotional problems (21%) were among the most frequently reported health conditions in children with special healthcare needs (younger than 17 years).
 - f. Alcohol is the most common psychoactive substance used during adolescence.
 - (1) 8% of both male and female 8th-grade students reported heavy drinking.
 - (2) 17% of 10th-grade males and 15% of females reported heavy drinking.
 - (3) 20% of 12th-grade males reported heavy drinking, compared with 21% of 12th-grade females.
 - g. Illicit drug use (marijuana, cocaine, etc.) within the past 30 days was reported by:
 - (1) 8% of 8th-grade students.
 - (2) 16% of 10th-grade students.
 - (3) 22% of 12th-grade students.
- Cultural and ethnic considerations
 1. Cultural weaknesses

- a. Lack of acculturation means children of immigrants (and their parents) are at greater risk for depression and suicide (Hovey & King, 1996, Sadock & Sadock, 2007).
 - b. Some folk medicine practices and child rearing practices may be perceived as abusive by Western cultural standards. The nurse needs to observe and educate parents about certain practices (Zimmerman, 1997), but needs to be aware of other cultural beliefs before imposing Western practices.
2. Cultural strengths
 - a. Strong loyalty to family, family cohesiveness, and family ownership of children's problems is prevalent in Native-American, African-American, and Asian families.
 - b. Strong supportive extended family linkages and sharing in child-care tasks by family, friends, and neighbors is prevalent in families of color.
 - c. Cultural emphasis on discipline, obedience to rules, and respect for elders who are sources of advice for child rearing is prevalent in Asian families.
 - d. Having bicultural competence preserves cultural identity while the child negotiates the dominant culture.
 - e. Humor as a means of coping with adversity is a strength.
 - f. Independence for children is prevalent in Native-American families; interdependence of siblings in Hispanic families.
 - g. Strong religious values, customs, rituals, and institutions that provide spiritual support and reinforce strong, ethical values for life decisions, and give meaning to life are prevalent; churches provide group socialization activities and supplementary child care.
 - h. Value placed on education of children, who are seen as hope for the future by African-American and Asian families.
 - i. Strong ethnic community representatives and organizations exist that help people of color to bargain, negotiate, and obtain resources from larger societal systems (Gaudin, 1993).
- Risk factors for mental and emotional disorders are increased in the following situations:
 1. Living in poverty and in crowded, inner city environments (poverty increases intensity of all other risk factors)
 2. Having mentally ill and substance abusing parents
 3. Being abused physically or sexually
 4. Being of minority ethnic status (associated with poverty)
 5. Having teenage parents
 6. Being in families with marital discord, parental conflict, divorce, instability in family environment; being in foster care
 7. Having a chronic illness or disability
 8. Living with prolonged parent-child separation, multiple separations, frequent changes in primary caretaker
 9. Homelessness (families with children are the fastest growing segment of the homeless population)
 10. Being a Native-American child from certain tribes whose suicide rates are 2–3 times that of the rest of the US population for the same age
- Genetic/Biologic origins
 1. Low birth weight
 2. Developmental delay
 3. Brain damage
 4. Epilepsy
 5. Addiction as a result of maternal substance abuse
 6. Early difficulties in adjustment between infant and primary caretaker temperament styles
 7. Mental retardation
 8. Genetic loading—there is an increased risk for developing a mental disorder for children with a first-degree relative afflicted with the disorder (specifically genetic links have been found among: mood and anxiety disorders, substance-related disorders, tic disorders, and ADHD) (Keltner *et al.*, 2007)
 9. Physical illness and impairments
 - a. Illness often interferes with the acquisition of skills and negotiation of developmental milestones.
 - b. Children have fears and anxieties related to their developmental age, and the younger the child, the fewer the coping strategies.
 - c. Regression occurs in the face of illness or disability.
 - d. Chronic illness may pose greater risk for psychological disturbance.
 - e. Children with AIDS are at particularly high risk due to
 - (1) Family dysfunction—extreme poverty, drug abuse, social isolation, and/or homelessness
 - (2) Parental ill health or social stigmatization
 10. Circumstances that may decrease risk include:

- a. Presence of primary attachment figure during the child's illness and or/hospitalization
 - b. Family's functionality—stress management, coping, competence, and ability to support child appropriately
 - c. Community support and respite care for family
 - d. Partnership of family and providers in assisting child to adapt to illness or impairment
 - e. Attention to psychological and social needs along with physical and medical issues within the context of the child's developmental stage
 - f. Assistance in achieving developmental milestones, realistic academic goals, self-esteem, mastery, and social support (Johnson, 1995)
 - g. Parents or caretakers who create an environment with nonthreatening language, descriptive praise, play and related activity, mediated learning experiences, and positive self-talk (Johnson, 1995)
 - h. Child factors that may contribute to reduced risk include:
 - (1) Problem-solving ability
 - (2) Social skills
 - (3) Warm, caring relationship with a supportive, consistent adult
 - (4) Compensatory experiences outside the home
 - (5) Personality characteristics, such as perceived competence and social acceptance
 - (6) Normal intellectual development
 - (7) Social support from family, peers, and teachers (Johnson, 1997; Krauss, 1993)
- Family constellations and stressors—child's functioning and well-being are dependent on the family and school setting in which he or she lives and studies (JAACAP, 1997a).
 1. Nuclear families
 - a. Economic pressures on both parents to work
 - b. Lack of adequate day care and the low priority given to child care
 - c. Poor parenting skills
 2. Adoptive families
 - a. Recent court rulings returning children to birth families
 - b. Adopted children at higher risk for emotional mental disorders for a variety of complex reasons
 3. Separation and divorce
 - a. Parental discord prior to a separation and divorce
 - b. Continuous discord regarding custody, visitation, child support, and each parent's activities and friends
 - c. Children exposed to parental separation before school entry may show increased risk of later conduct or oppositional and mood disorders.
 - d. Children exposed to parental separation after 10 years of age show increased risk of substance abuse.
 - e. Children and adolescents in therapy may focus on parent's separation as a major event in their lives.
4. Blended families
 - a. Children must adjust to stepparents, step-siblings and step-grandparents.
 - b. Visitation schedules often disrupt family routines; children often feel resentment, anger, and a sense of abandonment.
 - c. Loyalty conflicts and attachment problems are common and relate to child's developmental stages.
 5. Alternative lifestyles
 - a. Children sense they are different or are teased.
 - b. Adolescent peer pressure and developmental needs propel the youngster to fit in with the peer culture.
 6. Foster families—Number of children in foster care has recently decreased from record highs reported early this decade: 783,000 children served by the system in 2007, of which over 496,000 lived in foster care; 75% placed due to maltreatment or inadequate care (Trends in Foster Care report from the Administration for Children & Families: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends.htm).
- Access to health care
 1. Services for children are inadequate, inappropriate, or unavailable.
 2. Over 12 million US children lack health insurance.
 3. Cutbacks in funding of mental health services have affected psychiatric care of children and adolescents.
 4. Inadequate residential care is available.
 5. In order to obtain services for their children, many parents must give custody to the state.
 6. Inadequate numbers of mental health professionals are trained to provide the needed mental health services for children and adolescents.

7. Cost containment measures by managed care impact services.
- Community background factors
 1. Cultural context
 2. How family relates to neighborhood
 3. Religious and ethnic orientation
 4. Neighborhood resources and adverse circumstances
 - a. Poverty
 - b. Poor housing
 - c. Crime or urban violence (JAACAP, 1997a)

■ MENTAL DISORDERS DIAGNOSED IN CHILDREN & ADOLESCENTS

Mental Retardation (MR)—coded on Axis II in the DSM-IV-TR multiaxial system (American Psychiatric Association [APA], 2000; Sadock & Sadock, 2007)

- Levels
 1. Mild Mental Retardation—IQ level 50–55 to approximately 70
 - a. Can develop social and communication skills
 - b. Acquisition of academic skills to sixth-grade level
 - c. Acquire skills for minimum self-support
 - d. Can live in the community
 - e. May need guidance and support during stress
 2. Moderate Mental Retardation—IQ level 35–40 to 50–55
 - a. 10% of the population with MR
 - b. Can talk and communicate
 - c. Can profit from vocational training, but unlikely to progress beyond second grade level
 - d. May have difficulties with social conventions
 - e. Can live in supervised group homes
 - f. Need supervision and guidance under stress
 3. Severe Mental Retardation—IQ level 20–25 to 35–40
 - a. 3 to 4% of people with MR
 - b. Little or no communicative speech during preschool, may learn speech during school-age years
 - c. Can be taught limited hygiene skills
 - d. Can “sight-read” some survival words, such as “EXIT” “STOP” “MEN” “WOMEN”
 - e. May perform simple tasks under close supervision
 - f. May live in the community in group homes or with families, in the absence of an associated handicap
- Profound Mental Retardation—IQ level below 20 or 25
 - a. 1 to 2% of people with MR
 - b. Minimal capacity for sensorimotor functioning
 - c. Motor development, self-care and communication skills may improve if appropriate training provided
 - d. May live in group homes, intermediate care facilities or with families
 - e. Need day programs or sheltered workshop
- Associated disorders
 1. The more severe the retardation, the greater the likelihood of other abnormalities being present in one or more systems.
 2. In Down syndrome, social skills are much higher than could be expected for the level of retardation.
 3. Prevalence of mental disorders at least three or four times higher than in the general population.
 4. Common associated disorders
 - a. Pervasive Developmental Disorders
 - b. ADHD
 - c. Stereotypic Movement Disorder
- Mental status variations—need to be adjusted to level of retardation
 1. Passivity
 2. Dependency
 3. Low self-esteem
 4. Low frustration tolerance
 5. Aggressiveness
 6. Poor impulse control
 7. Stereotyped self-stimulating and self-injurious behavior
- Nursing diagnoses (NANDA, 2009)
 1. Powerlessness
 2. Self-Care Deficit, bathing
 3. Self-Care Deficit, dressing
 4. Self-Care Deficit, feeding
 5. Self-Care Deficit, toileting
 6. Communication, impaired verbal
 7. Role Performance, ineffective
- Genetic/Biologic origins (Sadock & Sadock, 2007)
 1. Hereditary factors in 5% of cases
 2. Inborn metabolism errors (Tay-Sachs disease; phenylketonuria)
 3. Single gene abnormalities (Tuberous sclerosis)
 4. Chromosomal aberrations (translocation Down syndrome, Fragile X syndrome)
 5. Early alterations of embryonic development (30%)

- a. Maternal alcohol consumption causing prenatal damage due to toxins
 - b. Pregnancy and perinatal problems (10%)
 - c. Fetal malnutrition, prematurity, or hypoxia
 - d. Maternal trauma—pregnant women more at higher risk for injury due to family violence than nonpregnant women
6. Physical disorders acquired in childhood
- Biochemical interventions—are diagnostic and symptom specific; include symptomatic treatment of associated features/behaviors
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins include: psychosocial deprivation, lack of stimulation, and complications of other mental disorders.
 2. Behavior modification specific for acting-out can be effective.
 3. Supportive treatment that raises self-esteem may be helpful for the higher functioning patient.
 4. Treatment interventions are based on the social, educational, psychiatric, and environmental needs of the patient.
 - Family dynamics/Family therapy
 1. Dysfunctional family processes, such as abusive and chemically dependent families may contribute.
 2. Families who undernurture and understimulate may contribute.
 3. Therapy is geared to correcting dysfunctional processes without pathologizing family; promote rewarding, praising.
 4. Deficits of mentally retarded child create severe stress for family; pattern of overprotection and overcompensation may develop.
 5. Families need both respite care and help in focusing on the child's strengths as well as realistic expectations.
 6. Psychoeducational approaches can be used to engender family cooperation with programs.
 - Group approaches
 1. Traditional, insight-oriented group is not indicated.
 2. Behavior modification, educational group may be helpful.
 3. Multiple family group therapy decreases family's sense of isolation and stress, and provides a forum for sharing effective management strategies.
 4. Socialization groups can be useful.
 5. Skills building can be useful.

- Milieu interventions
 1. Mental retardation, per se, is no longer generally considered a criterion for admission to a psychiatric inpatient setting.
 2. Day-care settings or sheltered workshops provide milieu.
 3. Community meetings can be helpful in group home, day-care settings or workshop settings.
 4. Designed to address specific problematic behaviors
 5. Aggressive behaviors are in response to overwhelming lack of power experienced by these children, so child needs help in coping with teasing, and protection from harm by others.
- Community resources
 1. Numerous resources exist in larger metropolitan areas.
 2. Rural areas have extremely limited resources.
 3. Steady decline in services has occurred in last 20 years.
 4. Retarded adults with supervision are reliable and effective workers for routine tasks.
 5. Federation for Children with Special Needs
 6. National Information Center for Handicapped Children and Youth

Learning Disorders

- Definition—Learning disorders, also called learning disabilities, occur in 4 to 6% of school-age children. There is controversy over the inclusion of these as mental disorders. Often there is no sign of psychopathology. Detection and treatment generally occurs within the school system.

Reading Disorder (APA, 2000; Keltner *et al*, 2007)

- Definition—Also called dyslexia, Reading Disorder involves lower achievement in reading skills than would be suggested by aptitude or intellectual abilities. Treatment involves remediation strategies to improve reading skills.

Mathematics Disorder (APA, 2000; Keltner *et al*, 2007)

- Definition—Mathematics Disorder involves lower achievement in math skills than would be suggested by aptitude or intellectual abilities. Treatment involves problem-solving strategies to improve math skills.

Disorder of Written Expression (APA, 2000; Keltner *et al*, 2007)

- Definition—Involves lower achievement in writing skills than would be suggested by aptitude or intellectual abilities. Treatment involves direct practice to improve writing skills.

Motor Skills Disorder/Developmental Coordination Disorder (APA, 2000; Sadock & Sadock, 2007)

- Definition & signs and symptoms—Deficits occur in coordination and ability to perform gross and/or fine motor skills associated with activities of daily living. Children with this disorder frequently struggle to perform activities including jumping, hopping, running, and may perform poorly academically due to clumsiness and poor writing skills. About 5% of all school-age children meet the criteria for Developmental Coordination Disorder. A diagnosis is informed by standardized testing.
- Differential diagnosis
 1. Mental retardation
 2. Neurological disorders
 3. Pervasive Developmental Disorders
 4. ADHD
 5. Elective mutism
 6. Inadequate schooling
 7. Impaired vision or hearing
 8. PTSD-induced regression and loss of recently acquired skills
- Mental status variations
 1. Determined by history, observation
 2. Teacher report/checklists essential
- Nursing diagnoses (NANDA, 2009)
 1. Behavior, risk-prone health
 2. Coping, ineffective
 3. Communication, impaired verbal
 4. Knowledge, deficient (specify)
 5. Development, risk for delayed
- Genetic/Biologic origins/Biochemical interventions
 1. Perinatal injury of various kinds may be a causative factor.
 2. No information on sex ratio for the arithmetic and coordination disorders; the others are from two to four times more common in males than females.
 3. Some research shows history in first-degree biologic relatives.
 4. No evidence that medication directly benefits children with these disorders; may be used for associated conditions.
- Individual psychotherapy
 1. May be helpful with issues of low self-esteem and school failure.
 2. Collaboration with school guidance counselor and school counseling may be helpful.
 3. Use of visual, auditory, and tactile materials have been successful in skill building.

- Family dynamics/Family therapy—families may need assistance in parent management strategies and psychoeducational approaches may be in order.
- Group approaches—may be helpful in self-esteem issues and to help overcome feelings of differentness.
- Community resources—educational intervention depends upon degree of impairment.
 1. National Learning Disabilities Association
 2. Federation for Children with Special Needs

Communication Disorders

- Definition—Communication disorders involve deficits in speaking or language (the formulation and comprehension of verbal exchange between people), and affect about 5% of preschool and 3% of school-age children. A diagnosis is informed by standardized testing (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007).

Expressive Language Disorder (APA, 2000; Sadock & Sadock, 2007)

- Definition & signs and symptoms—Children with this disorder tend to function below their intellectual abilities in terms of correct tense usage, complex sentence structure, vocabulary, and word recall.
- Therapeutic interventions may involve practice and possibly a speech specialist; other therapeutic options include psychotherapy to address self-esteem.

Mixed Receptive-Expressive Language Disorder (APA, 2000; Sadock & Sadock, 2007)

- Signs and symptoms (APA, 1994, p. 60–61)—include those for Expressive Language Disorder as well as difficulty understanding words, sentences, or specific types of words, such as spatial terms.

Phonological Disorder (APA, 2000; Sadock & Sadock, 2007)

- Signs and symptoms—failure to use developmentally expected speech sounds that are appropriate for age and dialect (e.g., errors in sound production, use, representation, or organization such as, but not limited to, substitutions of one sound for another [use of /t/ for target /k/ sound] or omissions of sounds such as final consonants)

Stuttering (APA, 2000; Sadock & Sadock, 2007)

- Signs and symptoms—disturbance in the normal fluency and time patterning of speech

(inappropriate for the individual's age), characterized by one or more of the following behaviors:

1. Repetition of sounds or syllables
2. Sound prolongations
3. Interjections
4. Pauses within a word
5. Filled or unfilled pauses in speech
6. Word substitutions to avoid problematic words (circumlocutions)
7. Words produced with an excess of physical tension
8. Monosyllabic whole-word repetitions (e.g., "I-I-I see him")

Information Common to All Communication Disorders

- Differential diagnosis
 1. Hearing impairment or other sensory deficit
 2. Speech-motor deficit
 3. Normal dysfluencies that occur in young children
 4. Severe environmental deprivation (for Phonological Disorder and Expressive Language Disorder)
 5. Neurological deficit
 6. Mental retardation with learning disabilities
 7. Autistic disorder (for Expressive Language Disorder)
 8. Mental retardation (for Expressive Language Disorder)
 9. Acquired aphasia due to general medical condition (for Expressive Language Disorder)
 10. Spastic dysphonia
 11. Anxiety disorder
- Mental status variations
 1. Often causes the speaker great anxiety and fearfulness of speaking.
 2. Speech rate may be altered.
 3. Motor movements frequently accompany stuttering, such as eye blinks, tics, tremors of the face and head, fist clenching.
 4. Severity of symptoms may increase under pressure to communicate, such as during interview.
- Nursing diagnoses (NANDA, 2009)
 1. Communication, impaired verbal
 2. Anxiety
- Genetic/Biologic origins
 1. Familial pattern is noted.
 2. Stuttering—research supports genetic evidence for origin of stuttering.
 - a. Male-to-female ratio is 3 to 1.
 - b. 50% of first degree biologic relatives affected.
- 3. May have generalized neurological soft signs.
- 4. No factors have been shown to be clearly associated with recovery.
- 5. Approximately 80% recover before 16 years of age.
- 6. Females more commonly recover than males.
- Psychotherapeutic and behavioral interventions
 1. Therapy should focus on overcoming associated anxiety and frustration.
 2. Relaxation training, positive self-talk and stress management may help provide a sense of mastery and self-control.
 3. Teach self-control strategies.
- Family therapy
 1. Family may help raise child's self-esteem.
 2. Assist parents to understand and be empathetic with patient.
 3. Contributory family dysfunctional patterns need to be addressed; confront interactions that maintain dysfunction.
 4. Challenge denial surrounding deficit in order to support actual interventions.
 5. Promote realistic expectations, e.g., filling in pauses (Jongsma *et al.*, 1996).
- Group approaches—overcome low self-esteem and impairment of social functioning.
- Community resources
 1. Speech and hearing therapy services—usually not covered by third-party payers.
 2. School systems may have special education services.

Pervasive Developmental Disorders (PDD)

Autistic Disorder (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)

- Definition & signs and symptoms—Autism is a PDD characterized by symptoms involving impairment in social interaction, communication, and restrictive repetitive and stereotyped patterns of behavior/interests. Autism disorder can be differentiated from other PDD due to early age of onset for autism (younger than 30 months); severe deficits in social relating, communication, and development (e.g., Rett syndrome involves a rapid decline in previously acquired skills); occurs in about 0.08% of children.
- Associated features (the younger the child and the more severe the impairment, the higher the number of associated features)

1. Abnormal development of cognitive skills
 2. Abnormal posture and motor behavior
 3. Odd response to sensory input such as oblivion to pain or cold, but hypersensitivity to benign sounds, such as birds chirping; may have a fascination for some sensations of touch, such as velvet pillow
 4. Abnormalities in eating, drinking, or sleeping
 5. Abnormalities of mood
 6. Mental retardation
 7. Temporal lobe deficit
 8. Prenatal complications
 9. Self-injurious behavior, such as head-banging, finger-biting, gouging skin
- Differential diagnosis
 1. Mental retardation—even seriously impaired, can socialize and communicate in some way
 2. Schizophrenia—rare in childhood
 3. Hearing impairments and specific developmental language and speech disorders
 4. Tic disorders and Stereotypic Movement Disorder
 5. Other PDD
 6. Schizotypal or Schizoid Personality Disorder
 - Genetic/Biologic origins—linkage studies have identified candidate genes associated with autism on chromosomes 7, 2, 4, 15, and 19.

Rett's Disorder

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—a rare PDD that involves a significant decline in functioning following normal development of at least 6 months
- Differential diagnosis
 1. Autistic Disorder
 2. Childhood Disintegrative Disorder
 3. Mental Retardation

Childhood Disintegrative Disorder

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—a marked regression in multiple areas of functioning after a period of normal development for at least the first 2 years after birth as characterized by significant deterioration of age-appropriate verbal and non-verbal communication, social relationships, play, and adaptive behavior
- Differential diagnosis—another PDD or Schizophrenia

Asperger's Disorder

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Children

with Asperger's disorder often have normal intelligence (compared to the high incidence of mental retardation among those with autism); verbal abilities/intellect are frequently higher than performance abilities/intellect; have a tendency to interpret language cues concretely; and possess social skills deficits that are evidenced by difficulties in reading social cues. Additional characteristics include clumsiness, difficulty managing transitions, and a preoccupation with areas of their own interest. The disorder is more common among boys.

- Therapeutic interventions for Pervasive Developmental Disorders
 1. Behavioral therapy to target behaviors that will improve abilities to assimilate into school and social relationships; and increase the likelihood of future independent living
 2. Symptomatic treatment of associated psychiatric conditions

Attention-Deficit and Disruptive Behavior Disorders

- Definition—Behaviors that are disturbing to others and often socially disruptive. The behaviors are referred to as “externalizing” symptoms. They interfere with the child's social functioning and learning.

Attention-Deficit/Hyperactivity Disorder (ADHD)

- Definition & signs and symptoms (American Academy of Child & Adolescent Psychiatry, 2007a; APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—ADHD is among the most common of childhood psychiatric conditions; characterized by symptoms of inattention, impulsivity, and overactivity that occur in at least two different settings (i.e., home and school) with significant impairment in functioning (socially, academically, occupationally). ADHD is divided into the following three subtypes that specify the dominant associated behaviors:
 1. Hyperactive-impulsive type
 2. Inattentive type
 3. Combined (hyperactive-impulsive and inattentive) type
- Associated features
 1. Child may become alienated from peers due to inability to cooperate with others or follow game rules; excessive talking is common.
 2. Child may engage in dangerous activities without considering consequences.
 3. Symptoms may not be evidenced when child is in a highly structured, novel, or one-to-one situation, or when watching TV or playing video games.

4. Age of onset is generally before 7 years of age (almost half before 4 years of age).
 5. Disorder is often diagnosed at entry into school.
 6. Low self-esteem, labile mood, and temper tantrums are often present.
- Differential diagnosis
 1. Considerations:
 - a. It is sometimes impossible to differentiate this diagnosis from response to a chaotic environment, including parenting problems.
 - b. Teacher reports are somewhat more valid than those from family since the family may either normalize or be unaware of what degree of compliance to expect from children at various ages.
 2. Rule out:
 - a. Specific learning disabilities
 - b. Acute situational reactions
 - c. Adjustment disorders
 - d. Conduct Disorder and Oppositional Defiant Disorder
 - e. Mental Retardation
 - f. Pervasive Developmental Disorders
 - g. Mood disorders, fear or anxiety
 - h. Impaired vision or learning
 - i. Seizures or sequelae of head trauma
 - j. Acute or chronic medical illness
 - k. Poor nutrition
 - l. Insufficient sleep
 - m. Various drugs that interfere with attention
 - (1) Phenobarbital
 - (2) Carbamazepine
 - (3) Alcohol
 - (4) Illicit drugs
 - (5) Theophylline
 - n. Early onset mania or bipolar illness
 - o. Undifferentiated Attention-Deficit Disorder—no impulsiveness or hyperactivity
 3. Utilize psychological evaluation and parent-teacher checklists such as:
 - a. Child Behavior Checklist (CBCL)
 - b. Teacher Report Form
 - c. ADHD Rating Scale-IV
 - d. Conner's Revised Parent and Teacher rating scales (CPRS-R & CTRS-R)
 - e. Parent interviews including family history of ADD/ADHD, other disorders, family conflict
 - Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective
 2. Social Interaction, impaired
 3. Communication, impaired verbal
 4. Role Performance, ineffective
 - Genetic/Biologic origins/Biochemical interventions
 1. Genetic link—evidence of higher concordance rates has been shown among monozygotic twins.
 2. Increased incidence of ADHD among first-degree relatives (although subtypes may differ) could be a factor.
 3. May be sex-linked—more males than females are diagnoses with ADHD.
 4. Fathers may be alcoholic or have Antisocial Personality Disorder.
 5. Children with ADHD have higher risk of developing Conduct Disorder, SUD, and Antisocial Personality Disorder than general population.
 6. Conduct Disorder and specific developmental disorders are more frequent in relatives.
 7. Predisposing factors
 - a. CNS abnormalities
 - b. Disorganized, chaotic environments
 - c. Noradrenergic, dopaminergic, and serotonergic abnormalities
 - d. Family history of ADHD
 8. Diagnostic studies—hyper/hypothyroid may be contributing factor; although no specific laboratory tests aid in the diagnosis of ADHD.
 9. Psychopharmacology (AACAP, 2007a; Sadock & Sadock, 2007; Stahl, 2008, 2009)
 - a. Between 70% and 80% of children with ADHD respond to medication.
 - b. First-line agents are slow-dose (sustained-release) stimulants; second-line agents are the immediate-release stimulants; and third-line options include antidepressants with noradrenergic properties, such as bupropion (See **Table 10-1**)
 - (1) In 2006, the FDA required labeling changes for all stimulants to warn about the effects of sudden death associated with stimulants used at unusual doses in children and adolescents with heart problems including structural cardiac abnormalities or other serious cardiac condition.
 - Mental status examination
 1. Observation in a free space situation, such as the playroom, is critical because the novelty of interview situation may encourage concentration.

■ Table 10-1 Medications Used in Treating ADHD

Drug Class	Generic Name	Trade Name	Usual Dose
Stimulants (Schedule II)	Methylphenidate	Ritalin	0.3 to 2 mg/kg bid or tid; up to 60 mg
		Ritalin-SR	20 mg/day or bid
		Ritalin LA	20 to 40 mg/day—am
		Metadate ER	10 to 20 mg/day or bid—am
		Metadate CD	20 to 60 mg/day—am
		Concerta	18 to 54 mg/day—am (extended release)
	Methylphenidate transdermal	Daytrana	10 mg/9 hour patch (off 15 hours); up to 30 mg/9 hour patch (off 15 hours)
	Dexmethylphenidate	Focalin	2.5 to 10 mg bid; up to 20 mg
		Focalin XR	10 to 20 mg/day—am
	Dextroamphetamine	Generic/Dexedrine	0.15 to 0.5 mg/kg bid; up to 40 mg/day
ProCentra		2.5 to 40 mg/day—in 1 to 3 doses/day	
Dextroamphetamine & amphetamine salt	Adderall	2.5 to 5 mg in divided doses; up to 40 mg/day	
	Adderall XR	10 to 20 mg/day—am	
Lisdexamfetamine	Vyvanse	30 mg/day; up to 70 mg/day	
Nonstimulants	Atomoxetine	Strattera	0.5 to 1.2 mg/kg/day; up to 70 mg/day
	Bupropion	Wellbutrin	1.4 to 6 mg/kg/day in divided doses; up to 300 mg/day
		Wellbutrin SR	Adult dose: 100 to 200 mg/day; not approved for children
		Wellbutrin XL	Adult dose: 150 to 450 mg/day; not approved for children
	Venlafaxine	Effexor	Adult dose: 25–150 mg/day; use bid; not approved for children
		Effexor XR	Adult dose: 37.5 to 150 mg/day; not approved for children
	Clonidine	Catapres	3 to 10 µg/kg/day—divided tid; up to 0.1 mg tid
Guanfacine	Tenex, Intuniv	0.05 to 0.12 mg/kg/day; up to 4 mg/day	

(Sadock & Sadock, 2007; Stahl, 2008, 2009)

- (2) In addition, there is an increased risk of abuse and dependency for stimulant class medications.
- (3) For adults with ADHD, first-line agents include nonstimulants (atomoxetine, guanfacine ER, and possibly modafinil), and sustained-release stimulants.
- c. Pemoline and dextroamphetamine sulfate are also used.
- d. Bupropion—contraindicated in children/adolescents with seizure disorders.
- Treatment approach for ADHD should be multimodal, incorporating pharmacotherapy with other indicated interventions including behavioral and family therapies.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Retarded ego development
 - b. Low self-esteem
 2. Psychotherapeutic interventions
 - a. Provide careful environmental control—tasks and chores broken down into short, manageable components; homework done in short periods with opportunities for breaks.
 - b. Convey unconditional positive regard since these children often have low self-esteem and respond to positive reinforcement.
 - c. Provide social skills training.
 - d. Provide problem-solving strategies/CBT.

- e. Assist with organization and planning, particularly related to study skills.
 - f. Approach child with firmness, consistency and limit-setting as well as patience.
- Family dynamics/Family therapy
 1. Dysfunctional family system
 2. Sociopathic, alcoholic, conduct disordered relatives
 3. Chaotic environment—promote consistency and schedules
 4. Family therapy and parenting classes—teach negotiation, problem solving and contingency contracting, parenting skills training
 6. Behavioral reinforcement from family therapist
 7. “Time out” vs physical punishment
 - Group approaches/Self-help
 1. Promote and encourage parent support group.
 2. Refer to parenting classes.
 3. Parents need information on structuring and planning the child’s milieu at home (See also Milieu interventions—next section).
 4. Provide skills building for anger management, decreasing impulsivity and rules compliance (Bloomquist, 1996).
 - Milieu interventions—children with a primary diagnosis of ADHD usually do not meet criteria for hospitalization unless they have other diagnoses such as Major Depression and Posttraumatic Stress Disorder.
 1. Limit-setting
 2. Point system
 3. Behavioral charts and schedules
 4. Decrease in external stimuli
 5. Providing for large muscle activity to discharge motor activity
 6. Limit setting on disruptive behavior
 7. Clear explanation of expectations
 8. Encouraging positive peer activities
 9. Multidisciplinary coordination involving child’s teachers
 10. Opportunities and incentives for success
 11. Academic skills training
 12. Social skills training and problem solving
 13. Therapeutic recreation
 - Community resources
 1. Support groups such as Attention Deficit Disorder Association (ADDA), Attention Deficit Information Network (AD-IN), and Children with ADD (CHADD)
 2. Parenting classes—Systematic Training for Effective Parenting (STEP) and Parent Effectiveness Training (PET) classes

Conduct Disorder (CD) (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)

- Definition & signs and symptoms—Children with conduct disorder engage in repeated acts of anti-social behavior including aggression that endanger themselves and others. Conduct disordered behaviors include: multiple violations of rules (truancy), aggression to persons or animals, destruction of property, theft, deceitfulness, and all of which may violate the rights of others. The disorder occurs in about 5% of the general population.
- Associated features
 1. Early use of tobacco, alcohol, nonprescribed drugs
 2. Lack of empathy, guilt or remorse; often blaming others
 3. Low self-esteem covered by bravado with low frustration tolerance, irritability, and recklessness
 4. Poor academic achievement
 5. Other conditions including anxiety and depression; specific developmental disorder; ADHD a common comorbid finding
 6. Adolescent chemical dependency has a high degree of comorbidity
 7. Adult Axis II disorder of Antisocial Personality may be given by 18 years of age.
- Differential diagnosis
 1. Not diagnosed by single acts of antisocial behavior, but by persistent and repetitive pattern
 2. Different from Oppositional Defiant Disorder in that the rights of others are violated as well as major age-appropriate social norms
 3. Bipolar disorder usually representing brief manic episodes
 4. ADHD
 5. Substance abuse
 6. PTSD
 7. BPD
 8. Adjustment Disorder
 9. Narcissistic Personality Disorder
 10. Schizophrenia (JAACAP, 1997e)
- Mental status examination
 1. May present as angry or superficially friendly; self-centered, lacks empathy or concern for others.
 2. Major defenses include denial, projection; blames or implicates others.
 3. Has poor insight.
 4. May attempt to bully examiner and behave in coercive or threatening ways.
- Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective

2. Violence, [actual/] risk for other-directed
 3. Violence, [actual/] risk for self-directed
 4. Anxiety
 5. Role Performance, ineffective
 6. Social Interaction, impaired
- Genetic/Biologic origins/Biochemical interventions
 1. Conduct Disorder is common in children with antisocial and alcoholic parents.
 2. Low levels of 5-HIAA (associated with aggression and violence) may be present.
 3. Associated conditions, such as ADHD, depression or Posttraumatic Stress Disorder may be treated pharmacologically.
 4. Atypical antipsychotics have been useful in managing aggressive behaviors.
 5. Drug screens to identify drug use and abuse are indicated.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Fixed in separation-individuation phase
 - b. Retarded ego development; id driven
 - c. Child maltreatment and associated parental substance abuse and psychiatric illness
 - d. Poverty, psychosocial toxicity, lack of supportive community structure (JAACAP, 1997e)
 2. Psychotherapy (the earlier the intervention occurs, the better the outcome)
 - a. Multimodal therapy—incorporate behavioral interventions that promote prosocial, nonaggressive behavior.
 - b. Security and trust provide climate for growth.
 - c. Self-esteem can be enhanced by behavioral change and increased autonomy.
 - d. Understand dynamics of anger to establish locus of control; incorporate skills building in anger management (Bloomquist, 1996).
 - e. Recognize and express feelings to eliminate dysfunctional defenses.
 - f. Provide for processing grief and loss.
 - g. Computer-assisted self-evaluation and provision of alternatives are helpful due to massive use of denial to cover vulnerability.
 - Family dynamics/Family therapy
 1. Multiple moves or schools
 2. Inconsistent management; harsh discipline; poor parenting
 3. History of parental rejection
 4. Shifting of parent figures
 - 5. Paternal absence, alcoholism, and parental mental illness
 - 6. Large family size
 - 7. Early institutional living
 - 8. Association with delinquent subgroup
 - 9. Isolation of self in family
 - 10. Court involvement/Child Protective Services; often known to multiple agencies
 - 11. Family therapy aimed at intervening in dysfunctional dynamics and training in new approaches.
 - a. Work with strengths.
 - b. Train parents to be consistent and decrease both overly permissive and overly harsh responses.
 - c. Foster self-responsibility, differentiation of self and decrease blaming communication.
 - d. Allow for expression of grief and tenderness.
 - e. Multiple family therapy approaches may be beneficial.
 - f. Conduct family stress management.
 - Group approaches
 1. Allow for confrontation.
 2. Test new ways of relating, including practicing empathy.
 3. Model effective coping.
 4. Form healthy relationships with non-CD peers; promote appropriate peer network.
 5. Utilize exercises designed to deal with feelings, facilitate trust and develop healthy coping skills.
 6. Conduct psychosocial skills building.
 7. Refer to Alateen or Children of Alcoholics (COA) group.
 8. Provide chemical dependency assessment and referral to appropriate 12-step program or adolescent intensive outpatient program.
 9. Provide anger management training.
 10. Encourage alternatives to sexual promiscuity; sex education program (Jongsma, *et al.*, 1996).
 - Milieu interventions
 1. Crisis shelters when indicated, and residential treatment or group homes may be appropriate.
 2. Provide for physical safety of patient and others.
 3. Promote regulation of impulse control.
 4. Promote positive problem-solving abilities.
 5. Promote healthy expression of anger, such as providing safe place, e.g., gymnasiums, etc.
 6. Provide structured mechanisms for learning trust.

7. Disseminate accurate information about staff changes, turnover, etc. since changes may re-awaken old abandonment issues.
 8. Provide job and independent living skills training.
 9. Primary nursing promotes bonding with adult.
- Community resources
 1. Appropriate 12-step program
 2. Big Brother, Big Sister programs
 3. CASA (Court Appointed Special Advocates)
 4. Promoting sports, fitness activities
 5. Outward Bound therapeutic programs; boot camps
 6. Parents Involved Network
 7. Federation of Families for Children's Mental Health
 8. Case management is essential due to multiple agency involvement and family tendency to seek help only in times of crisis.
 9. Coordination with school and appropriate other community systems, such as juvenile probation and parole

Oppositional-Defiant Disorder (AACAP, 2007b; APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)

- Definition & signs and symptoms—Occurs in 16–20% of school-age children and is characterized by persistent patterns of disobedience, negativity, and hostility toward authority figures; failure to take responsibility for mistakes and placing blame on others. These behaviors are evidenced by frequent arguments with parents and other adults, annoyance with others, and a generally angry and resentful demeanor. There is an absence of aggression and destructive behavior characteristic of Conduct Disorder.
 - Differential diagnosis—diagnosis only made if behavior is more common than that of other children of the same age; usually defiance is only seen with adults and peers the child knows well, and is justified by the child.
 1. Conduct Disorder
 2. Passive Aggressive Personality Disorder
 3. Chemical dependency
 4. ADHD
 - Mental status examination
 1. Few signs of disorder are seen on mental status examination.
 2. When confronted with behavior, client often utilizes projection and blames others.
 3. Associated features include labile mood, bad temper, and low frustration tolerance.
 4. History, including teacher reports, is essential.
- Nursing diagnoses (NANDA, 2009)
 1. Coping, ineffective
 2. Anxiety
 3. Role Performance, ineffective
 4. Social Interaction, impaired
 - Genetic/Biologic origins/Biochemical interventions
 1. No information on familial pattern
 2. Age at onset by 8 years old, no later than early adolescence
 3. Medication for associated ADHD
 4. Antidepressants for associated depression
 - a. SSRI
 - b. Bupropion
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Treatment is focused on building behavioral management skills for the child and parent/caregiver.
 2. May be related to physical or sexual abuse, or both.
 3. Play therapy may be used to encourage awareness of feelings, facilitate disclosure of issues, learn new ways of effective coping. For preverbal children, play is the child's language and the toys are their words. How the toys are used in play themes (nurturing, power/control, protection, etc.) provides insight into the child's emotional world.
 - a. Board games
 - b. Talking, Feeling, Doing Game
 - c. The Ungame
 - d. Therapeutic stories
 - e. Role playing
 4. Conduct art therapy—drawing, modeling, clay, sand tray to process unconscious issues. Promote self-esteem and self-worth.
 5. Promote skill building in interpersonal relationships, anger management, increasing compliance and effective problem solving (Bloomquist, 1996).
 6. Provide social skills training.
 - Family dynamics/Family therapy
 1. Utilize family therapy to promote healthy family interaction and decrease tendency to pathologize child.
 2. Support parental hierarchy.
 3. Explore alternate ways of coping, especially assisting parents to avoid playing into oppositional tendencies.
 - Group approaches
 1. Encourage verbalization of feelings and develop positive social support mechanisms.

2. Learn alternate ways of coping.
 3. Psychodrama encourages trying out new behaviors.
 4. Provide positive reinforcement.
 5. Social skills groups can be useful.
 6. Promote positive peer relationships.
- Milieu interventions
 1. Children with this diagnosis are rarely admitted to inpatient settings, although they may have a dual diagnosis with a major mental health problem such as depression or Bipolar Disorder.
 2. Environmental activities and group process are necessary, as well as those mentioned under Conduct Disorder.
 - Community resources
 1. Parenting classes, such as STEP and PET
 2. Sports and team activities
 3. Wilderness and Outward Bound type programs
 4. Camps, YMCA, YWCA programs
 5. Big Brother, Big Sister
 6. See also resources in Conduct Disorder

Feeding and Eating Disorders of Infancy or Early Childhood

Pica

- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Pica is characterized by the eating of non-nutritive substances for a period of at least one month. More common among the very young and among those with mental retardation (up to 15% in MR population).
- Treatment interventions
 1. Determine etiology of eating of substances such as zinc or iron deficiency.
 2. Remove or eliminate access to toxic substances such as lead.
 3. Therapeutic intervention focus—psychological, environmental, behavioral strategies, and family education and guidance
- Community resources
 1. Public health nurses
 2. Well-child clinics
 3. Lead poisoning prevention programs
 4. Social services

Rumination Disorder of Infancy

- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—A rare feeding disorder of rumination, meaning “to chew a cud,” as evidenced by rhythmic sucking of the tongue and

regurgitation behavior (arching of back to initiate regurgitation of stomach content); the rumination is a self-soothing or self-stimulating behavior. Partially digested food is brought up into the mouth without nausea, retching, disgust. The food is ejected, or chewed and reswallowed. The condition is potentially fatal. With an onset after 3 months of age, children with this disorder usually have inadequate emotional interaction; rumination disorder may lead to failure to thrive.

- Differential diagnosis
 1. Congenital anomalies (e.g., pyloric stenosis)
 2. GI infections
- Nursing diagnoses (NANDA, 2009)
 1. Feeding Pattern, ineffective infant
 2. Attachment, risk for impaired
 3. Parenting, impaired
 4. Parenting, readiness for enhanced
 5. Knowledge, deficient (specify)
- Genetic/Biologic origins—no information; spontaneous remissions are common.
- Family dynamics/Family therapy
 1. Treatment is focused on education of caregiver and behavioral techniques.
 2. Parents may become alienated from the infant due to their frustration and his/her failure to respond.
 3. Noxious odor of the regurgitate may cause parent to avoid holding the infant.
 4. Health teaching regarding nature of illness and suggestions for coping are essential.
- Community resources—Public health nursing

Anorexia and Bulimia

- Definitions—Eating disorders are a risk for adolescents. Anorexia has a mortality rate of 10 to 15%. Hallmarks of these disorders are secretiveness, denial of the problem, and resistance to therapy or any treatment that will lead to weight gain (Mohr, 1998; Hartman & Burgess, 1998).
- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)
 1. Classic DSM-IV criteria may not be applicable.
 2. Begins in late school age (10 to 12 years old); onset most common between 12 and 18 years of age.
 3. Child does not have to lose the percentage of weight applicable for an adult with an eating disorder.

- a. Prepubertal children have lower percentage of body fat, and thin children may become unhealthy quickly.
 - b. Boys and girls present with childhood anorexia.
 - c. Affects 1 in 200 adolescent females.
- Intrapersonal origins/Psychotherapeutic interventions
 1. Origins
 - a. Adolescent anorexia
 - (1) Consider issues relative to puberty
 - (2) Separation dynamics and increased independence from family
 - (3) Increased autonomy in problem solving
 - (4) Peer pressure, including sexuality
 - (5) Difficulty with interpersonal intimacy and closeness
 - (6) May have a history of sexual trauma
 - b. Adolescent bulimia
 - (1) Generally not common in children; begins between ages 13 and 18
 - (2) Initiation into process of major life choices
 2. Psychotherapeutic interventions
 - a. Close coordination with medical care
 - (1) Establish minimum daily caloric intake.
 - (2) Initiate food journal.
 - (3) Monitor vomiting, bingeing, exercise, and laxative abuse.
 - b. Implement within the context of the adolescent's developmental, social, and academic needs.
 - c. Individual therapy
 - d. Group approaches
 - e. Family therapy—major component; need to understand dynamics of the family as a system (Antai-Otong, 1995).
 - f. Bibliotherapy

Tic Disorders (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)

- Definition—Tics are defined as sudden, rapid, recurrent, nonrhythmic, motor movements, vocalizations, repetitive movements, gestures, or utterances that mimic some aspect of normal behavior. Tics cannot be controlled, but can be suppressed for varying lengths of time. They are worsened by stress and diminished during sleep. Types include:
 1. Simple Motor Tics—eye blinking, facial grimacing
 2. Simple Vocal Tics—coughing, throat clearing, sniffing, snorting, barking

3. Complex Motor Tics—facial gestures, grooming behaviors, touching
4. Complex Vocal Tics
 - a. Repeating words and phrases out of context
 - b. Coprolalia—use of socially unacceptable words
 - c. Palilalia—repeating one's own sounds or words
 - d. Echolalia—repeating the last heard sound or word
 - e. Echokinesis—repeating someone else's movements

Tourette's Disorder

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Tourette's is characterized by multiple motor tics and at least one vocal tic that are not caused by a substance or medical condition—with onset prior to 18 years of age (average age at onset is 7 years old); and is 3 times more likely in boys than in girls. Tourette's is associated with ADHD and OCD in clinical populations.
- Differential diagnosis
 1. Abnormal motor movements associated with neurologic disorders
 2. Organic mental disorders
 3. Schizophrenia
- Mental status examination
 1. The definitive manifestations of these disorders may be present on assessment, or the caretaker may describe the salient features.
 2. There may be associated anxiety due to social situation embarrassment.
 3. Depressed mood is common.
- Nursing diagnoses (NANDA, 2009)
 1. Social Interaction, impaired
 2. Social Isolation
 3. Communication, impaired verbal
 4. Powerlessness
 5. Anxiety (related to unexpected manifestation of tics)
 6. Coping, ineffective
 7. Self-Esteem, chronic low
 8. Sensory Perception, disturbed/kinesthetic
- Genetic/Biologic origins
 1. Age-dependent expression of symptoms
 2. Familial patterns reported for all cases of tic disorders—more common in first degree biologic relatives of people with Tourette's

3. OCD more common in first degree biologic relatives of those with Tourette's than those with other tic disorders
 4. At least three times more common in males than females
 5. Controversy over association with:
 - a. Exposure to phenothiazines
 - b. Head trauma
 - c. Administration of CNS stimulants
 - d. Intrauterine environment
 - (1) Maternal life stress
 - (2) Complications of pregnancy
 - (3) First trimester nausea
 6. EEG abnormalities in 50% of patients
- Biochemical interventions
 1. Haloperidol (Haldol) has been effective in chronic tic disorders and Tourette's
 - a. Children 3 to 12 years old—initial dose: 0.025 to 0.05 mg/kg/day in divided doses, with gradual increase to 0.5 mg/kg in 5 to 7 days to bring symptoms under control
 - b. Children older than 12 years—initial dose: 0.5 to 5 mg two or three times daily; dosage increased by 0.5 to 1 mg increments to maximum dose of 100 mg/day
 - c. Side effects
 - (1) Similar to piperazine phenothiazines
 - (a) Low incidence of sedation and autonomic effects
 - (b) High incidence of extrapyramidal reactions
 - (2) Food and Drug Agency Pregnancy Category C
 2. Pimozide (Orap)—strongly antidopaminergic like haloperidol (Haldol)
 3. Other pharmacologic options include:
 - a. Clonidine (Catapres)
 - (1) Not as effective as Orap or Haldol
 - (2) No tardive dyskinesia risk
 - b. SSRIs (used alone or with antipsychotics) have been successful in treating Tourette's.
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Behavioral therapy can be effective in symptom modulation.
 2. Symptoms may be exacerbated by stress; autogenic relaxation and stress management may help the patient to self-regulate.
 3. Massed practice behavioral technique where patient practices intentionally the undesired behavior can be effective.
 4. Acceptance by therapist is a key in treatment.
 - Family dynamics/Family therapy

1. Parents need guidance in understanding biologic determinants of this disorder and in recognizing compulsive nature of behavior.
 2. Punishment may reinforce symptoms.
 3. Efforts to help child overcome socialization problems should be emphasized.
- Group approaches
 1. May benefit from inclusion in a diverse group with opportunity to receive support from other members.
 2. Self-help is an important aspect of care, and support groups are available in larger cities.
 - Milieu interventions
 1. Rarely admitted to inpatient unit unless associated with depression or ADHD.
 2. Provide opportunity to process feelings of differentness in the milieu as an extension of normal adolescent growth and development.
 - Community resources—Gilles de la Tourette Foundation

Chronic Motor or Vocal Tic Disorder

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—characterized by the presence of either motor or vocal tics, but not both.

Transient Tic Disorder

- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—characterized by the presence of single or multiple motor or vocal tics or both.
- Differential diagnosis for all tic disorders except Tourette's
 1. Other movement disturbances
 2. Neurological conditions
 3. Medication reaction
- Biochemical interventions—medication only used in very severe cases of Chronic Motor or Vocal Tic Disorder

Elimination Disorders

Enuresis

- Definition & signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Enuresis is a persistent, repeating pattern (intentional or unintentional) of voiding of urine into clothes or bedding after the age of 5 years; occurring at least twice weekly for 3 or more months (or causing significant social or academic distress/impair-

ment to the child); and is not a result of a physical condition.

- Differential diagnosis
 1. Medical conditions
 2. Urinary tract infection
 3. Anxiety disorders, e.g., phobias related to toileting
- Mental status examination
 1. Child may have low self-esteem due to caretaker rejection or social ostracism by peers.
 2. Incidence of associated major mental illness is greater among those with functional Enuresis than in the general population.
- Associated features
 1. Functional Encopresis, Sleepwalking Disorder, Sleep Terror
 2. Associated with other behavioral disorders and psychopathology, however, associated disorders may stem from Enuresis
- Nursing diagnosis (NANDA, 2009)—Urinary Incontinence, functional
- Biologic origins/Biochemical interventions
 1. Low functional bladder volume
 2. More males than females
 3. 75% have first-degree biologic relative with disorder
 4. Imipramine
 - a. 1.5 mg/kg/day to no more than 5 mg/kg/day
 - b. Side effects include:
 - (1) Dry mouth
 - (2) Constipation
 - (3) Tachycardia
 - (4) Drowsiness
 - (5) Postural hypotension
 - (6) Cardiac conduction slowing
 - c. ECG monitoring essential with baseline
- Intrapersonal origins/Psychotherapeutic interventions
 1. Secondary enuretics have same rate of emotional or behavioral problems as primary enuretics.
 2. Psychotherapy alone is not effective treatment, but may be helpful with associated psychiatric conditions.
 3. Hypnotherapy may be effective, although duration of recovery has not been substantiated.
 4. Behavioral techniques (conditioning)
 - a. Mowrer apparatus (bell and pad awaken child when he wets and work by a com-

bination of Pavlovian conditioning, avoidance learning, and placebo effect)

- b. Intermittent reinforcement and overlearning to reduce relapse
- c. Retention control training
- d. Training in rapid awakening
- e. Reinforcement for daytime micturition
- f. Avoiding negative social consequences
- g. Encouraging active participation
- h. Encouraging patient responsibility
- i. Challenging/confronting noncompliance (Jongsma *et al.*, 1996)

Encopresis

- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Defecating in inappropriate places (such as in clothing or other places) at least one a month for 3 consecutive months, after the age of 4 years; and the passing of feces is not caused by a physical condition. Usually resolves by 16 years of age. May be related to psychogenic megacolon—with bowel retention leading to constipation and eventually to chronic rectal distention—and desensitization to rectal pressure with deficient signaling of the urge to defecate. This condition can lead to overflow encopresis where leaking of small amounts of soft or loose bowel content can occur.
- Nursing diagnoses (NANDA, 2009)
 1. Bowel Incontinence
 2. Constipation
 3. Constipation, perceived
 4. Constipation, risk for
- Genetic/Biologic origins/Biochemical interventions
 1. 15% of fathers of encopretics were encopretic.
 2. Ratio of male-to-female encopretics ranges from 66% to 88% of samples.
 3. Common with mental retardation but poorly defined.
 4. Can originate from inadequate physiological functioning of defecation.
- Intrapersonal origins/Psychotherapeutic interventions
 1. Social learning theory attributes disordered learning or insufficient learning.
 2. Secondary encopresis involves learned avoidant behavior, reinforced by delay of painful defecation.
 3. Psychogenic theories formulated by Freud—compliance vs opposition in “anal period.”
 4. Treatment determined by thorough assessment.

- a. Toilet training needed if appropriate training has not taken place.
 - b. Provide positive behavioral reinforcement of appropriate toileting behavior.
 - c. Secondary encopresis related to more serious psychopathology—need to treat high levels of anxiety, anger, or depression.
 - d. If encopresis in response to severe environmental stress, modifying stressor brings relief.
- Family therapy for Enuresis and Encopresis
 1. Orient family counseling to supporting behavioral techniques.
 2. Treat family psychopathology if present; some theorists postulate issues of paternal distance and maternal anxiety, as well as parental absence.
 3. Support and management alternatives lessen parental pressure on child, enabling learning to take place; parental management training (PMT) can be effective.
 4. Explore rigidity in toilet training.
 5. Confront and challenge hostile and critical behavior.
 6. Interrupt cycle of hostile dependent angry interactions.
 7. Identify and defuse secondary gains (Jongsma, *et al.*, 1996).
 - Milieu interventions—behavioral techniques as outlined should be incorporated in care plan.
 - Community resources—parenting classes

Mood Disorders in Children and Adolescents

Depression

- Prevalence of depression is extremely low until 9 years of age, but rises sharply from 9 to 19, especially in females (Federal Interagency Forum on Child and Family Statistics, 2009; Lewisohn, Clarke, Seeley & Rhode, 1994).
- Signs and symptoms
 1. Same diagnostic criteria are utilized for children and adolescents as for adults. Depressed mood in children and adolescents may be expressed as irritability.
 2. The criteria for weight change or appetite disturbance in children is failure to achieve expected gain, or greater than 5% loss of body weight in 1 month.
 3. Declining academic performance
 4. Isolation and refusal to communicate
- Differential diagnosis
 1. Conduct Disorder and Oppositional-Defiant Disorder
 2. School phobias
 3. Learning problems
 4. Attention-deficit disorders
 5. Chemical dependency
 6. Anxiety disorders
 7. Specific developmental disorders
 8. Chronic illness
 9. Grief and loss/bereavement
- Family dynamics—experiences of abuse and violence, runaways, family chemical dependency, and having one or both parents with a mood disorder increases the risk.
- Suicide
 1. Adolescent depression is positively associated with suicidal behavior.
 2. Suicide incidence is rising among adolescents with mood disorders.
 3. Suicide attempts in children younger than 12 years of age are relatively rare (Johnson, 1997).
 4. Suicide attempts rise sharply at ages 13 to 14 years.
 5. Suicide is third leading cause of death for youth ages 15 to 24 years.
 - a. Highest rates occur in white males.
 - b. Next highest rates occur in nonwhite males.
 6. Risk factors for suicide include:
 - a. Affective illness—depression or mania
 - b. Parental divorce
 - c. Use of firearms
 - d. Antisocial or aggressive behavior
 - e. Family history of suicidal behavior
 7. Signs of suicide possibility include:
 - a. Change in grades
 - b. Giving away possessions
 - c. Decreased interest in after-school activities
 - d. Few friends
 - e. Breakup with girlfriend or boyfriend
 - f. Pressure by family to stop dating one person
 - g. Wearing black
 - h. Listening to morose or violent music
 - i. Drug and/or alcohol use
 - j. Discussing suicide
 - k. Self-mutilation (Botz & Bidwell-Cerone, 1997)
 8. Cluster suicides may be preceded by exposure to fictional suicide in media, completed suicide in a school system, and friendship with someone who has completed suicide.

9. Reducing suicide contagion
 - a. Avoid simplistic explanations for suicide.
 - b. Do not engage in repetitive discussion of the recent suicide event.
 - c. Do not provide graphic descriptions of suicide.
 - d. Do not glorify suicide or persons who commit it.
 - e. Focus on deceased's nonsuicidal characteristics (Botz & Bidwell Cerone, 1997).
 10. Nursing interventions include:
 - a. Monitoring potential for harm to self or other
 - b. Focusing on the motivations of the suicidal youngster
 - c. Coordinating the support system
 - d. Working with school-based crisis teams
 - e. Reinforcing patient's open expression of underlying feelings
 11. Psychotherapeutic interventions—efficacy of CBT, interpersonal therapy, behavior problem solving, brief solution-focused therapy have been reported (American Academy of Child and Adolescent Psychiatry [AACAP], 2007c).
 - Biochemical interventions (AACAP, 2007c; Sadock & Sadock, 2007; Stahl, 2008, 2009)
 1. SSRIs (e.g., sertraline, fluoxetine, fluvoxamine, paroxetine, citalopram, escitalopram), SNRIs (e.g., venlafaxine, desvenlafaxine), and NDRIs (e.g., bupropion) are first-line antidepressants. Caution: increased suicide risk—use with caution in children and adolescents, particularly in first months of treatment—monitor depressive symptoms and suicide ideation.
 2. Tricyclics are second-line treatment options and also carry increased risk for suicide among children and adolescents.
 - a. Tricyclic antidepressant (TCA)—seizures occur more frequently in children than in adults.
 - b. Rapid clearance may mean that therapeutic response takes longer in children than in adults.
- Bipolar Disorders (often not diagnosed or misdiagnosed in children and adolescents)***
- Signs and symptoms
 1. Adolescents—resemble the adult course of illness; 20% of all cases present prior to 19 years of age (AACAP, 2007d).
 2. Children younger than 9 years of age are more likely to present with irritability and affective lability (Johnson, 1995).
 3. Older children present with labile moods, paranoia, grandiose delusions, and other psychotic symptoms.
 - 4. Severe behavioral deterioration is present.
 - 5. Screening/psychological testing may be utilized in diagnostic evaluation.
 - a. Children's Depression Inventory (CDI)
 - b. School-Age Depression Listed Inventory (SADLI)
 - c. Bellevue Index of Depression (BID)
 - d. Children's Depression Rating Scale—Revised
 - e. Mania Rating Scale
 - Differential diagnosis
 1. Effects of drug/medication use, e.g., corticosteroids, sympathomimetics, isoniazid, antidepressants, stimulants
 2. Abusive substances, e.g., amphetamines, cocaine, inhalants, phencyclidine (JAACAP, 1997d)
 3. Endocrine disorders, such as hyperthyroidism
 4. Neurologic conditions, such as head trauma, temporal lobe seizures, tumors, HIV, multiple sclerosis
 5. Infections—encephalitis, influenza, syphilis
 6. The following psychiatric conditions:
 - a. Childhood disruptive disorders
 - b. PTSD
 - c. Substance abuse
 - d. Schizophrenia
 - e. Schizoaffective Disorder
 - f. Borderline Personality Disorder
 - g. Agitated depression
 - Mental status examination—presentation similar to adults
 1. Adolescents may have psychotic symptoms.
 2. Markedly labile and erratic symptoms
 3. Severe behavioral deterioration
 - Nursing diagnoses—same as for adult bipolar disorders
 - Genetic/Biologic origins (See also Mood Disorders chapter)
 1. Affects both sexes equally
 2. Males more affected in early onset cases
 - Biochemical interventions (AACAP, 2007d)
 1. Medication management addresses manic or mixed symptoms, depressive symptoms, and prevention of relapses.
 2. Lithium is the only agent with FDA approval for Bipolar Disorder in youth (approved for children 12 years of age and older)
 - a. Renal clearance of lithium is higher in children than in adults; children and adolescents may require higher dosages to

- achieve therapeutic blood levels (Antai-Otong, 1995).
 - b. Complete physical examinations and baseline laboratory studies must be done prior to initiating drug therapy.
 - c. Children and adolescents often tolerate lithium better than adults.
 - d. Dosage ranges from 600 mg daily for a weight of 15 to 25 kg given in divided doses to 1500 mg per day for a weight range of 50 to 60 kg given in divided doses.
 - 3. Anticonvulsant mood stabilizers and atypical antipsychotic agents approved for adult treatment of manic symptoms have also been used in treating children and adolescents.
 - a. Anticonvulsant mood stabilizers
 - (1) Carbamazepine (Tegretol) is given in doses of 15 to 30 mg/kg/day
 - (2) Valproic acid (Depakene) given in nonresponse to lithium or Tegretol—dose is 25 to 60 mg/kg/day, with a blood level of 50 to 120 mEq/L
 - b. Atypical antipsychotics (e.g., aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
 - 4. Benzodiazepines are a possible adjunct for acute mania and SSRIs for management of associated depression.
 - 5. Neuroleptics
 - 6. Antimania agents
 - 7. ECT
- Intrapersonal origins/Psychotherapeutic interventions
 - 1. Mania is common among families—it is thought that bipolar parents may exercise inadequate parenting techniques.
 - 2. Cohort effect indicates increased incidence of bipolar illness in individuals born after 1940.
 - 3. Hospitalization is frequently indicated.
 - 4. Age-specific psychotherapy/play therapy—CBT and/or interpersonal therapy may be useful to address skill building, and monitoring of symptoms/progress.
 - Family dynamics/Family therapy
 - 1. Psychoeducational approaches essential for patient and family.
 - 2. Psychotherapeutic interventions include:
 - a. Support and empathy
 - b. Academic and occupational functioning
 - c. Social and family functioning
 - d. Relapse prevention
 - 3. Biologic origins of this disorder must be taken into account (therapist may be dealing with several bipolar persons in family).

- Group approaches
 - 1. Self-esteem group
 - 2. “Time out” provided to protect other group members
 - 3. Addressing associated psychological problems
 - 4. Anger management
- Milieu interventions
 - 1. Same as adults, but modified for developmental level
 - 2. Must provide safe environment for other patients

Anxiety Disorders in Children and Adolescents

- Definition—Powerlessness, increased dependency, impaired self-esteem, and poor social skills are common manifestations of anxiety disorders in children. Child and adolescent anxiety disorders are on a continuum with, and may become adult anxiety disorders. Retrospective studies of adults with anxiety disorders indicated that 65% had two or more anxiety disorders as children. Insecurely or ambivalently attached infants develop more anxiety diagnoses in childhood and adolescence. Behavioral inhibition is a risk factor in the development of anxiety disorders in young children. Anxiety disorders in children do not appear in isolation. They are part of an array of other symptoms and traits.

Separation Anxiety Disorder

- Definition & signs and symptoms (AACAP, 2007e; APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Separation anxiety disorder (commonly termed stranger anxiety) is one of two anxiety disorders found in the child and adolescent section of the DSM-IV-TR. This disorder is characterized by persistent fear, shyness, and social withdrawal when confronting unfamiliar people and settings; the disorder is diagnosed when upon separating from a major attachment figure, the child exhibits intense, excessive, and developmentally inappropriate fear/anxiety. The anxiety must be present for at least 1 month and produce significant impairment in functioning at home, school, or with friends. The fear/anxiety is manifested by reluctance or refusal to separate from the attachment figure and nightmares about separation; occurs in about 15% of all children and 4% of school-age children.
- Differential diagnosis
 - 1. Somatic complaints
 - 2. Developmentally appropriate separation anxiety

3. Overanxious disorder
 4. Panic Disorder with Agoraphobia
 5. PDD or Schizophrenia
- Mental status examination
 1. May refuse to separate from parent.
 2. May cling or cry and fuss if parent tries to leave; if separated, checks frequently in spite of reassurances and knowledge that parent is close by.
 - Nursing diagnoses (NANDA, 2009)
 1. Anxiety—mild, moderate, severe
 2. Coping, ineffective
 3. Powerlessness
 4. Self-Esteem, situational, low
 5. Social Interaction, impaired
 6. Social Isolation
 7. Fear
 - Genetic/Biologic origins/Biochemical interventions
 1. Specific developmental disorders involving language and speech may predispose to this condition.
 2. Mothers with anxiety disorders more common in this population according to some studies.
 3. More common in females than males.
 - Interpersonal origins/Psychotherapeutic interventions
 1. Moderate to catastrophic stressor as defined on Axis IV may contribute.
 2. More research needed on genetic vs environmental transmission.
 3. Brief, symptom-focused therapy approaches include:
 - a. Psychodrama
 - b. Art work
 - c. Play therapy utilizing role play, doll house, sand box, puppets to explore anxieties, fears, and worries
 - d. Therapeutic games, storytelling to expand awareness
 - e. Emphasis on symptom reduction, empowerment, mastery and control
 - f. Goal to decrease symptoms quickly to enhance functioning, avoid permanent dysfunction
 - g. Relaxation training—diversion, deep breathing; muscle relaxation (Jongsma *et al.*, 1996)
 - Family dynamics/Family therapy
 1. Decrease anxiety and rigidity in parental system.
 - 2. Decrease conflict and increase problem-solving.
 - 3. Clarify communication.
 - 4. Increase individual autonomy and decrease fusion.
 - 5. Take focus off child as symptom-bearer.
 - 6. Educate parents re: developmentally normal anxiety.
 - 7. Educate parents to decrease their own anxiety and overprotection.
- Group approaches
 1. Self-esteem group
 2. Play therapy group
 3. Theraplay
 4. Organized and informal play/sports opportunities
 - Milieu interventions
 1. Highly unusual to admit these children to an inpatient setting; treated as outpatients
 2. Organization and predictability helpful, while gradually fostering child's independence and self-reliance
 - Community resources
 1. Educational programs for parents
 2. Church and sports activities
- Selective Mutism (Elective Mutism)**
- Definition & signs and symptoms (APA, 2000; Sadock & Sadock, 2007)—Although fully capable of speaking competently, children with selective mutism remain completely silent or whisper nearly inaudible one-syllable words when experiencing a socially anxiety-producing situation, most typically at school. Selective mutism is one of two anxiety disorders found in the child and adolescent section of the DSM-IV-TR. The disorder has been associated with Social Phobia, and may be a subtype of social anxiety/social phobia. Familial factors contributing to selective mutism (and other anxiety conditions) include maternal anxiety, depression, and heightened dependency needs.
 - Differential diagnosis
 1. Severe or Profound Mental Retardation, Pervasive Developmental Disorder, Developmental Expressive Language Disorder
 2. Children of families who have recently emigrated to a country of a different language
 3. Organic factors/medical problems
 - Mental status examination
 1. Attempts to engage the patient in conversation are futile, although the presence of adequate receptive language is apparent.

2. May communicate by gestures, nodding or shaking head, or by short monotone utterances.
- Nursing diagnoses (NANDA, 2009)
 1. Anxiety [specify level]
 2. Coping, ineffective
 3. Fear
 4. Powerlessness
 5. Self-Esteem, chronic low
 6. Social Interaction, impaired
 7. Communication, impaired verbal
 - Biologic origins/Biochemical interventions (Sadock & Sadock, 2007)
 1. May be related to neurobiologic precursor of Anxiety Disorder, specifically Social Phobia
 2. A multimodal approach to treatment, incorporating Cognitive-Behavior therapy, psychoeducation, and medication (SSRI), is recommended.
 3. SSRIs shown to decrease anxiety in selective mutism include:
 - a. Fluoxetine—20 to 60 mg/day for children older than 8 years
 - b. Sertraline—25 to 200 mg/day for children older than 6 years
 - c. Paroxetine—10 to 50 mg/day for children older than 7 years
 - Intrapersonal origins/Psychotherapeutic interventions
 1. Associated with shyness and other oppositional behavioral problems.
 2. Case histories report symptoms developed following reprimand for verbalization.
 3. Challenging to treat since these patients don't talk to therapist and often passively refuse nonverbal communication.
 4. Psychoanalysis reportedly is beneficial.
 5. Behavior therapy may be beneficial.
 6. Resolve core conflict contributing to mutism so patient speaks consistently in all social situations.
 - Family dynamics/Family therapy
 1. Maternal overprotection
 2. Major personality or psychiatric conflict or a combination of both
 3. Families seen as vulnerable to a hostile world
 4. Symptom seen as an expression of family conflict
 5. Silence used as manipulation
 6. Increased rate of psychiatrically ill/abnormal family dynamics
 7. Family therapy and school counseling essential
 - a. Confront family denial so parents cooperate with treatment plan.
 - b. Assist in developing realistic expectations.
 - c. Teach effective communication skills to family.
 - d. Utilize parent-training models to enhance child and family coping (Elder, 1997).
- Group approaches—not indicated—although preschool children may benefit from a therapeutic nursery/preschool setting.
 - Milieu intervention—provide reinforcement for verbal responses.
 - Community resources
 1. Parenting classes
 2. Socialization and sports activities
- Anxiety Disorders Not in Child and Adolescent Section of DSM-IV-TR**
- Social Phobia** (See also Anxiety and Stress Related Disorders chapter)
- Definition & signs and symptoms (AACAP, 2007e; APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—Avoidant behaviors in children and adolescents are manifested as persistent or extremely constricted social interaction with unfamiliar people. There is fear of acting in a humiliating or embarrassing manner.
 - Differential diagnosis for anxiety disorders
 1. Physical conditions
 - a. Hypoglycemic episode
 - b. Hyperthyroidism
 - c. Cardiac arrhythmias
 - d. Caffeinism
 - e. Pheochromocytoma
 - f. Seizure disorders
 - g. Migraine
 - h. CNS disorders
 2. Medication reactions
 - a. Antihistamines
 - b. Anti-asthmatics
 - c. Sympathomimetics
 - d. Antipsychotics
 - e. Nonprescription drugs, e.g., diet pills, cold medicine (JAACAP, 1997b)
 3. Mood disorders
 4. ADHD
 5. Adjustment Disorder
 6. Substance-Use Disorder
 - Etiology
 1. Modeling of shy aloof behaviors by primary caregivers

2. Child abuse
3. Early traumatic childhood losses
4. Chronic medical problems
5. Impaired social skills

- If continued into adulthood, becomes Avoidant Personality Disorder

Generalized Anxiety Disorder (includes Overanxious Disorder of childhood) (See also Anxiety and Stress Related Disorders chapter)

- Children with this disorder are extremely sensitive.
- Overanxious behavior is exaggerated during times of stress.
- Overly concerned about social performance and competency.

Obsessive-Compulsive Disorder (See also Anxiety and Stress Related Disorders chapter)

- Thought to be rare in children until recently.
- Symptoms in children include obsessive thoughts, rituals, such as washing, checking, and repeatedly rewriting letters or numbers until perfect.
- Adults realize the behaviors are unreasonable; children may not.

Panic Disorder—uncommon before the prepubertal period; peak age of onset is 15–19 years of age

Posttraumatic Stress Disorder (See Anxiety and Stress Related Disorders chapter)

Treatment Measures—should be a multimodal approach incorporating behavioral/CBT, psychodynamic, family therapies as well as pharmacotherapy.

- Biochemical interventions (AACAP, 2007e; Sadock & Sadock, 2007; Stahl, 2008, 2009)
 1. SSRIs have emerged as the medications of choice for treating childhood anxiety disorders (monitor for increased risk of suicidality)—complete routine screening for Bipolar Disorder prior to initiating treatment with SSRIs.
 - a. Fluoxetine (20 to 60 mg/day)—OCD, panic disorder
 - b. Fluvoxamine (50 to 200 mg/day divided)—OCD
 - c. Escitalopram (10 mg/day)—GAD
 - d. Paroxetine (10 to 60 mg/day)—GAD, OCD, Panic Disorder, PTSD, Social Anxiety Disorder
 - e. Sertraline (25 to 50 mg/day)—OCD, Panic Disorder, PTSD

2. Tricyclic antidepressants (imipramine, clomipramine) have been successful in treating school phobia—use customary TCA protocol including baseline vital signs, ECG, and serum levels.
3. Buspirone (Bernstein, Borchadt, & Perwein, 1996; AACAP, 2007e)
4. Other medications such as antispasmodics and antihistamines
5. Benzodiazepines have not shown efficacy in child/adolescent anxiety disorders.

- Psychotherapeutic interventions
 1. Objectives
 - a. Overcoming fear of threat
 - b. Differentiating and understanding various feelings
 - c. Elevating self-esteem and feelings of security
 - d. Understanding the link between feelings, thoughts, and behaviors
 - e. Understanding that arousal is a symptom of fear
 - f. Enhancing problem-solving skills
 - g. Gaining a sense of mastery
 - h. Developing adaptive coping skills
 - i. Resolving core conflicts
 - j. Eliminating anxiety
 2. Psychotherapy
 - a. Systematic desensitization
 - b. Exposure and response prevention
 - c. Cognitive-Behavioral Therapy
- Family therapy—psychoeducation for parents to help reinforce healthy parenting skills
 1. Support child's increasing autonomy and competence.
 2. Modify family functioning.

■ OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

Reactive Attachment Disorder (RAD) of Infancy or Early Childhood

- Definition & signs and symptoms (American Academy of Child & Adolescent Psychiatry, 2005; APA, 2000; Sadock & Sadock, 2007)—RAD involves abnormal social behaviors in young children as a result of an environment of maltreatment (involving sensory deprivation and neglect) that interfered with the development of normal attachment behaviors. RAD is characterized by a lack of a clearly identified attachment figure, nonresponsiveness, excessive inhibition, hypervigilance, indiscriminant socialization, or disorganized attachment behaviors. RAD is divided into two subtypes:

1. Inhibited type—emotionally withdrawn—failing to initiate or respond, in a developmentally appropriate manner, to most social interactions; experiencing hyper-arousal, difficulty in regulation of emotion (irritability, anger/aggression in response to efforts to comfort)
 2. Disinhibited type—indiscriminant sociability—little, if any, fear of strangers; seeking and accepting comfort from unfamiliar adults; sometimes considered to be emotionally shallow, attention seeking, and interpersonally superficial
- Differential diagnosis
 1. Physical examination to determine/treat factors contributing to disturbance in rates of growth and development
 2. Mental Retardation or Pervasive Developmental Disorder, such as Autistic Disorder
 3. Children with severe neurological abnormalities, including deafness, blindness, profound multisensory defects, major central nervous system disease, or severe chronic physical illness
 - Mental status examination
 1. Lack of developmentally appropriate social responsiveness
 2. Apathy and lack of interest in environment
 3. Child may stare, have weak cry and poor muscle tone, as well as low motility.
 4. Home visit often required to investigate neglect or abuse since caregiver reports not reliable.
 - Nursing diagnoses (NANDA, 2009)
 1. Parenting, risk for impaired
 2. Role Performance, ineffective
 3. Social Interaction, impaired
 4. Caregiver Role Strain, risk for
 5. Attachment, risk for impaired
 6. Growth and Development, delayed
 - Intrapersonal origins/Psychotherapeutic interventions—response to neglect/provision of adequate caretaking
 - Family dynamics/Family therapy
 1. Parents—severe character pathology
 2. Severe depression, isolation, and lack of support systems
 3. Lack of bonding in first weeks of life
 4. Transgenerational pattern of dysfunctional parenting, abuse, neglect, and mental illness
 5. Overwhelming psychosocial stresses in parents with emotional deficits
 6. Family therapy
 - a. First, engage principle caregiver (then other relevant family members) in treatment.
 - (1) Therapist can act as coach for caregiver to promote child's healthy attachment behaviors.
 - (2) Alternatively, therapist can model attachment-promoting behaviors in dyadic work with caregiver in joint therapy with child.
 - b. Identify family stresses.
 - c. Assess family resources.
 - d. Assess and intervene in dysfunctional conflicts affecting child's well-being.
 - e. Supervise care.
 - f. Recommend out-of-home placement if necessary.
 - Milieu interventions
 1. Does not meet criteria for psychiatric hospitalization.
 2. Patient may be placed in infant home or pediatric unit to treat other conditions while awaiting placement; cuddling and stimulation essential; staff may model appropriate behavior for parents.
 - Community resources
 1. Community mental health parent support groups
 2. Parenting classes
 3. Public health nursing
 4. Pediatric/family-centered outpatient program
 5. Child protective services
 6. Child abuse prevention services
 7. Multidisciplinary team approach—case management and coordination of care essential

Stereotypic Movement (Formerly Stereotypy/Habit) Disorder

- Signs and symptoms (APA, 2000; Keltner *et al.*, 2007; Sadock & Sadock, 2007)—characterized by repeated voluntary, often rhythmic movements (head banging, hand/arm biting, hand flapping, rocking); more frequently occurs in PDD and Mental Retardation.
- Differential diagnosis
 1. Normal rocking and thumb-sucking are common in infants and young children.
 2. Pervasive Developmental Disorder, Tic Disorder, and Obsessive-Compulsive Disorder
- Mental status examination—behavior appears compulsive and involuntary.

- Nursing diagnoses (NANDA, 2009)
 1. Injury, risk for
 2. Behavior, risk-prone health
 - Biologic origins
 1. Common in Mental Retardation
 2. Associated with congenital deafness and blindness
 3. Associated with degenerative and CNS disorders
 4. Temporal-lobe epilepsy and severe Schizophrenia
 5. May be induced by certain psychoactive substances such as amphetamine, in which case the diagnosis of Psychoactive Substance-Induced Organic Mental Disorder should also be made
 - Treatment measures
 1. Promote safety and reduced episodes of self-injury.
 2. Behavioral techniques (habit reversal differential reinforcement of alternative behavior) and pharmacological interventions have yielded successful results.
 3. Dopamine agonists, specifically phenothiazines, such as haloperidol, chlorpromazine (Thorazine) have been the most frequently used medications for treating stereotypic movement/injurious behaviors
 4. Haloperidol—Children older than 3 years—initial dose: 0.05 to 0.15 mg/kg/day in divided doses, with gradual increase to 0.5 mg/kg in 5 to 7 days to bring symptoms under control; maximum dose of 100 mg/day. Side effects include sedation, headache, extrapyramidal symptoms, tardive dyskinesia, neuroleptic malignant syndrome, orthostatic hypotension, photosensitivity, anorexia, constipation, paralytic ileus, impaired liver function, hypersalivation, agranulocytosis, anemia, leucopenia, cough reflex suppression, laryngeal edema, bronchospasm, diaphoresis
 5. The efficacy of opiate antagonists in reducing self-injury is presently under study.
 - Family dynamics/Family therapy—provide family support and information re: management and pharmacology.
2. Associated with mood, anxiety, and disruptive behavior disorders.
 3. Adolescent drug and alcohol abuse is major health problem and precedes later drug and alcohol dependency.
 4. Disrupts adolescent's ability to meet developmental tasks.
 5. Associated with:
 - a. Accidents, suicides, and psychiatric illness
 - b. Dual diagnosis, especially depression, ADHD, and Conduct Disorder
 - c. Teenage pregnancy, infant morbidity and mortality, high-risk sexual behavior and STDs
 - (1) Children of cocaine-addicted mothers may experience difficulty in bonding; at risk for multiple problems, including low birth weight.
 - (2) Cocaine interferes with parental bonding and empathy.
 - (3) Infants born to alcohol-dependent/alcohol-addicted mothers are at risk for fetal alcohol syndrome; infants are difficult to soothe, are at high risk for later developmental abnormalities, disruptive behavior disorders, and mental retardation.
 - d. Parental substance use
 - e. Emotional distance between parent and adolescent and lack of involvement in adolescent's life
 - f. Lack of supervision and discipline
 - g. Low self-esteem, high population density, high crime (JAACAP, 1997g)
 6. Developmental issues are often delayed, disrupted, or arrested when adolescents become substance abusers.
 7. Strong evidence exists to support a genetic or constitutional risk for SUD.
 8. Diagnostic/Screening instruments include the Teen Addiction Severity Index (T-ASI) and Adolescent Drug and Alcohol Diagnostic Assessment (ADAD).
 9. Treatment programs use interventions similar to adult programs (12-step programs, family involvement, reliance on group confrontation)
 - a. Treatment is designed to prevent substance-use behaviors and provide education for patient and family.
 - b. Address coexisting behavioral and psychiatric problems; family functioning, academic functioning, and peer relations (JAACAP, 1997g).
 - c. Substance abuse is often a way of dealing with chronic stress and family dysfunction, so entire family must be targeted for intervention.

Substance-Use Disorders (SUD) in Childhood & Adolescence (Sadock & Sadock, 2007)—See also Substance-Related Disorders chapter

1. Prevalence rate among adolescents is 32%; higher among those at high risk for social impairment.

10. Level of treatment service decisions can be determined using the Child and Adolescent Levels of Care Utilization Services (CALOCUS) instrument (levels range from 0 to 6; 0 = basic preventative services, whereas 6 = secure/locked inpatient setting with intensive 24-hour care).

Early-Onset Schizophrenia (EOS)/ Childhood-Onset Schizophrenia (COS)

- Definition & signs and symptoms: (APA, 2000; Sadock & Sadock, 2007)
 1. Onset of psychotic symptoms before 12 years of age (prepuberty) for COS; after for EOS; onset before 6 years of age very rare.
 2. Similarity of cognitive, neurologic, and linguistic deficits suggests the same disorder as adults, with greater severity and chronicity.
 3. Same criteria used as for adults, but difficulties in applying criteria to children.
- Differential diagnosis
 1. Autism and other pervasive developmental disorders
 2. Neurological disorders
 3. Multidimensionally impaired (MDI)
 - a. Mood lability and social ineptness present but not social withdrawal
 - b. Most meet criteria for ADHD
 - c. Fleeting hallucinations
 - d. Odd thinking, often in conjunction with language disorder
 4. Affective disorder—psychosis associated with Bipolar Disorder often misdiagnosed as Schizophrenia
 5. Medical conditions and pharmacological agents (stimulants)
 6. Substance abuse
 7. Dissociative states
 8. Trauma-related symptoms
 9. Associated with Borderline Personality Disorder (Volkmar, 1996; (JAACAP), 1997f)
 10. Easier to diagnose in adolescents (EOS) than children (COS)
 - a. Inability of preschool children to use rules of logic or notions of reality makes it difficult to establish delusions or thought disorder.
 - b. Focus on disorganized speech makes it difficult to evaluate a child with a language disorder.
 - c. Hallucinations difficult to distinguish from sleep-related and other developmental phenomena.
 - d. Need accurate information about premorbid functioning.
- Nursing diagnoses—same as adults
- Biologic origins:
 1. Neurodevelopmental models suppose a fixed lesion in interaction with a combination of genetic or nongenetic factors such as early viral CNS infection, autoimmune mechanisms, or pregnancy/birth complication.
 2. Association of Asperger's with psychotic phenomena in children has been found.
 3. Children with EOS may come from families with greater prevalence of disorder.
 4. Chromosomal abnormalities/prenatal insult is possible.
 5. Eye-tracking abnormalities reported in adolescents at risk for Schizophrenia; smooth pursuit abnormalities, or the inability to track a moving object with the eyes, specific for vulnerability to Schizophrenia.
 6. Information processing deficits could underlie illogical thinking and loose associations.
 7. Position Emission Tomography (PET) evaluation shows striking right posterior parietal hypometabolism.
- Mental status examination
 1. Prodromal illness, exaggeration of that seen in adults
 2. Motor clumsiness
 3. Speech and language problems
 4. Delay in language acquisition
 5. Early diagnosis of disruptive or avoidant behaviors
 6. Positive and negative symptoms
 7. Auditory hallucinations most frequent, somatic and visual, less frequent
 8. Higher baseline levels of thought disturbance
 9. Loose associations and illogical thinking not typically seen in normal children after 7 years of age
- Biochemical interventions
 1. Similar medications used with both adults and children.
 2. Atypical antipsychotics, such as risperidone and clozapine useful due to limited extrapyramidal side (EPS) effects; side effects of clozapine include agranulocytosis, and need close monitoring.
 3. Comorbid depression may guide choice of agents in polypharmacy.
 4. Since onset of therapeutic effect not apparent until some time after treatment started, rapid switching of agents is not helpful.
 5. Stimulant use contraindicated due to capacity to induce psychotic symptoms (Volkmar, 1996).

- Psychotherapeutic interventions
 1. Individual therapy based on the following factors:
 - a. Developmental stage
 - b. Degree of active thought disorder
 - c. Ability to tolerate intimacy, and assessment of the degree of importance of the relationship to the child
 - d. Encouragement of focus on reality of outside world
 - e. Refocusing disordered thinking
 - f. Setting limits on inappropriate behavior (Jongsma, Peterson & McInnis, 1996)
 2. Supportive therapy based on whether expression or suppression of affect is desired
 3. Expressive therapy
 4. Social skills training
 5. Special educational interventions
- Family dynamics/Family therapy
 1. Parents often report children appeared normal at birth.
 2. Families experience profound sadness, guilt, and self-blame; older theories of “schizophrenogenic mothers” and cold, rejecting parents may still be held by some mental health professionals.
 3. Parents may view themselves as victims of child’s disorder.
 4. Lack of respite care and services places additional burdens on family.
 5. Family therapy with psychoeducational approaches fosters clear communication.
- Group approaches—enhance socialization skills
- Milieu interventions
 1. Facilitate child’s highest level of functioning.
 2. Facilitate age appropriate skills.
 3. Consistency and predictability essential.
 4. Use isolation sparingly to facilitate child’s integration into unit (Johnson, 1995).
 5. Staff needs education and help with child’s uneven developmental presentation and variety in functioning.
 6. Expectations must be realistic.
- Community resources
 1. Support groups for parents
 2. National Association for the Mentally Ill (NAMI)
 3. Case management services to coordinate diverse services
 4. Federation of Families for Children’s Mental Health
 5. Parents of Schizophrenics

- Nursing research agenda
 1. Outcome studies of treatment models that best facilitate patient functioning
 2. Impact of illness on siblings

Personality Disorders

- Although personality disorders are not generally included in the disorders of infancy, childhood, and adolescence, the presentation, defenses and symptomatology of these disorders are presaged by the childhood disruptive behavior disorders. According to DSM IV-TR (APA, 2000), one may see the following personality disorders or the initial signs in older children or adolescents:
 1. Antisocial
 2. Avoidant
 3. Borderline
- Signs and symptoms—See Behavioral Syndromes and Disorders of Adult Personality chapter
- Biologic/Intrapersonal origins
 1. Faulty ego functioning may be related to developmental arrests in childhood as well as genetic predisposition and trauma (See Behavioral Syndromes and Disorders of Adult Personality chapter)
 2. Primitive defenses of personality disorders may be triggered by experiences of poor parenting, family dysfunction, and inadequate caretaking.
 3. Children reared in unstable environments have low self-esteem, lack trust, and have poor social skills.
 4. Early trauma, including physical abuse and sexual abuse.
- Family dynamics/Family therapy
 1. Parents lack empathy and affection; often rejecting and chaos ridden.
 2. Family substance abuse, mental illness, abuse, and violence may be present.
 3. Review family and environmental dynamics for Conduct Disorder.

■ TREATMENT MODALITIES FOR MENTAL DISORDERS IN CHILDHOOD AND ADOLESCENCE

- Individual psychotherapy—current treatment of child and adolescent mental disorders involves a multimodal approach (Keltner *et al.*, 2007; Sadock & Sadock, 2007).
 1. Supportive therapy
 2. Play therapy—historically, the most commonly used modality with children; play therapy is

an intervention defined as the purposeful use of toys and other equipment to assist the child in communicating his or her perception of the world and to help him or her master environment (Zimmerman, 1997); play therapy has not received the empirical support that other therapies (CBT, interpersonal therapy) have experienced. Behavioral play (practice/rehearsal exercises) can help child learn and experience new ways of behaving.

3. Behavioral modification—behavior therapists actively direct treatment.
 - a. Most useful when implemented in home, classroom, and with individual child.
 - b. Parents taught behavioral management strategies.
 - c. Children and adolescents learn self-control and relaxation techniques.
 - d. Treatment goals are mutually set with child, therapist, and parents.
 - e. Compatible with solution focused, short term approaches. (Zimmerman, 1997).
 4. Cognitive therapy is beneficial for children aged 9 to 10 and older; cognitive therapy enables child and adolescent to utilize coping self-statements and to overcome dysfunctional cognitive distortions.
 5. Skills training has as its goal helping children achieve competence in mastering developmental tasks and to make use of environmental and personal resources to achieve a good outcome (Bloomquist, 1996)
- Group approaches
 1. Childhood
 - a. Social skills groups
 - b. Emotional expression
 - c. Behavioral expression
 - d. Protection from unsafe environment
 - e. Coping with divorce, separation, and blended families
 - f. Recovery groups for children of substance abusing parents
 - g. Art therapy groups for identification and expression of feeling
 2. Adolescence
 - a. Peer relationships
 - b. Substance abuse recovery/12-step group
 - c. Communication with parents
 - d. Coping with divorce, separation, and blended families
 - e. Critical incident debriefing
 - f. Decreasing impulsive and high-risk behavior
 - Family dynamics/Family therapy
 1. Helps family achieve healthy coping and interrupts behaviors that maintain child or adolescents symptoms
 2. Usually a mandatory component of a child's therapeutic environment; parental involvement is strong predictor of positive outcomes for child
 3. Problems treated:
 - a. Communication and expression of feelings among family members
 - b. Limit-setting skills
 - c. Rules, consequences, and rewards
 - d. Dealing with separation dynamics
 - Milieu interventions
 1. Physical setting
 - a. Age-appropriate furniture that is mobile for arranging small conversation area
 - b. Games, puzzles, books and toys geared to developmental level of residents
 - c. Provision for safety
 - d. Sociopetal structure with all client rooms entering a central family room to foster interaction and support safety
 - e. Warm, home-like ambience with pictures, plants, padded furniture
 - f. Provision for privacy in sleeping, dressing, and bathing while allowing necessary monitoring and supervision
 - g. Respect for children's and adolescents' need for own "space" for possessions, school work, writing, etc.
 - h. Provision of active orientation to treatment
 - (1) Bulletin boards with calendars, schedules, staff names
 - (2) Patient names, assignments, primary therapist and staff member, privilege level and point system
 2. Structured treatment programs
 - a. Philosophy—child and adolescent programs often based on a family systems model with developmental perspective
 - (1) Inpatient unit becomes a family that provides for expression of feelings, effective communication between members, development of coping skills, and positive recreational experiences.
 - (2) Family life simulated with meal preparation and other routine activities; birthdays and celebrations are planned and implemented.
 - b. Rules, limit setting, and consequences
 - (1) Unit rule books

- (2) Consistency in application of rules and consequences
 - (3) Peer or buddy system for older children and adolescents
 - (4) Positive reinforcement rather than punishment
 - (5) Point system for privileges with higher points indicating a higher level with more privileges
 - (6) Recognition in community meeting
 - (7) Limit setting on a continuum with positive social interaction at one end and time out on the other
 - (a) Positive social interaction such as smiles, nods, and encouragement
 - (b) Extinction is used for mildly inappropriate behaviors by withholding positive reinforcements or ignoring behavior; inappropriate behavior usually escalates after period of ignoring prior to extinguishing
 - (c) Providing direction
 - (d) Verbal reprimand or specific statements that point out consequences if inappropriate behavior continues
 - (e) Privilege removal that is natural consequence to the behavior
 - (f) Time out to child to reflect and regain control and equating to one minute per year of development (Johnson, 1995; Antai-Otong, 1995)
- c. Treatment level system—organized, concrete way to show child's progress through treatment
- (1) Expectations and privileges increase with advance to next treatment level or phase.
 - (2) Child or adolescent may earn a set number of points each day; increased privileges are attached to higher levels.
- d. School program must be provided as part of inpatient, partial, or residential programs for children and adolescents.
- Medication management considerations for children
 1. Children differ in response to medication's main and side effects.
 2. Children may metabolize and eliminate medications more rapidly.
 3. When medicating children, start slow, titrate carefully, use lowest effective dose.
4. Final dose may be higher than in adults because of metabolic and organ differences.
 5. Clinical observations of effects are essential because of absence of carefully controlled studies of pharmacotherapy in children.
 6. Variation in dosing between adults and children considers difference in size, metabolism, and desired action.
 7. Combined pharmacotherapy is being used safely in children; same considerations in introducing multiple medicines apply to children as to adults.
 8. Antihistamines lower seizure threshold and cause delirium and worsening of tic disorders.
 9. Lithium is cleared rapidly by children, so they may require higher doses to stabilize a mood disorder.
 10. Valproate (Depakote) may be hepatotoxic in children younger than age 10.
 11. MAOIs are contraindicated in pediatric population due to dietary and other risks.
 12. Children both metabolize neuroleptics more rapidly and are more sensitive to their main effects.
 13. Stimulants are first line of treatment for attention deficit hyperactivity disorder (ADHD), and this practice is generally continued through adolescence into adulthood.
 14. SSRIs are generally considered safe and effective for treatment of depression and some anxiety disorders in children; however, an increased risk for suicide among children, adolescents, and young adults exists for this class.
 15. Buspirone (BuSpar) may be helpful in managing aggression and agitation in children with Mental Retardation or a Pervasive Development Disorder (PDD) (Zimmerman, 1997)
- Medication management for adolescents
 1. Establishment of trust is essential because of developmental issues regarding control by authority.
 2. Adolescents are more susceptible to extrapyramidal side effects.
 3. Teens have poor fluid intake, which makes them susceptible to constipation, dry mouth, and urinary retention.
 4. Vital signs need monitoring for potential hypotension.
 5. Drowsiness may interfere with school.
 6. Abuse of medications, including selling medications at school, especially anti-anxiety or sympathomimetic agents is a risk factor.
 7. Adolescent, family, and school professionals should understand indications, responses, interactions and compliance issues to facilitate proper adjustment of medication dosage.

8. Adolescent, family, school, and other psychiatric professionals must have reasonable expectations of medications.
9. Monitor for potential overdose when patient is experiencing suicidal thoughts (Botz & Bidwell-Cerone, 1997).

Adolescent Behavioral Issues

- Violence (Federal Interagency Forum on Child and Family Statistics, 2009)
 1. Adolescent acting-out behaviors continue, but the juvenile crime rate has declined from an all-time high rate in 1993 (26% of all violent crimes); juvenile crime rate decreased in 2007 to 17% (all such victimizations reportedly involved a juvenile offender); 56% of all violent crimes committed by a juvenile involved multiple perpetrators.
 2. Rate of victimization of teens (ages 12–17) is twice that of the general population.
 3. Girls 14 to 15 years of age have highest risk of any age group of being raped (Johnson, 1997).
 4. Violence by juveniles usually acted out on other juveniles; nearly one million juveniles between 12 and 19 years of age are raped, robbed, or assaulted, twice that of the general population.
 5. Lethality of teenage violence is increasing; teenage violent death rate rose 13% between 1985 and 1991.
 6. 12% to 31% of the general adolescent population have elevated depressive symptomatology placing them at risk for Major Depression and suicide.
 7. Positive correlation between juvenile violent behavior and adult violent behavior.
- Youth gangs and violence
 1. Results from a National Youth Gang Center (NYGC) survey in 2007 (Egley & O'Donnell, 2009) indicate that gang activity among youth has begun to rise (2007 prevalence rate of 35%), following a low in 2001 (24%).
 2. Antisocial behavior in adolescence is positively associated with depression.
 3. Conduct disorder is associated with involvement with a delinquent peer group.
 4. Victims of teen violence are being killed rather than injured (Johnson, 1997); increasingly, firearms are involved in adolescent homicide and suicide; teenage homicide rate has doubled since 1985.
- Runaways (Hammer, Finkelhor, & Sedlak, 2002)
 1. Definition—A runaway child is one who leaves home without permission and stays away overnight; or is 14 years old or younger and voluntarily chooses not to come home when expected; or child older than 15 years stays away for more than two nights.
 2. 500,000 to 2 million youngsters (mainly adolescents) run away from home each year and another 900,000 have no home (Mohr, 1998)—68% of all runaways are older adolescents (aged 15–17)
 - a. Situational runaways—largest subgroup; circumstances include:
 - (1) Eldest daughters seeking relief from major household responsibilities (delegating family dynamics)
 - (2) Adolescents used as pawns in parental conflicts
 - (3) Parents trying to obstruct normal adolescent separation process (binding family dynamics)
 - (4) Reunion fantasy causing adolescents to run away as a ploy to pull parents together
 - b. Departure runaways—depressed and angry about treatment at home and hungry for affection and a sense of belonging; escape is a genuine survival tactic
 - c. Throwaways—youth who are asked to leave home (expelling family dynamics); usually endure lifestyles similar to departure runaways; approximately 200,000 to 600,000 have been thrown out, agree to leave, or are removed by authorities (Hammer, Finkelhor, & Sedlak, 2002; Mohr, 1998).
 3. Circumstances associated with departure runaways and throwaways include the following:
 - a. Parental criminal activity, violence, alcoholism, and addiction
 - b. Overall chaotic home environment
 - c. Physical, emotional, and sexual abuse and neglect
 - d. Conflicts over same-sex orientation
 4. Population of children and adolescents with no social service support
 - a. Become homeless street people and often turn to prostitution, drug dealing, stealing and panhandling to survive; most cannot return home due to high degree of dysfunction.
 - b. Are vulnerable to exploitation; group at highest possible risk for rape, assault, homicide, depression, suicide, drug overdosing, pregnancies, poor nutrition, poor hygiene, sleep deprivation, and STDs including HIV/AIDS and communicable diseases (Botz & Bidwell-Cerone, 1997; Haber, 1997; Mohr, 1998).

Child Maltreatment

- Incidence (US Department of Health and Human Services, Administration on Children, Youth and Families, 2009)
 1. 794,000 children were victims of child abuse and neglect, and 1,760 children died as a result of abuse/neglect, during 2007. Of the fatalities, 75.7% were younger than 4 years of age. Infants (age birth to 1 year) had the highest rate of victimization (2.2%); more than half were female (51.5%) and nearly half were white (46.1%), although boys were more likely to die as a result of the abuse/neglect.
 2. The most common form of maltreatment is neglect (56.0%); followed by physical abuse (10.8%); sexual abuse (7.6%); and psychological maltreatment (4.2%).
 3. Perpetrators of the child maltreatment were parents (79.9%) or relatives of the victim (6.6%); female (56.5%), and under the age of 40 years (74.8%). Of the perpetrators who were child daycare providers, nearly 24 percent (23.9%) committed sexual abuse.

Neglect—may be impossible to estimate actual scope because neglect is easily overlooked.

- Physical neglect—most widely recognized and commonly identified form of neglect; includes failure to protect from harm or danger and provide for child's basic physical needs (shelter, food, clothing)
- Emotional neglect—more difficult to document or substantiate, often beginning when children are too young to communicate or know they are not receiving appropriate care
 1. Extreme form of neglect leads to nonorganic failure to thrive.
 2. American Humane Association describes emotional neglect as passive or passive/aggressive inattention to child's emotional needs, nurturing, or emotional well-being (Erickson & Egelund, 1996).
 3. "Psychologically unavailable" parents overlook infants' cues and signals, especially cries and pleas for warmth and comfort.
 4. Has serious long term consequences for child; emotionally neglected children expect their needs will not be met, and do not even try to solicit care and warmth; they expect failure, therefore lack motivation.
 5. Neglectful parents:
 - a. Lack an understanding of children's behavior and parent-child relationship.
 - b. Experience a great deal of stress.
 - c. Are socially isolated or unsupported.

- d. Have a history of inadequate care themselves.
6. Emotional availability of parents includes:
 - a. Parental sensitivity
 - b. Child responsiveness
 - c. Parental nonintrusiveness
 - d. Involvement of parent with child
- Medical neglect
 1. Caregivers' failure to provide prescribed medical treatment for their children, e.g., immunizations, prescribed medication, recommended surgery
 2. May involve clash between parents' religious beliefs and recommendations of medical community
- Mental health neglect—caregivers' refusal to comply with recommended corrective or therapeutic procedures
- Educational neglect—failure to comply with state regulations for school attendance (Erickson & Egelund, 1996)

Physical Abuse (measures of incidence and prevalence rates can vary based on restrictiveness of definition)

- Child characteristics related to abuse
 1. Early health problems increase risk, including:
 - a. Medical
 - b. Intellectual
 - c. Developmental aberrations
 2. Temperament/behavior
 - a. Difficult temperament (impulsivity, crying)
 - b. Conduct problems
 - c. High activity
 - d. Limited sociability
- Parental characteristics related to abuse
 1. Heightened levels of distress or dysfunction
 - a. Depression
 - b. Physical symptoms
 - c. Substance abuse
 - d. Posttraumatic Stress Disorder (PTSD)
 2. Early physical punishment of parent
 - a. Adults who experience or witness abuse during childhood are exposed to aversive models and use aggressive discipline with children.
 - b. Violence becomes transgenerational and multiplied; victims may reenact the trauma by identifying with the aggressor and acting out on others.
 - c. 30% of those abused as children abuse their own children.

3. Personality disturbances
 - a. Hostile personality
 - b. Parental explosiveness
 - c. Irritability and use of threats
4. Cognitive style
 - a. Negative cognitive attributional style—perceive children in negative light
 - b. Belief in strict physical discipline
 - c. Have high expectations of children in relation to age-appropriate behaviors and cognitive skills
5. Behavioral functioning
 - a. Inconsistent child-rearing practices reflecting critical, hostile, or aggressive management styles
 - b. Poor problem-solving ability; less attention-directing verbal and physical strategies, less mutual interaction in free play and problem-solving situations
6. Biologic factors—hyperarousal to stressful child as measured by autonomic arousal
7. Family system characteristics
 - a. Coercive parent-child interactions
 - b. Poor family relationships/family context of hostility
8. Experiences of abuse and violence are related to development of personality disorders, depressive, anxiety, and dissociative disorders.

Sexual Abuse

- Definition—occurs between a child and adult, or older child; is defined as sexual contact or interaction for purpose of sexual stimulation/gratification of adult or older child (Monteleone, Glaze & Bly, 1994)
- Sexual acts range from least severe to most severe and intrusive
 1. Noncontact acts—making sexual comments to child, exposure, voyeurism, pornographic material viewing, inducing child to undress
 2. Sexual contact
 - a. Offender touching child's breasts, buttocks, genitals or asking child to touch his/her genitals
 - b. Frottage—rubbing genitals against victim's body or clothing for pleasure
 - c. Digital or object penetration
 - d. Oral sex—offender to child or child forced to perform on offender
 - e. Penile penetration—vaginal or anal
 - f. Intercourse with animals
- Circumstances of sexual abuse
 1. Dyadic
 2. Group sex
 3. Sex rings

4. Sexual exploitation
 5. Child pornography
 6. Child prostitution
- Social conditions increasing risk of sexual abuse
 1. Separated from both biologic parents or runaway
 2. Raised in poverty
 3. Child handicapped
 4. Alcoholic family member
 5. Drug abusing family member
 6. Prostitution at home
 7. Transient adults living in home
 8. Mentally ill caretaker
 9. AIDS related disability of caretaker (Monteleone, Glaze, & Bey, 1994)
 - Impact of sexual abuse on child
 1. Traumatic sexualization
 2. Stigmatization
 3. Betrayal
 4. Powerlessness
 5. Traumatic amnesia—may interfere with processing event and placing it in past memory (Whitfield, 1998)

Assessment of Child Maltreatment—conducted within the context of the environment

- Issues to be considered
 1. Ethnicity and socioeconomic status
 2. Social desirability and reporting bias
 3. Professional roles affecting outcomes of assessment (interviewer bias, lack of training, leading questions)
 4. Use of standardized measures
 5. Multi-axial assessment
 6. Information from children
 - a. Behavioral report and/or observation
 - b. Casual observations
 - c. Mental status examination
 - d. Projective assessments and drawings
 - e. Projective storytelling/apperception tests
 - f. Rorschach
 - g. Cognitive assessments
 - h. Bayley scales of infant development (BSID)
 - i. Wechsler series of intelligence tests for children
 - j. Kaufman assessment battery for children (K-ABC)
 - k. Clinical interviews
 - l. Nondirective play sessions
 - m. Structured psychiatric diagnostic interviews
 7. Information from parents
 - a. Child Behavior Checklist (CBCL)
 - b. Vineland Adaptive Behavior Scales (VABS)

8. Family assessment
 - a. Standardized measures of family assessment
 - b. Clinical interviews
9. Supplemental information
 - a. Teachers/school personnel
 - b. CBCL Teacher Report
 - c. Caseworkers
 - d. Foster parents/supplemental caretakers
10. Risk assessment of harm to self and/or others
 - a. Suicide
 - b. Self-destructive behavior
 - c. Danger to others
 - d. Risk of revictimization

Maltreated Children and Therapy

- Reasons most children are brought to therapy
 1. Child is showing symptoms of abuse or neglect.
 2. Parents are concerned about how child is affected by abuse or neglect.
 - Child factors that affect progress in therapy
 1. Willingness to participate in therapy
 2. Ability to acknowledge experience of abuse or neglect
 3. Capacity to use therapy
 - a. Genetic make-up
 - b. Level of functioning
 - c. Phase of development
 - d. Content and intensity of the event
 - e. Accumulated life events and history of prior trauma
 4. Child needs reassurance to know that his/her needs will be addressed in therapy.
 - Essentials components of successful therapy
 1. Trust—physical and emotional
 2. Needs assessment
 3. History taking (essential)
 4. Family genogram (essential)
 5. Strong alliance with parent or caretaker
 - Stages of therapy in treating sexual assault (Hartman & Burgess, 1998)
 1. Management of defensive patterns
 2. Anchoring for safety
 3. Psychoeducation regarding complex trauma response
 4. Strengthening personal resources
 5. Surfacing trauma information
 6. Processing the trauma
 7. Future and transformation
 - Assessment of sexual abuse
 1. Specialized skill—should be performed by professionals who have been trained and supervised in this modality.
2. Structured and semistructured interview protocols (e.g., Cognitive Interview, Step-Wise Interview) have been established to increase accuracy of information obtained, and to minimize mistaken or false information from children who become confused, frightened, overwhelmed, or intimidated with the interview process (Sadock & Sadock, 2007).
 3. Recommended that role of evaluator and therapist be kept separate (American Professional Society on the Abuse of Children [APSAC], 1997).
 4. Sexual acts are considered abusive when the following are present:
 - a. Power differential
 - b. Knowledge differential
 - c. Gratification differential
 5. History is most difficult phase of evaluation and most important.
 6. Both physical and behavioral assessments are necessary in establishing likelihood of abuse, however, majority of sexually abused children have no physical evidence.
 - a. Child Sexual Behavior Inventory-3—valid instrument for assessing sexually abused children aged 2 to 12 (Friedrich, Berliner, Butler, Cohen, Damon, Shafram, 1996)
 - b. Sexualized behavior continues to be one of the most valid markers of sexual abuse in children (children who demonstrate sexual behavior), including:
 - (1) Sexual play
 - (2) Sexual talk
 - (3) Sexual actions, e.g., compulsive masturbation or attempts to engage others in sexual activity
 - (4) Touching others' genitals
 - (5) Asking others to touch them (Friedrich, *et al.*, 1996)
- Sexual abuse treatment
 1. Goals
 - a. Deal with effects of sexual abuse
 - b. Decrease risk for future abuse
 2. Treatment issues for victim
 - a. Trust
 - b. Emotional reactions to sexual abuse
 - c. Responsibility for act
 - d. Altered sense of self
 - e. Anxiety and fear
 - f. Behavioral reactions to sexual abuse
 - (1) Sexualized behavior
 - (2) Aggression
 - (3) Runaway
 - (4) Self-harm
 - (5) Criminal activity
 - (6) Substance abuse
 - (7) Suicidal behavior

- (8) Hyperactivity
- (9) Sleep problems
- (10) Eating problems
- (11) Toileting problems
- Therapeutic questions
 1. What happened?
 2. What thoughts/beliefs did you experience during the (incident) . . . and since then?
 3. What will you do if something like this happens again?
- Modalities
 1. Group approaches
 - a. Treatment of choice for sexual abuse except for patients who are too disturbed or disruptive
 - b. Screen members
 - c. Six-to eight-members; three to six with younger children
 - d. Minimum of 16 to 20 sessions
 - e. Long-term, open-ended treatment helpful for adolescents
 - f. Include several well socialized children (Friedrich, *et al.*, 1996)
 - g. Skills building for problem solving (Bloomquist, 1996)
 2. Individual psychotherapy (including play therapy)—also appropriate with an emphasis on alliance building
 3. Dyadic treatment—used to repair relationship between victim and nonoffending adult
 4. Family therapy—if reunification is in victim's best interest
 5. Use of multiple therapists indicated
 - a. Range of services
 - b. Shared responsibility for multiproblem families; one therapist can be overwhelmed with demands of highly needy families with multiple problems and multiple agency involvement
 - c. Therapist support
 - d. Cotherapy demonstrates a variety of roles to the patient
 - e. Shared decision making (Faller, 1993)
 6. Cognitive reactions to sexual abuse—child must be able to make sense of the abuse before it becomes suppressed, denied, or repressed and not resolved (Friedrich, *et al.*, 1996)
 7. Protection from future victimization
 8. Pharmacotherapy to alleviate target symptoms, such as anxiety, depression, or indications of posttraumatic stress
 9. Therapy performed as part of a larger context in which safety, stability, and support are provided (Friedrich, *et al.*, 1996)

- Implications for therapy with ritual abuse
 1. Higher incidence of PTSD
 2. Higher incidence of dissociative disorder
 3. Greater symptom severity
 4. Vicarious traumatization of the therapist because of greater impact on victim

Confidentiality

- Applies regardless of patient's age.
- Information cannot be disclosed to outsiders without parental consent.
- Decision to reveal information to parents is relative to child or adolescent's developmental age.
 1. May be developmentally inappropriate to seek child's "consent" for disclosure to parents of information revealed during therapy.
 2. May be developmentally and therapeutically appropriate to safeguard an adolescent's disclosures, even from parents.
 3. Nurse should set ground rules for confidentiality during assessment/evaluation.
- If parent has abused or neglected a child, disclosure of confidential information to maltreating parent may be contraindicated regardless of the child's age.
- Nurse should be familiar with legal concept of privilege.
- Written records, notes, videotapes, drawings, and photographs may be subpoenaed.
 1. Attorney issuing subpoena cannot require/force professional to produce records.
 2. Subpoena does not override confidentiality requirement.
 3. Patient should be consulted when subpoena for records is received.

Legal Issues in Child Abuse and Neglect

- First child abuse reporting laws enacted in 1963, following societal awareness of need for child protection.
 1. C. Henry Kempe published the seminal article on Battered Child Syndrome in 1962.
 2. All professionals who work with children are mandated to report suspected abuse or neglect to designated child protection or law enforcement authorities.
 - a. This includes both the generalist and specialist in psychiatric nursing.
 - b. Reporting laws override ethical duty to protect confidential information (Myers, 1992).
 - c. Reporting requirement is triggered when there is evidence that would lead a

- competent professional to believe abuse or neglect is reasonably likely.
 - d. No requirement to prove abuse or neglect in order to file a report.
 - e. Professionals protected from retaliation for an unfounded or unsubstantiated report if report was made in good faith.
 - f. Misdemeanor charge for intentional failure to report.
- Congress enacted Child Abuse Prevention and Treatment Act in 1974
 1. This established the National Center on Child Abuse and Neglect (NCCAN)
 2. States must comply with federal guidelines to receive federal funding, but have some choice how services are provided.
- States have three kinds of laws (Pence & Wilson, 1992; Feller, 1992; Depanfilis & Salus, 1992).
 1. Reporting laws
 - a. Define child abuse and neglect.
 - b. Specify conditions for state intervention in family life.
 - c. Encourage treatment approach rather than punitive.
 - d. Encourage coordination/cooperation among services.
 - e. Designate administrative structures for handling.
 2. Juvenile and Family Court laws
 - a. Emergency hearings—determine need for protection of alleged maltreated child.
 - b. Adjudicatory hearings—determine if child has been maltreated.
 - c. Dispositional hearings—determine action to be taken after adjudication.
 - d. Review hearings—review dispositions and determine need to continue placement for services and/or court intervention.
 3. Criminal laws
 - a. Define criminally punishable offenses.
 - (1) Law enforcement agencies investigate.
 - (2) Prosecutor decides if prosecution will occur.
 - b. Burden of proof must be beyond a reasonable doubt (stronger than in Juvenile or Family Court).
 - c. Defendants have full protection of 4th, 5th and 6th amendments (jury, cross examination, appointed counsel, and speedy trial).
 - d. Directed at deterring or rehabilitating defendant (probation or incarceration).
- Role(s) of advanced practice PMH nurse may include:
 1. Evaluating children suspected of abuse
 2. Providing therapy for abused children and for children experiencing legal proceedings related to abuse
 3. Serving as expert witness in child abuse cases
 4. Political action on behalf of children
 5. Case management on behalf of children
- Nurses must be familiar with the following:
 1. Roles and responsibilities of various systems involved in child protection, including child protective services, police, and court system
 2. Emergency protective custody—all states provide mechanism to protect children in emergencies; police officers and in some states, child protective services' professionals and physicians have authority to take children into temporary protection custody; these laws have strict time limits
 3. Guidelines established for evaluation of children suspected of abuse (APSAC Guidelines, 1997)
 4. Laws in some states authorizing professionals to take pictures and x-rays without parental consent
- Expert witness testimony by advanced practice PMH nurses
 1. Before a person may testify as an expert witness, they must provide documentation of their expertise.
 - a. Educational accomplishments and licensure
 - b. Specialized training, including board certifications and continuing education
 - c. Extent of experience with children or adolescents and direct clinical experience (percent of practice time devoted to specified problem)
 - d. Familiarity with relevant professional literature
 - e. Membership in professional organizations
 - f. Publications, presentations, teaching
 - g. Honors, awards, professional recognition
 2. The forms of expert testimony
 - a. Opinion—expert witness is permitted to offer professional opinions; expert must:
 - (1) Be reasonably confident of the opinion.
 - (2) Employ appropriate methods of assessment and consider all relevant facts.
 - (3) Understand pertinent clinical and scientific principles.
 - (4) Be objective
 - (5) Provide rationale and information leading to the opinion.

- b. Answer to a hypothetical question
 - (1) Legal strategy whereby an attorney gives an extensive or lengthy, hypothetical statement and asks the expert to provide an answer to the hypothetical scenario
 - (2) Strategy generally falling out of favor
- c. Expert testimony in the form of a dissertation
 - (1) Expert provides a lecture on a particular subject, e.g., the dynamics of a syndrome.
 - (2) Testimony assists judge or jury to understand a phenomenon (Myers, 1992).
- Issues regarding child testimony
 1. Linked to interviewing of children (specialized training to avoid leading child's responses)
 2. Interviews classified as investigative or therapeutic
 3. Interviews conducted for purpose of treatment may be used in investigations
 4. Goals for child investigative interviews include:
 - a. Minimizing trauma of the investigation
 - b. Maximizing information obtained
 - c. Minimizing contaminating effects of interview on the child's memory of the event
 - d. Maintaining integrity of the investigative process (Goodman & Bottoms, 1993)
 5. Efforts underway to minimize gap between child's ability to testify and demands of legal system
- Sources of stress in legal proceedings involving children
 1. Long delays before trial which may:
 - a. Create anxiety for victims.
 - b. Hamper therapeutic interventions.
 - c. Affect child's memory (gives support to concept of videotaping early interviews).
 2. Lack of legal knowledge
 - a. Preparation or orientation may help diminish child's anxiety.
 - b. Concept of "Court School" for child witnesses has been implemented; specialized training is available for child advocates to help orient children to courtroom procedures and stresses.
 3. Intimidating courtroom environment
 4. Giving evidence in presence of accused
 - a. Videotaped testimony and videolink can alleviate some stress.
 - b. Child's live testimony may have more impact on jury.
 - c. Possible prejudicing of the defendant must be considered.

5. Being examined and cross-examined; difficulties for child include:
 - a. Formality of interview procedures
 - b. Unfamiliarity of language
 - c. Challenging nature of cross-examination
 - d. Time element in serious trials (Goodman & Bottoms, 1993)
- Forensic nursing (Lynch & Burgess, 1998)
 1. APN-PMH nurse may serve as sexual assault nurse examiner (SANE) for children and adolescents.
 2. APN-PMH nurse may have advanced training in collection of forensic evidence and classification of wounds.
 3. APN-PMH nurse may review equivocal child death cases.
 4. APN-PMH nurse may provide counseling for homicide victim's families.

■ QUESTIONS

Select the best answer

1. Estimates of children and adolescents experiencing a mental disorder in the United States are:
 - a. 7.5 million
 - b. 10 million
 - c. 250,000
 - d. 2.5 million
2. Among children and adolescents with psychiatric disorders about ____ are receiving treatment.
 - a. 90%
 - b. 50%
 - c. 20%
 - d. less than 10%
3. Since the 1960s, the suicide rate for youngsters 15 to 19 years of age has:
 - a. Been unknown
 - c. Declined
 - b. Stayed the same
 - d. Increased
4. Children of immigrants who experience a lack of acculturation may be at greater risk for:
 - a. PTSD
 - b. PDD
 - c. Mental retardation
 - d. Depression
5. Risk factors are those that increase the likelihood of developing an emotional mental disorder. Which of the following risk factors increases the intensity of all other risk factors?

- a. Physical and sexual abuse
 - b. Adolescent parents
 - c. Divorce, parental conflict, and family instability
 - d. Poverty
6. Biologic or genetic factors that negatively impact a child's mental health include:
 - a. Personality characteristics
 - b. Low birth weight
 - c. Problem-solving ability
 - d. Normal intellectual development
 7. Life in a blended family may increase the risk of developing inadequate coping skills due to:
 - a. Child support issues
 - b. Step-siblings replacing peers
 - c. Visitation schedules disrupting family routines
 - d. Economic pressures for all parents to work
 8. Children in foster care are at very high risk for developing psychiatric disorders. One reason for this may be due to:
 - a. Cutbacks in funding
 - b. Poorly selected foster families
 - c. Lack of turnover in placement
 - d. Lack of permanency preventing development of significant interpersonal relationships
 9. A major factor in lack of access to health care for children in the United States is the lack of health insurance and:
 - a. Inadequate numbers of prepared mental health professionals to provide needed services
 - b. Poor follow-through by foster parents
 - c. Inadequate primary prevention by school nurses
 - d. Poor psychiatric skills among primary care providers
 10. Teens are victimized at a rate that is _____ that of the general population.
 - a. Twice
 - b. Three times
 - c. Four times
 - d. Five times
 11. Which group has the highest risk of being raped?
 - a. Girls 16–18
 - b. Boys 11–14
 - c. Boys 6–8
 - d. Girls 14–15
 12. Violence by juveniles is most often inflicted on which population?
 - a. Other juveniles
 - b. Younger children
 - c. Middle-aged adults
 - d. Elderly people
 13. Cults are attractive to alienated adolescents who have not internalized social norms. Cults are usually led by:
 - a. Adults who provide substitute parenting to the adolescent
 - b. Same sexed peers with organizational skills
 - c. Charismatic authority figures who claim to possess certain powers
 - d. Peers who have dabbled in Satanism
 14. Runaways are a population of children and adolescents who are at high risk for emotional and physical health problems. Family forces that contribute to runaway behavior include delegating dynamics. Which of the following is an example of delegating dynamics?
 - a. Preventing the adolescent from after school activities
 - b. Telling the adolescent to move out when he finishes high school
 - c. A single father using the adolescent girl as a maternal figure for the younger siblings
 - d. Physical abuse of the adolescent
 15. A 15-year-old girl's parents divorced and proceeded to continue to argue with each other around issues of child support and visitation. The girl was interrogated about life at each parent's home by the other, and the mother prevented visitation when the child support check was late. In addition, the mother became angry when the youngster came back from visitation and reported having a good time. The girl ran away and stayed with different friends for 10 days. This is an example of which type of runaway?
 - a. Departure
 - b. Situational
 - c. Throwaway
 - d. Emotional survival
 16. Harry, age 16, ran away from home because his parents were both abusive alcoholics. There was little structure or predictability in the home environment, with people often moving in or out. Harry became a "street person." Harry is at high risk for:
 - a. Victimization and exploitation
 - b. Having a reunion fantasy
 - c. Developing a gender identity disorder
 - d. Having difficulty with time management

17. Amy, age 19, is addicted to crack cocaine and becomes pregnant. She continues drug use while pregnant. A serious problem that may occur due to her addiction is low birth weight. Another serious problem may be:
- Pervasive Developmental Disorder
 - Failure to thrive
 - Failure to bond
 - High utilization of health services
18. Adolescent substance abuse affects what percentage of the adolescent population?
- 12%
 - 46%
 - 24%
 - 32%
19. Substance abuse is potentially more serious among adolescents because:
- They are difficult to manage at home
 - There are few 12-step programs for youngsters
 - There is an interference with developmental issues
 - It perpetuates substance abuse throughout the generations
20. The incidence of child abuse and neglect includes:
- An increased risk for children younger than 4 years old
 - An increased risk for adolescents
 - Decreased risk for infants
 - Decreased risk for preschool children
21. A 3-year-old boy regularly arrives at the daycare center inappropriately dressed for cold weather. He appears undernourished and is often dirty. This may be an example of:
- Medical neglect
 - Emotional neglect
 - Physical neglect
 - Passive inattention
22. The type of neglect that is difficult to document or substantiate is:
- Medical neglect
 - Emotional neglect
 - Physical neglect
 - Educational neglect
23. Suzanne is a 3-year-old who was born prematurely and spent the first several months of her life in the hospital. When she was sent home, she was on a cardiac monitor. Suzanne was slow to walk, talk, and toilet train. What is her risk for experiencing abuse?
- Less than most children since her parents will want to protect her
 - No different from any other child, as children do not bring on abusive behavior
 - Slightly higher than other children
 - Higher than other children due to the fact that early health and medical problems increase risk of abuse
24. Jeffrey is a 6-year-old who has ADHD and difficulty attending to social cues. He is always on the go and is noted to have behavior problems in school. What, if any, is Jeffrey's risk of being abused?
- No different from other children
 - Greater than others
 - Less than others
 - Impossible to predict
25. Donna Barry, a single mother, brings her daughter Lorraine, age 7, in for an evaluation of "behavior problems." Ms. Barry speaks about Lorraine in negative terms. She acknowledges that Lorraine does not present a problem at school, and says she spansks Lorraine if her room is not cleaned to Ms. Barry's satisfaction. Lorraine appears to be anxious and somewhat depressed. An appropriate intervention would be:
- Counseling aimed at teaching Ms. Barry effective management skills
 - Reporting Ms. Barry for child abuse
 - Referring Lorraine for medication management
 - Asking Lorraine's teacher to report any unusual bruising
26. Assessment of child sexual abuse requires specialized skills and training. It is important that the interviewer use age-appropriate language, provide a safe environment, and avoid leading questions. An example of a leading question is:
- What happened after you went to bed?
 - Where did you touch him?
 - He put his fingers in your bottom, didn't he?
 - Tell me what happened next.
27. Most children who have been maltreated are in therapy because they are showing symptoms of being abused or neglected and:
- Social services requires treatment of the child
 - Therapy enables the child to be a better witness
 - Therapy may be used to gather information to prosecute the perpetrator
 - The parents are concerned about how the child is affected by the abuse or neglect

28. Cynthia is a 5-year-old kindergarten child who was digitally penetrated by her babysitter's teenage son. She is usually eager to come to her therapist's office and has been able to describe what happened to her. Other factors that may impact on her progress in treatment include:
- The perpetrator's apology to Cynthia
 - The babysitter's apology to Cynthia
 - The therapist's alliance with the parent
 - Cynthia's mother's abuse history
29. A primary focus in the beginning of therapy with abused children includes establishing trust and rapport and:
- Integrating the child's thoughts about herself
 - Helping the child to take risks
 - Reliving or reexperiencing the abuse
 - Determining the child's coping style
30. Helping the child to develop ways to cope effectively with symptoms, memories, sensations, thoughts, and feelings is a focus of which stage of therapy?
- Assessment
 - Beginning
 - Middle
 - Termination
31. Sexual acts are abusive clinically when there is a differential between the victim and the offender in terms of power, knowledge, and:
- Gratification
 - Intellect
 - Socioeconomic level
 - Gender
32. In assessing sexual abuse, current recommendations regarding the role of evaluator and therapist are that they should be:
- Kept separate
 - Integrated
 - Done in different agencies
 - Aimed at keeping the child's story consistent for court purposes
33. Danny is a 6-year-old boy who reported to his teacher that his stepfather often fondles him and forces him to suck his penis. A physical examination reveals no evidence of sexual abuse. Which of the following statements is true?
- Most sexually abused children show physical signs of abuse.
 - Most sexually abused children are molested by persons outside the home.
 - The majority of children who are sexually abused have no physical evidence of abuse.
 - It is probable that someone coached Danny to say negative information about the stepfather.
34. Conditions that increase the likelihood of a child being sexually abused are life apart from both biologic parents, poverty, mental illness of a caretaker, and:
- Having a grandparent in prison
 - Academic failure
 - Attention Deficit Hyperactivity Disorder
 - Alcoholic family member
35. The advance practice PMH nurse has developed specialized skills in the treatment of sexually abused children. The intervention regarded as the treatment of choice for sexually traumatized children is:
- Conjoint family therapy
 - Solution-focused therapy
 - Analytical play therapy
 - Group therapy
36. Advantages of cotherapists in working with sexually abused children include:
- Greater protection from further victimization
 - Greater consensus on validation of the abuse
 - Protection from further victimization
 - Shared responsibility for multiproblem families
37. Common target symptoms related to child sexual abuse that may be alleviated by pharmacotherapy include anxiety, depression and:
- Poor school performance
 - Regressed behavior
 - Soiling
 - Posttraumatic symptoms
38. Ritual abuse is defined as the intentional physical, sexual, or psychological abuse of a child when the abuse is repeated and stylized and typified by acts such as cruelty to animals, threats of harm to the child, other people, or animals. Which of the following is true of ritual abuse?
- The impact on the victim is greater than in other forms of abuse, and the children are more symptomatic as assessed by standardized instruments.
 - There is less impact on the victim than in other forms of abuse because of a greater tendency on the part of the victim to dissociate.
 - The ritually abused child's parents have a greater sense of control than when their children are victimized in nonritualized ways.
 - This type of abuse is well documented and thoroughly researched.

39. The psychiatric and mental health advanced practice nurse working with children must be aware of the laws regarding reporting child abuse. Which of the following provides a guideline for the nurse?
- All abuse must be thoroughly investigated by the APN-PMH nurse before it is reported.
 - The reporting requirement does not require proving abuse before reporting.
 - There is generally a felony charge for intentional failure to report.
 - The reporting laws do not override the ethical duty to protect confidential information.
40. Who decides whether or not the psychiatric and mental health advanced practice nurse is qualified as an expert witness?
- The nurse
 - The nurse's peers
 - The attorney issuing a subpoena
 - The judge
41. Professionals who qualify as expert witnesses are permitted to offer opinions about which they are confident. In arriving at an opinion, it must be demonstrated that the expert considered all relevant facts, employed appropriate methods of assessment, and:
- Is advocating for the patient
 - Has a doctoral degree
 - Interviewed all parties in a dispute
 - Demonstrates objectivity
42. Interviews of children may be therapeutic or investigative. It is important in conducting investigative interviews that the interviewer:
- Makes sure that sufficient evidence is gathered for a prosecution in spite of the impact on the child of repeated interviews
 - Minimizes the investigative trauma for the victim
 - Is qualified as an expert witness
 - Reports all details of the child's disclosures to the child's therapist
43. Sources of stress for children experiencing legal proceedings include:
- The constitutional right for the offender to have a speedy trial
 - Lack of familiarity with the courtroom environment
 - Going to "court school"
 - Rapid changes in development
44. The major stressor for children who testify in trials of accused abusers is:
- Unfamiliarity with legal terminology
 - The judge's black robes
 - Confronting the accused
 - Lack of memory for the events over time
45. States must comply with federal child abuse and neglect guidelines to receive federal funds, yet have autonomy in deciding how services are provided to abused and neglected children. The types of laws that are relevant to reporting, intervention, and prevention of child abuse include reporting laws, criminal laws, and:
- Affirmative action laws
 - Sexual harassment statutes
 - Anti-pornography statutes
 - Juvenile and Family Court laws
46. Rationale for parents "rooming in" with a sick child are theories of:
- Ego development
 - Attachment
 - Psychodynamic development
 - Communication
47. Marylou is a 4-year-old hospitalized with a severe upper respiratory infection. Her mother notes that she has begun wetting the bed after being dry for the last two years. She expresses her concern to the consultation liaison nurse clinical specialist. In helping the mother to understand this change in her daughter's behavior, the nurse should teach the mother about which of the following?
- Learning strategies for relaxing
 - Understanding concepts of regression in illness
 - Promoting family functioning
 - Retraining toileting
48. Children hospitalized with chronic illnesses need opportunities for stress management, play and related activities, promoting family functioning, and:
- Learning and academic activities
 - Learning ways to express hostility by abreaction
 - Family therapy
 - Continuing relations with their outpatient therapist
49. Childhood-Onset Schizophrenia is defined as an onset of psychotic symptoms at approximately which age?
- Before age 16
 - By age 8
 - Between 4 and 10
 - Before age 12

50. Childhood-Onset Schizophrenia is considered:
- The same disorder as adult Schizophrenia
 - A different disorder from adult Schizophrenia
 - A Pervasive Developmental Disorder
 - Related primarily to poor prenatal nutrition
51. Differential diagnosis of Childhood-Onset Schizophrenia needs to take into consideration that symptoms may yield the possibility of neurological disorders, affective disorders, and:
- Trauma-related symptoms
 - Reactive Attachment D
 - Developmental Learning Disorder
 - Anxiety Disorder NOS
52. Brain scans of children with Childhood-Onset Schizophrenia show:
- Left posterior parietal hypometabolism
 - Right posterior parietal hypometabolism
 - Left anterior temporal hypermetabolism
 - Right anterior temporal hypermetabolism
53. Children with Schizophrenia show loose associations and illogical thinking. This type of thought disturbance is:
- Typically seen in normal children between ages 5–11
 - Unusual before 6 years of age in normal subjects
 - Not typically seen in normal children after 7 years of age
 - Not responsive to medication management
54. Treatment of childhood Schizophrenia involves the use of medications that are similar to adult medication. Care should be exercised in the use of which medications that may cause psychotic symptoms?
- Minor tranquilizers
 - SSRIs
 - Stimulants
 - Antiparasitical agents
55. An appropriate intervention for the schizophrenic child on an inpatient unit would be:
- Tailoring rules and expectations to his or her level of functioning
 - Using isolation to protect the other children from anxiety about the schizophrenic child's odd behavior
 - Facilitation of age-appropriate skills through having the same rules for everyone
 - Having high expectations to promote development of skills
56. The community mental health case manager in child and adolescent psychiatric nursing may be called upon to coordinate care for the schizophrenic child. This may include arranging for hospitalization if indicated, involving the families with NAMI, referring to a child study team, and:
- Providing direct services
 - Prescribing medication to a stressed parent
 - Arranging for respite care
 - Providing inpatient services
57. Four-year-old Nicholas screams when he is held, does not go to a caretaker when hurt, plays in isolation with the same object for long periods of time, has numerous rituals, and cannot tolerate the sound of computer keys clicking. A possible diagnosis to screen for would be:
- Attention Deficit Hyperactivity Disorder
 - Oppositional Defiant Disorder
 - Reactive Attachment Disorder
 - Pervasive Developmental Disorder
58. Andy, age 2, had a history of normal development for the first 6 months of life as well as apparently normal prenatal and perinatal development. After 6 months, his head growth slowed down, he began to wring his hands constantly, showed a decline in social engagement, had a poorly coordinated gait, and showed impaired expressive language and psychomotor retardation. The most likely diagnosis would be:
- Mild Mental Retardation
 - Childhood Disintegrative Disorder
 - Rett's Disorder
 - Autistic Disorder
59. Adult personality disorders may be presaged by which of the following child and adolescent disorders?
- Reactive Attachment Disorder
 - Dysthymia
 - School Phobia
 - Oppositional Defiant Disorder
60. Which of the following of the personality disorders may be diagnosed in older children or adolescents?
- Narcissistic
 - Borderline
 - Schizotypal
 - Phobic
61. Depression is unusual up until the age of:
- 10
 - 13

- c. 7
d. 9
62. Change in weight or appetite disturbance are vegetative signs of depression. This criterion is modified in children to include failure to achieve expected gain or:
- Greater than 5% loss of body weight in 1 month
 - Greater than 10% loss of body weight in 1 month
 - Loss of 5 pounds in 3 months
 - Weight gain of 5% in 6 weeks
63. Depression in children is comorbid with many other disorders, including:
- Childhood-Onset Schizophrenia
 - Childhood Disintegrative Disorder
 - Anxiety disorders
 - Rumination Disorder of Infancy
64. The risk of a child having a mood disorder increases with which of the following?
- Family chemical dependency
 - Divorce of the child's parents
 - Change in schools
 - Obesity
65. Suicide among adolescents increases markedly at which age range?
- 15–17
 - 13–14
 - 15–24
 - 17–20
66. The highest suicide rates occur in:
- Black males
 - Black females
 - White males
 - White females
67. Two youngsters in a small school successfully complete suicide. The psychiatric and mental health advanced practice nurse is invited to do a crisis debriefing for the school personnel. It is important to help the staff to avoid simplistic explanations for the suicide and:
- Avoid graphic descriptions of the suicides
 - Glorify the deceased
 - Focus on the deceased's nonsuicide characteristics
 - Pretend as if nothing had happened
68. Bipolar children and adolescents usually require dosing that is:
- Lower than adults
 - Divided in smaller doses
 - The same as adults
 - Higher than adults
69. Bipolar youngsters are often a diagnostic challenge. Children less than 9 years old who are manic are usually:
- Extremely aggressive
 - Difficult to soothe
 - Good team players
 - Irritable with emotional lability
70. Which of the following conditions may present in a similar way to bipolar illness in children?
- Neurological conditions, such as head trauma
 - Munchausen's Syndrome by Proxy
 - Chromosomal abnormalities
 - Hepatitis
71. The age of onset for anorectic youngsters is most commonly at:
- 10–14
 - 12–18
 - 14–19
 - 9–12
72. What is important for the nurse to keep in mind when evaluating a child who has lost weight due to anorexia?
- The same percentage of body weight lost applies to children and adults.
 - Three-percent weight loss in children is diagnostically certain for anorexia.
 - Anorectic children do not lose weight if attention is not focused on them.
 - Children do not have to lose the percentage of weight applicable for an adult with an eating disorder.
73. Stephen, age 7, throws up his breakfast every morning before school. The least likely disorder is:
- Separation Anxiety Disorder
 - School Phobia
 - Bulimia Nervosa
 - Anxiety disorder not otherwise specified
74. Which of the following is essential to include in developing a plan of care for an adolescent with an eating disorder?
- Art therapy to uncover childhood trauma
 - Music therapy
 - Psychodynamic approaches to ascertain the underlying motivations for difficulties with food
 - Family therapy to modify dysfunctional patterns that maintain the disorder

75. The peak age of onset of Panic Disorder is:
- 10–12
 - 15–19
 - 14–16
 - 10–15
76. Play therapy in which the child tells a story and a therapist also tells a story in reciprocal fashion is a technique that enables a child to express his or her:
- Ways of behaving
 - Cultural norms
 - Unconscious feelings
 - Autonomy
77. Marcie is a 9-year-old girl with severe Attention Deficit Hyperactivity Disorder. Her parents have developed a chart that tracks Marcie's ability to manage and succeed at her various responsibilities and activities. This technique is part of which type of therapy used with children?
- Cognitive therapy
 - Family therapy
 - Behavior therapy
 - Solution-focused therapy
78. Which of the following is a strong predictor of positive outcomes for a child who has a DSM IV diagnosis?
- Intellectual abilities
 - Positive peer relationships
 - Parental involvement in therapy
 - Absence of chemical dependency issues in family of origin
79. Many children and adolescent inpatient settings are based on which of the following models:
- Family systems model
 - Community mental health model
 - Medical model
 - Strategic and solution-focused model
80. "Time out" is a way for a child to reflect upon his or her behavior and regain control. Time in "time out" is generally determined by which of the following?
- Two minutes for each day on the unit
 - One minute for each year of development
 - Level of care
 - Staffing adequacy
81. Joshua, a new boy on the unit, runs up to the nurses' station and crosses over a line meant to keep the children at some distance from the staff. This is the first time you have seen him do this. Which would be the most appropriate response?
- Smiling at him because it is important to help him feel welcome
 - Ignoring the behavior
 - Saying "Josh, remember the unit rules we reviewed earlier today? No running and no crossing the line. The rules are posted in the dining room if you aren't sure."
 - "Stop running. If you do that again, you'll have to go to time out in your room."
82. Which of the following is NOT a medication consideration for children?
- Children differ in response to a medication's main and side effects.
 - When medicating children, start slow, titrate carefully, use the lowest effective dose.
 - Children may metabolize and eliminate medications more rapidly.
 - Antihistamines are safe over the counter medications which have no effect on psychotropic medications.
83. Kevin is a 12-year-old boy recently diagnosed with Bipolar Disorder. In planning medication management for Kevin, it is important to remember:
- Children, adolescents, and adults require the same dosing range.
 - Lithium is hepatotoxic to children.
 - Lithium is cleared rapidly by children, so they may need higher doses to stabilize a mood disorder.
 - Lithium is only used for augmentation in children.
84. The psychiatric and mental health advanced practice nurse is discussing medication management with a 16-year-old adolescent. It is important to remember that adolescents are often resistant to complying with medication due to:
- Resistance to perceived control by authority
 - The success of anti-drug education
 - Side effects
 - A resurgence of interest in "natural medicines"
85. Adolescents may abuse medications by giving or selling them to their friends. Which medications are likely to be abused this way?
- Major tranquilizers
 - Anti-anxiety agents
 - MAO inhibitors
 - SSRIs
86. Skills training as a therapeutic intervention has as its goal:

- a. Career preparation
 - b. Arts and crafts therapy
 - c. Competence in mastering developmental tasks
 - d. Activities of daily living training
87. Which of the following interventions encourages the child to express feelings or reenact loss or trauma?
- a. Structured play
 - b. Supportive therapy
 - c. Behavioral play
 - d. Mutual story telling
88. The child psychiatric nurse clinical specialist provides a sand tray with small figures and objects to encourage a child to tell a story by setting up a scene. This is known as:
- a. Structured play therapy
 - b. Nondirective play therapy
 - c. Solution-focused play therapy
 - d. Stress management
89. One of the most serious outcomes of substance-abuse disorders (SUD) among adolescents is which of the following?
- a. Lack of social mobility
 - b. Interruption of developmental tasks
 - c. Poor social skills training
 - d. Conflict with parents
90. Adolescent substance abuse would be more likely in which of the following families?
- a. Rural farming family
 - b. Emotionally detached parents with lack of involvement in youth's life
 - c. Dual career parents
 - d. Parents who are not involved with community issues
91. Seven-year-old Danielle was sexually assaulted by the babysitter's adolescent son. She has no memory of the event, and has been diagnosed as having traumatic amnesia. Which of the following is a probable outcome of the experience of amnesia?
- a. Traumatic amnesia interferes with the processing of the event and placing it in past memory.
 - b. The child is protected from the effects of the abuse.
 - c. She will likely recall the event when she is ready.
 - d. She will recall the event in traumatic dreams.
92. Conditions to be ruled out in establishing a diagnosis of Attention Deficit Hyperactivity Disorder would include:
- a. Seizures or sequelae of head trauma
 - b. Posttraumatic stress disorder
 - c. Hypersomnia
 - d. Selective mutism
93. Which of the following is contraindicated for the treatment of Attention Deficit Disorder if there is a coexisting seizure disorder?
- a. Tricyclic antidepressants
 - b. SSRIs
 - c. Mirtazapine
 - d. Bupropion
94. Benzodiazepines may be used on a short term basis for children with anxiety disorders. A side effect of clonazepam is:
- a. Behavior inhibition and shyness
 - b. Behavior disinhibition
 - c. Cardiotoxicity
 - d. Excessive clinginess
95. Which of the following is NOT true of adolescents with an eating disorder?
- a. The adolescent is a high risk patient.
 - b. Adolescents with eating disorders tend to be extremely secretive about their illness.
 - c. The mortality rate is 10 to 15%.
 - d. They are extremely compliant with treatment.
96. The latest consensus regarding selective mutism is that:
- a. It is a form of social phobia
 - b. Medicine is ineffective in the treatment of this condition
 - c. These patients have highly controlling parents
 - d. Most of these children have associated hearing problems
97. Which ADHD medication is NOT a controlled substance?
- a. Methylphenidate
 - b. Amphetamine
 - c. Atomoxetine
 - d. All are controlled substances

■ ANSWERS

- | | | |
|--------------|--------------|--------------|
| 1. b | 34. d | 67. a |
| 2. c | 35. d | 68. d |
| 3. d | 36. d | 69. d |
| 4. d | 37. d | 70. a |
| 5. d | 38. a | 71. b |
| 6. b | 39. b | 72. d |
| 7. c | 40. d | 73. c |
| 8. d | 41. d | 74. d |
| 9. a | 42. b | 75. b |
| 10. a | 43. b | 76. c |
| 11. d | 44. c | 77. c |
| 12. a | 45. d | 78. c |
| 13. c | 46. b | 79. a |
| 14. c | 47. b | 80. b |
| 15. b | 48. a | 81. c |
| 16. a | 49. d | 82. d |
| 17. c | 50. a | 83. c |
| 18. d | 51. a | 84. a |
| 19. c | 52. b | 85. b |
| 20. a | 53. c | 86. c |
| 21. c | 54. c | 87. d |
| 22. b | 55. a | 88. a |
| 23. d | 56. c | 89. b |
| 24. b | 57. d | 90. b |
| 25. a | 58. c | 91. a |
| 26. c | 59. d | 92. a |
| 27. d | 60. b | 93. d |
| 28. c | 61. d | 94. a |
| 29. d | 62. a | 95. d |
| 30. c | 63. c | 96. a |
| 31. a | 64. a | 97. c |
| 32. a | 65. b | |
| 33. c | 66. c | |

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The Larger Mental Health Environment

■ MENTAL HEALTHCARE DELIVERY SYSTEM

- The number and variety of psychiatric-mental health delivery care settings have both greatly increased since the 1970s.
- In the United States, the major focus has been in treatment of mental disorders, not the prevention of mental disorders.
- Types of settings
 1. Acute care inpatient settings, either psychiatric units in general hospitals or in psychiatric hospitals
 - a. Often psychiatric units specialize in adults, children, adolescents, alcohol, substance abuse or geriatrics.
 - b. In recent years, changing reimbursement of inpatient stays has resulted in shorter psychiatric lengths of stays.
 - c. From this decline in hospitalization days, many psychiatric units offer an array of services including partial hospitalization, outpatient, and home care.
 - d. Today, most patients that are admitted to the hospital are in crisis with the treatment goal of stabilization.
 - e. Inpatient treatment is focused on preventing harm to oneself or others and the need for multidisciplinary assessment and stabilization.
 2. Public mental hospital settings
 - a. Deinstitutionalization, which began in the 1970s, has reduced the census of the public mental hospitals established by state governments.
 - b. Over the last 40 years, public mental hospital census has declined, while the number of admissions has risen.
 - c. Public mental hospitals have seen an increase in admission rates of younger, violent patients.
 - d. The goals of deinstitutionalization are:
 - (1) To save clients from debilitating effects of lengthy, restrictive periods of hospitalization.
 - (2) To return the client to home and community as soon as possible after hospitalization.
 - (3) To maintain the client in the community for as long as possible.
 - e. In general, the public mental hospital patient population decreased by returning the patients to their families, transferring them to nursing homes, and by shifting them into the community, where unfortunately some became homeless street people because community support did not work.
 3. Ambulatory settings
 - a. Community Mental Health Centers (CMHC)
 - (1) The CMHC Act passed by Congress in 1963 supported mental health centers and deinstitutionalization in all 50 states.

- (2) This legislation represented a shift from the focus of the mentally ill in public mental hospitals to flexible, community care.
- (3) A principle in the development of CMHC was that people with mental illness have a right to treatment in the least restrictive environment.
- (4) In 1965, the five essential services for a federally funded CMHC were inpatient services, outpatient services, partial hospitalization, and consultation and education.
- (5) The legislation provided federal funding to local communities for construction and staffing of CMHC, with the understanding that funding would eventually shift to state and local resources.
- (6) In 1975, seven other essential services were added including children's services, geriatric services, aftercare, state hospital prescreening, drug abuse treatment, alcohol abuse treatment, and transitional housing.
- (7) After deinstitutionalization, the patients were discharged from public mental health hospitals to a CMHC system so that the CMHC staff could provide adequate follow-up.
- (8) CMHC experienced the following problems working with discharged public mental health hospital patients:
 - (a) Many discharged patients found it difficult to adjust to independent community living because patients needed a slow, gradual introduction to independent living.
 - (b) Patients had difficulty keeping appointments and complying with medication schedules.
 - (c) Many patients became involved in a revolving door syndrome or had many, short hospital admissions.
 - (d) Some discharged patients did not receive the anticipated services due to homelessness or incarceration.
- (9) CMHC are successful in working with chronic patients by using crisis intervention, extensive community outreach programs, supportive living arrangements, and work programs.
- (10) Psychiatric emergency crisis/walk-in programs are centralized community mental health programs that offer face-to-face evaluations of patients 24 hours a day.
 - (a) Most of these programs are community-based with some operating in conjunction with a general hospital emergency department.
 - (b) Emergency services were originally targeted for suicide prevention and outpatient treatment of acute psychosis.
 - (c) Crisis programs provide care for the acutely decompensated chronically mentally ill patient living in the community
- (11) Psychiatric emergency services have continued to evolve in the community over the last 20 years as most urban settings have centralized emergency services in one or a few sites.
 - (a) Many rural areas are coordinating networks of emergency services at a limited number of sites, usually in a general hospital.
 - (b) Many emergency services have expanded roles so that patients can stay for several days.
 - (c) Some programs offer community outreach programs whereby staff go into the community to work with patients.
 - (d) Many emergency services start long-term medication regimes such as antidepressants.
- (12) The current state of mobile crisis services by a 50-state survey:
 - (a) By 1995, 73% of the states had mobile emergency services and provided services in private homes, hospital emergency rooms, residential programs, shelters, correctional facilities, bus and train stations, and general hospital medical units.
 - (b) Mobile crisis units were reported to provide for patients and families: earlier interventions, improved access to care, support for families, minimizing patient's trauma (Geller et al, 1995).
 - (c) A 2009 Agency for Healthcare Research & Quality (AHRQ) report described reduced inpatient hospitalization, shorter stays if hospitalized, and a significant reduction in healthcare costs for children in crisis who were managed by a mobile

- multidisciplinary crisis team in Milwaukee, WI—report available at: <http://www.innovations.ahrq.gov/content.aspx?id=1719>
4. Day treatment programs and partial hospitalization programs (PHP) are ambulatory treatment programs that include the major, diagnostic, medical, psychiatric, and pre-occupational treatment modalities designed for patients with serious mental disorders who require coordinated, intensive, and multidisciplinary treatment not provided in the usual outpatient setting. The length of these programs varies from 4-to-8 hours per day and from 1-to-5 days a week, and programming can occur at nearly any time of the day (day-time, evening, or night) (Keltner, Schwecke, & Bostrom, 2007; Rosie, Azim, Piper, & Joyce, 1995).
 - a. The four functions of partial hospitalization include:
 - (1) Treatment of acutely ill patients who would be inpatients
 - (2) Rehabilitation of patients who are in transition from acute inpatient to outpatient care
 - (3) Intensive treatment of patients who do not require inpatient care but who may benefit from more intensive care than it is possible to provide on an outpatient basis
 - (4) Long-term maintenance of chronic psychiatric patients
 - b. For maximum treatment effectiveness, partial hospitals should match the functional level of patients with treatment intensity.
 - (a) An intensive group-oriented psychotherapy program may lead to deterioration of acutely ill patients.
 - (b) If low functioning patients are treated with patients needing intensive group-oriented psychotherapy, the intensity of the program may be diluted.
 5. Other community settings
 - a. There are many psychiatric nurse roles, including case managers, psychiatric home health nurses, psychiatric community outreach nurses, psychiatric nurses who practice in vocational and rehabilitation centers, and psychiatric nurses who work in a variety of collaborative practice settings.
 - b. A psychiatric nurse who is a case manager can work with patients, families, and groups over the continuum of care, from an inpatient setting to community-based care such as an outpatient clinic or home.
 - c. Case management, a standard of PMH nursing care (ANA, APNA, ISPN, 2007), is a clinical system that focuses on the accountability of an identified individual or group by:
 - (1) Coordinating patient or group patient care across an illness episode or continuum of care (for example, clinic to hospital to home)
 - (2) Ensuring and facilitating achievement of quality and clinical cost outcomes
 - (3) Negotiating, obtaining, and coordinating services and resources needed by patients/families
 - (4) Intervening at key points for individual patients (for example, using critical pathways)
 - (5) Addressing and resolving patient patterns that cause poor quality-cost outcomes within collaborative teams
 - (6) Creating opportunities and systems of health care to enhance patient outcomes (Easterling, Avie, Wesley & Chimner, 1995)
 - d. Community mental health nurses assist patients with a range of psychological problems and are concerned with the patient's stress, coping and adaptation.
 - e. Community mental health nurses assist individuals and families to anticipate the course of events in the mental healthcare system.
 - f. Psychiatric mental health nursing in home health
 - (1) In recent years, there has been an increased need for psychiatric nurses in the home.
 - (2) A criterion for providing home health is usually that the patients are homebound or their illnesses result in them not being able to leave their home.
 - (3) Three groups of common homebound patients include:
 - (a) People living alone especially the elderly
 - (b) People with medical illnesses, especially chronic illnesses
 - (c) Chronically mentally ill people
 - (4) The psychiatric nurse may provide:
 - (a) Direct caregiving, such as assisting a depressed patient to perform his/her activities of daily living

- (b) Counseling, such as assisting a depressed patient to modify negative thinking
 - (c) Education, such as teaching a depressed patient about his/her antidepressant medication side effects
 - (d) Referral, such as scheduling an appointment when the patient needs medication adjustment
 - (e) Health promotion for patients and family, such as guiding the families in preparing balanced nutritional meals
- (5) A community mental health nurse who provides psychotherapy for individuals, families, or groups should possess a graduate degree and be nationally certified.
6. Outpatient & private practice
- a. Since the 1960s, psychiatric nurses have engaged in private practice, especially clinical specialists who hold national certification, e.g., American Nurses Credentialing Center (ANCC) Certification in Advanced Practice (Peplau, 1990).
 - (1) ANCC certification exams for psychiatric nursing include specialty certification in psychiatric and mental health (PMH) nursing for RNs, and several advanced practice certifications:
 - (a) Adult PMH clinical nurse specialist
 - (b) Child/Adolescent PMH clinical nurse specialist
 - (c) Adult PMH nurse practitioner
 - (d) Family PMH nurse practitioner
 - (2) Building concerns about the potential fragmentation of advanced practice PMH nursing suggested by multiple certification titles prompted an analysis of the job skills associated with the various areas of advanced practice PMH nursing.
 - b. Findings from a collaborative study involving the ANCC and American Psychiatric Nurses Association (APNA) found artificial divisions and considerable overlap among the advanced practice roles (of the 335 PMH advanced practice tasks, 332 were deemed essential for both CNS & NP practitioners) (Rice, Moller, DePascale, & Skinner, 2007). The findings prompted recommendation for development of one exam for advanced practice nurses certifying as PMH CNS or NP.
 - c. Nurses can practice alone or with other healthcare professionals.
 - d. Nurses' private practice can include a variety of functions, including individual and family assessment; individual, group, and family psychotherapy; and prescriptive authority for psychotropic medication, depending applicable restrictions of practice as defined by the state nursing practice act, as well as rules for reimbursement.
 - e. In general, barriers to Certified Psychiatric Clinical Nurse Specialists include difficulty in obtaining third-party reimbursement, limited autonomy in organized practice settings, and low salaries (Merwin, Fox & Bell, 1996; Puskar & Bernardo, 2002).
 - f. The following are important considerations in working in private practice. The private practitioner:
 - (1) Has the client as the primary obligation.
 - (2) Determines who the client will be.
 - (3) Determines the techniques to be used in service to this client.
 - (4) Determines practice professionally, not bureaucratically.
 - (5) Receives a payment directly from or on behalf of the client.
 - (6) Is educated in a graduate program.
 - (7) Is sufficiently experienced as an advanced practice nurse.
 - (8) Adheres to advanced practice nursing values, standards, and ethics and is professionally responsible.
 - (9) Is licensed and certified where applicable to engage in private practice.
 - g. Disadvantages of private practice include:
 - (1) Economic uncertainties and possible financial difficulties
 - (2) Professional isolation, loneliness, and lack of advancement
 - (3) Malpractice suits
 - (4) Total responsibility for professional accountability and professional competence
 - h. Guidelines for establishing a viable private practice
 - (1) Evaluate whether solo or group practice is desirable.
 - (2) Create a financial management system.
 - (3) Obtain malpractice and office liability insurance.
 - (4) Establish criteria for hiring employees and using consultants.
 - (5) Ensure that private practice is geographically accessible.

- (6) Implement successful marketing strategies, including specialization and courteous attention to referrals.

■ MANAGED CARE—AN INTERNAL FORCE OF CHANGE WITHIN THE MENTAL HEALTH DELIVERY SYSTEM

- Managed care is a healthcare strategy designed to achieve the positive outcomes that can result from adopting price competition while controlling for unfavorable effects.
- For competitive low prices, there must be a variety of healthcare providers such as hospitals, physicians, and Health Maintenance Organizations (HMOs).
- For competitive low prices, healthcare providers must keep their costs low by, for example, using cost containment strategies.
- Along with low prices, healthcare providers must provide a quality service.
- Healthcare changes as the result of managed care in the following ways:
 1. Change of provider incentives, change from fee-for-service reimbursement to capitation (See changes resulting with Mental Health & Addiction Equity Act of 2008—capitation is prohibited with this law)
 - a. Fee-for-service reimbursement is the traditional method of paying healthcare providers, where providers determine what healthcare services the patient needs, and the insurer passively pays for each service received by the patient according to the reasonable charge in a given geographical area.
 - b. Capitation is a preset amount of money allocated to provide set services for a population over a stated period of time, regardless of service used. Typically, an employer or third-party payor will contract with a behavioral managed care company or a provider organization to provide comprehensive mental health care for a lump sum payment. The managed care company and/or the provider organization then decides what care the patient needs. In capitation, the managed care company and/or the provider organization incurs more risk if healthcare costs for a group of people exceed the capitated payment.
- Organizational changes needed in managed care include:
 1. Promotion of team-based care or creating a seamless organization
 2. Aggressive promotion of self-care
 3. Case management for high-cost, high-use members
 4. Continuous improvement emphasis
- Impact of managed care on hospital nurses (Buerhaus, 1994)
 1. Decreasing patient length of stay, which results in more staff layoffs, buyouts, retirement, and termination
 2. Downsizing of hospitals including contracting (outsourcing) some services
 3. Tracking specific patient hospital and nursing costs, resulting in more administrative tasks
 4. Substituting of lower skill workers for higher skill workers to lower labor costs
- Ethical dilemmas in managed care
 1. Early patient discharge because of financial incentives
 2. Providers limiting and denying patient treatments and options because of financial incentives, which may result in denial of care
 3. Providers monitoring and controlling patient treatments and resources
- Impact of managed care on advanced practice nurses (Buerhaus, 1994)
 1. Substituting advanced practice nurses for physicians
 2. Professional conflicts among different providers who provide similar services
 3. Increasing responsibility of advanced practice nurses to lower costs and monitor patients' source consumption

■ REIMBURSEMENT FOR MENTAL HEALTH SERVICES

- Sources of reimbursement include:
 1. Government payers—Medicaid & Medicare
 2. Private insurers—HMOs and other private indemnity organizations
 3. Private pay—patients paying their own bills “out of pocket”
 4. Contracts—with business, other agencies, etc. (Buppert, 2008)

■ TYPES OF HEALTHCARE INSURANCE PLANS

- Health Maintenance Organizations (HMOs) are organizations that receive money from consumers

in exchange for a promise to provide all health care required during a defined period of time. Consumers have restricted choice of healthcare providers, no cost for services beyond insurance payment, restricted choice to hospitals, reduced cost to employers who buy the insurance (Cleverley, 1997).

- Preferred Provider Organizations (PPO) are programs that contract with healthcare providers to provide healthcare services to consumers, usually at a discounted rate. Consumers have some restricted choice by using contracted healthcare providers, copay for services, access to contracted hospitals, some reduced cost to employers who buy the insurance (Cleverley, 1997).
- Traditional fee-for-service insurance plan—Consumers have freedom of choice of healthcare providers, usually pay a deductible and 20% of outpatient charges, unlimited access to choice of hospitals. Employers usually pay a higher cost but employees have freedom of choice.
- Combinations and variations of HMOs, PPOs and traditional fee-for-service types can be available.

▣ EXTERNAL FORCES INTERACTING WITH THE MENTAL HEALTH SYSTEM

- Social issues
 1. Role behavior
 - a. Stereotyping behavior is useful in examining roles such as men and women, nurse and physician, and female patient and male therapist, male patient and female therapist.
 - b. In general, there are distinct beliefs about the characteristics of men and women, including:
 - (1) Male characteristics reflect competencies such as competitiveness, independence, and objectivity.
 - (2) Females are perceived as being opposite of these characteristics and therefore dependent, noncompetitive, and subjective.
 - (3) Men are perceived as being blunt and unable to express feelings.
 - (4) Women are seen as having tact, awareness of other's feelings, and an ability to express their feelings.
 - (5) These sex role stereotypes can impact many areas of a person's life including:
 - (a) A person's self-esteem and prescribed role in society
 - (b) The nurse-client therapeutic relationship

(c) Nursing roles with other health-care disciplines

2. Power
 - a. Definition—the potential of an individual or a group to influence the behavior of another
 - b. Types of power (Marquis & Huston, 1994)
 - (1) Legitimate power—power gained by a title or official position
 - (2) Expert power—power gained through knowledge and expertise
 - (3) Reward power—power obtained by the ability to grant favors or to reward others with what they value
 - (4) Coercive power—power obtained on fear of punishment
 - (5) Referent power—power obtained by an individual because of an association with others
 - c. Strategies for acquiring and using power in communities and organizations (Marquis & Huston, 1994)
 - (1) Present a powerful image and assume authority in your interactions.
 - (2) Learn to speak the community's or organization's language.
 - (3) Acquaint yourself with who is powerful and network.
 - (4) Seek experts' advice and build a knowledge base.
 - (5) Increase visibility and use the politicians' priorities to speak your needs.
 - (6) Empower others by sharing knowledge and increasing team building.
- Political issues
 1. Current healthcare legislative issues include concerns about:
 - a. Healthcare coverage for the uninsured and other vulnerable populations such as children, women, and the chronically ill
 - b. Developing and implementing a national healthcare plan to assure adequate health care, including mental health care, for all citizens
 2. The care of people with mental health disorders is challenged by their vulnerability and lack of voice in the political process.
 3. Key past mental health legislation
 - a. In 1935, the Social Security Act influenced mental health care because of the shift from state to the federal government in the care of ill people.
 - b. In 1955, the Mental Health Study Act created the Joint Commission on Mental Illness and Health that recommended shift of patient populations from state hospital

- systems to community mental health systems.
- c. In 1963, the Community Mental Health Centers Act created community mental health centers and led to deinstitutionalization. Federal funds were to match state funds in creating CMHC.
 - d. In 1975, the Developmental Disabilities Act focused on the rights and treatment of people with developmental disabilities and provided a foundation for individuals with mental disorders.
 - e. In 1977, the President's Commission on Mental Health supported community mental health centers, protection of human rights, and insurance for mentally ill people.
 - f. In 1986, the Protection and Advocacy for Mentally Ill Individuals Act provided advocacy programs for mentally ill people.
 - g. In 1990, the Americans with Disabilities Act promoted employment opportunities and prohibited discrimination for all people with disabilities including mental disorders.
 - h. In 1998, the Mental Health Parity Act of 1996 prohibited lifetime or annual limitations on mental health coverage for certain insured employees.
 - g. In 2008, the Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act of 2008 (P.L. 110-343) amended the 1996 Mental Health Parity Act (to take effect January 2010). The law does not require health insurance plans to provide mental health and substance abuse benefits, but prohibits employer healthcare plans from imposing caps or limitations on mental health treatment or substance-use disorder benefits that aren't applied to nonpsychiatric benefits (Retrieved from: http://www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp)
4. Use of seclusion/restraints—within the Patient Rights Document, the Centers for Medicare & Medicaid Services (CMS) has published strict rules for the use of seclusion and restraints.
 - a. Seclusion and restraint are defined as follows:
 - (1) Restraint—the physical control of a patient to prevent injury to patient, staff, and others
 - (2) Seclusion—the involuntary confinement of a patient to a specially designed room for their own safety (O'Brien, Kennedy & Ballard, 2008)
 - b. The use of seclusion and restraints should occur only after all other therapeutic interventions have been exhausted. All patients have the right to be free from any form of restraint (physical or chemical) (2009 update of the CMS document retrieved from: http://www.cms.hhs.gov/manuals/Downloads/som107ap_a_hospitals.pdf).
 5. National healthcare agenda, under the Public Health Service, Healthy People 2010 (US Department and Health and Human Services, 2000) creates a national focus on promoting health and preventing disease. The following are areas related to mental health and mental disorders:
 - a. Reduce suicide, especially among children and adolescents and in jails.
 - b. Reduce mental disorders among children, adults, and elderly.
 - c. Among those with serious mental illness, reduce homelessness, increase employment.
 - d. Reduce relapse among those with eating disorders.
 - e. Increase the numbers receiving screening for mental disorders when receiving care in primary healthcare setting.
 - f. Increase treatment for people with depressive disorders, anxiety, schizophrenia, substance abuse and co-occurring substance abuse and mental disorders.
 - g. Increase access to care for people with personal and emotional problems.
 - h. Increase cultural competence of providers.
 - i. Among recipients, increase satisfaction with mental healthcare services
 6. Strategies for psychiatric-mental health nurses to serve as change agents for addressing mental health issues include:
 - a. Write and verbalize concerns and solutions to legislative bodies and the media.
 - b. Seek membership on community committees that recommend or formulate policy.
 - c. Be familiar with the legislative process, obtaining copies of bills and making presentations at local, state, and federal hearings.
 - Financial issues
 1. The United States finances health care by both public and private monies.
 2. With the passage of Medicare and Medicaid legislation in 1965, the federal government embarked upon a significant subsidy to health care, greatly increasing access to care (McCloskey & Grace, 1994).
 3. Expenditures for mental health treatment grew from \$33 billion in 1986 to \$100 billion in 2003 (Mark et al., 2007).

4. Since 1986, more mental health care is being provided in the outpatient setting with an increased use of psychotropics.
5. Reimbursement for advanced practice nursing
 - a. With the Budget Reconciliation Act in 1997 (the legislation included the Primary Care Health Practitioner Incentive Act), Congress authorized direct Medicare reimbursement for all advance practice nurses (at 85% of physician fee rate), regardless of geographic practice area (Buppert, 2008; Frakes & Evans, 2006).
 - b. Types of reimbursements (McCloskey & Grace, 1994)
 - (1) Fee-for-service reimbursement—current trends throughout the country indicate that probably less than 20% of mental health care will be delivered through the traditional fee-for-service model.
 - (2) Medicare reimburses health care for the elderly and some disabilities by this federal program. Hospitals are now reimbursed a flat amount based (Diagnostic Related Group) upon the patient's medical diagnosis, age, surgical procedure, and comorbidity (existence of other medical conditions). Home care, including psychiatric home care, is reimbursed under Medicare.
 - (3) Medicaid is a federally assisted and state-administered program for the indigent.
 - c. Contract payment and services
 - (1) Nurses can develop contracts to provide specific services independently for patient subgroups being served by HMOs or other healthcare providers.
 - (2) Many times, these providers are interested in the cost of the service and who can legally and safely provide that service.
 - (3) Service contracting is a matter of defining a required service for a group of clients that is difficult to provide with existing staff.
 - (4) Reasons for promoting contractual liaisons (Marshall, 1994) include: defining a particular population, increasing profitability for selected healthcare professionals, and lowering the cost for third-party payers and facilities.
 - d. Obtaining third-party reimbursement (Buppert, 2008)
 - (a) When making an application to managed care organization/insurer provider panels, requests for the following information are usually included in the credentialing application:
 - i. Advance practice PMH nurse's identifying information (name, address, birth date, social security number, military service, etc.)
 - ii. Licensure information (RN, state advance practice authorization, specialty area)
 - iii. National provider identifier (NPI) number
 - iv. DEA license number (if prescriptive authority includes controlled substances)
 - v. Professional liability coverage
 - vi. National certification in area of specialty
 - vii. Any professional sanctions
 - viii. Practice type and location
 - e. Billing for private practice (Billings, 1993)
 - (1) Not all clients have or want to work with insurance; some will pay for services themselves.
 - (2) Give new clients a handout so the financial arrangement will be clear.
 - (3) Before the first visit, have the client check with their insurance to see what services are covered or whether visit needs to be preauthorized.
 - (4) On the first visit, use an initial data form to obtain all necessary information, such as date of birth, social security number, and insurance information.
 - (5) If the client is filing for his/her own reimbursement, provide the necessary information.
 - (6) If the client requests your assistance, approach the insurer with the assumption that you will be reimbursed.
 - (7) If need be, apply to become an authorized provider.
 - (8) One way to increase referrals is to develop a relationship with the referral source.
 - f. Questions that assist in determining private practice charges include:
 - (1) How much do other advanced practice nurses providing a similar service in the area charge?
 - (2) How much do other similar helping professionals in the area charge?
 - (3) What is your level of experience and education?

- (4) What do third-party payers say are “reasonable and customary charges” for professionals in your area?
- (5) What is the most attractive rate for the clientele that you hope to attract?
- g. Private practice in managed care (Godschalx, 1996)—In fee-for-service reimbursement, the nurse must evaluate the client to obtain a diagnosis and to match the client to available services. Reimbursement is based upon the diagnosis.

▣ LEADERSHIP AND MANAGEMENT

- Leadership theory and roles
 1. Leadership is the process of influencing others toward goal setting.
 2. Gardner identifies the tasks of leaders as: envisioning goals, affirming values, motivating, managing, achieving workable unity, explaining, serving as a symbol, representing the group, and renewing their energy (Swansburg, 1996).
 3. Early leadership studies focused on identifying leadership traits in individuals, such as intelligence, personality, and abilities.
 4. Studies of leadership styles in the 1930s by Lewin and colleagues examined the decision-making styles of leaders:
 - a. Autocratic—leaders make decisions alone.
 - b. Democratic—leaders involve followers in the decision making process.
 - c. Laissez-faire—leaders are permissive and allow followers to have complete autonomy.
 5. Hersey and Blanchard’s Life-Cycle of Situational Leadership (Swansburg, 1996)
 - a. Assumes that the type of leadership depends on the situation.
 - b. The three main factors to consider in the leadership process are: the leader, the situation, and level of maturity (readiness) of the followers.
 - c. As a follower becomes more mature, the follower needs less structure (task structure) and more focus on building relationships in the group (relationship behavior).
 - d. Leadership strategies vary depending on the follower and include:
 - (1) Telling—for followers who are immature and need high task structure and low relationship behavior; leaders provide specific instructions and closely supervise performance
 - (2) Selling—for followers who are a little less immature and need high task structure and high relationship

behavior; leaders explain decisions and provide opportunity for clarification

- (3) Participating—for followers who are more mature and need low task structure and high relationship behavior; leaders share ideas and facilitate decision making
- (4) Delegating—for followers who are mature and need low task structure and low relationship behavior; leaders turn over responsibility for decisions and implementation

- Management theory and roles—classical management theory describes the functions of management as planning, directing, organizing, and evaluating.
 1. Planning
 - a. Using epidemiology for planning priorities
 - (1) Epidemiology is the study of disease in human populations.
 - (2) Epidemiologists are concerned with patterns of disease such as communicable, congenital, and chronic illnesses within a population.
 - (3) Epidemiology focuses on characterizing health outcomes in terms of what, who, where, when, and why. For example, what is the disease? Who is affected by the disease? When do disease related events occur? Why did the disease related events occur?
 - (4) Epidemiological research has shown a positive relationship between physical and psychiatric disorders, and that the strength of this relationship varies among different populations.
 - (5) Epidemiological findings assist researchers and funding agencies to establish priorities to guide future research.
 - (6) Epidemiology has been useful in examining mental illness caused by poisoning, chemicals, drug usage, nutritional deficiencies, biological agents, and electrolyte imbalances (Stuart & Sundeen, 1996).
 - (7) The following epidemiological triangle is useful to explain the presence or absence of illness:
 - (a) Host or population characteristics in the occurrence, nonoccurrence, or prognosis of an illness—includes factors such as age, gender, marital status, ethnicity,

- low self-esteem, poverty and unemployment.
- (3) Three major causes of mortality in women are heart disease, cancer, and cerebrovascular disease.
- f. Planning men's health
- (1) Men are physiologically more vulnerable, evidenced by more male infant deaths and shorter predicted lifespan. Many reasons account for this difference including genetics, risk-taking behaviors, and ignoring warning signals.
 - (2) Males have more significant death rates in AIDS, suicides, homicides, and accidents.
 - (3) Male suicide rate is four times higher than females and the eighth leading cause of death overall.
 - (a) Men are more likely to make a serious attempt to kill themselves rather than use it as a cry for help.
 - (b) Suicide risk factors for men include: over 65 years of age, unmarried, unemployed, previous attempt, positive family history, and suffering from terminal illness or other medical condition.
 - (4) Alcohol disorders remain high for men—chronic liver disease and cirrhosis are health diseases affecting men.
 - (5) Men have a higher incidence of anti-social behavior.
- g. Planning for the homeless
- (1) Homelessness and criminalization are concerns for many people with chronic mental illness.
 - (2) It is believed between 25–33% of the homeless population is chronically mentally ill.
 - (3) The new “revolving door” is not within the state hospital but has been now described as inside the county jail, with the criminal justice system being described as the newest mental hospital.
- h. Three types of planning
- (1) Strategic planning is a continuous, systematic process of making risk-taking decisions today with the greatest possible knowledge of their impact on the future, usually done for the next 5-year period.
 - (2) Functional planning is a specialty service planning, such as planning for a staff development department.
- (3) Operational planning is everyday work management, develops shorter term goals from both long-range and short-range plans.
- i. Steps in preparing a planning project proposal, for example, starting an adolescent therapy group for an outpatient practice setting include:
- (1) Describe the current business or the current outpatient practice.
 - (2) Analyze the strengths and weakness within the outpatient setting of starting the proposed adolescent group.
 - (3) Analyze the opportunities and threats outside of the setting of starting the proposed adolescent group; for example, are other outpatient settings also conducting the same group?
 - (4) Describe the product or group therapy, including all staff, facility, and financial resources.
 - (5) Describe how the program will be marketed.
 - (6) Describe how the program fits into the organizational chart.
 - (7) Show a projected time line or the steps and dates when the project or group therapy will begin.
 - (8) Describe how much the program will cost, and how much revenue the program will produce.
2. Directing
- a. Definition—coordinating or activating work
 - b. The manager directs work activities such as issuing assignments, orders, and instructions that permit the worker to understand what is expected as well as contribute to the attainment of organizational goals.
 - c. The manager needs to establish work guidelines, manage time efficiently, resolve conflict, facilitate collaboration, and negotiate for needed resources.
 - d. The manager needs to create a motivating climate for staff by using motivation theories.
 - (1) Reinforcement Theory—B. F. Skinner's Behavior Modification. To motivate staff, managers need to:
 - (a) Create a consistent, visible reward system.
 - (b) Reward positive staff behaviors or the behaviors will be extinguished.

- (2) Herzberg's Two Factor Motivation Theory (Swansburg, 1996). Assumptions are:
 - (a) People want to work and do that work well.
 - (b) Workers can be motivated by work itself.
 - (c) It is possible to separate personal motivators from job dissatisfiers.
 - (d) Job motivators (satisfiers) present in work itself and encourage workers to do the work well—include achievement, recognition, the work itself, responsibility, advancement, possibility for growth, status, company policy.
 - (e) Maintenance factors (hygiene factors) keep workers from being dissatisfied but do not motivate—include salary, supervision, job security, positive working conditions, personal life, interpersonal relations/peers.
- e. The role of the manager in creating a motivating climate (Marquis & Huston, 1994)
 - (1) Communicate clear expectations to staff.
 - (2) Develop the idea of working as a team.
 - (3) Request staff input for decisions that affect staff.
 - (4) Give positive reinforcement.
 - (5) Be fair and consistent with all employees.
 - (6) Allow employees to make as many autonomous decisions as possible.
 - (7) Integrate the uniqueness of each individual into meeting organizational goals.
 - (8) Explain your own and organizational decisions to staff.
- f. Resolving conflicts
 - (1) Conflicts are inevitable outcomes of social interactions.
 - (2) Levels of conflict include: intrapersonal, intragroup, intraterritorial, interpersonal, intergroup, and interterritorial.
 - (3) Questions for diagnosing the conflict (Swansburg, 1996)
 - (a) What is the issue in question?
 - (b) What is the magnitude of the stakes?
 - (c) How interdependent are the parties?
 - (d) Are the parties in a continuing relationship?
 - (e) What is the power and work structure of the parties?
 - (f) How involved are third parties?
 - (g) How do the parties perceive the progress of the conflict?
- (4) Conflict resolution strategies
 - (a) Avoidance or keeping the conflict quiet
 - i. Ignoring the conflict—when issue is trivial or symptomatic of a more basic issue
 - ii. Imposing a solution—when a quick decision is needed or when an unpopular decision is going to be made and the group can not reach a decision
 - (b) Defusion or cooling the emotions of the parties involved
 - i. Smoothing—playing down its importance and magnitude, giving people time to cool down and gain perspective; used when conflict is with issues not related to work
 - ii. Appealing to superordinate goals—when there are important goals that both parties cannot meet without the other's help
 - (c) Containment allows some conflict to come out into the open, but in tightly controlled manner.
 - i. Bargaining—when two parties have relatively equal power
 - ii. Structuring the interaction—when a third party is needed so that the conflict does not escalate
 - (d) Confrontation is openly discussing all areas of conflict with the end result of finding a solution to conflict.
 - i. Integrated problem solving—when there is limited trust among parties and unlimited time to problem solve
 - ii. Redesigning the organization—when sources of conflict come from work processes and the work can be divided into more self-contained work groups

3. Organizing

- a. Open systems theory

- (1) An organization is greater than the sum of its parts.
 - (2) Permeable boundaries exist between the organization and its environment.
 - (3) The input, throughput, and output processes are goal-oriented, focused on accomplishing organizational work.
 - (4) The components of the throughput (work) process are the workers, the work itself, the formal support processes, and the informal support processes.
 - (5) The organization is dependent on the environment for resources to do the work and to accept its work.
 - (6) The organization is constantly adapting.
 - (7) Over time, the organization will become larger and will become increasingly complex and specialized.
- b. Organizing patient care delivery
- (1) Many nursing units organize patient care based on the existing delivery system or by the latest trend.
 - (2) Patient care delivery systems include case management, primary nursing, team nursing, functional nursing, and any variation of these.
 - (3) Factors to be considered in the decision of selecting the optimal patient care delivery system include (Marquis & Huston, 1994):
 - (a) Quality of care and cost-effectiveness
 - (b) Patient and family satisfaction
 - (c) Nursing and other discipline satisfaction
 - (d) Consistency with organizational philosophy and goals
 - (e) The nature of work that needs to be accomplished
- c. Organizing the budget
- (1) Managers are concerned with following types of budgets:
 - (a) Personnel budgets reflecting the amount of money spent on staffing, including full-time personnel, part-time personnel, and personnel hired as needed.
 - (b) Operating budgets reflect expenses that fluctuate up or down when services are provided, such as electricity, supplies, rent, and repairs.
 - (c) Capital expenditure budgets reflect large purchase items that have use over a year's time, such as hospital beds or desks.
 - (2) Stages of the budget include:
 - (a) Planning the budget, usually 6 months to a year
 - (b) Reviewing and justifying the final budget
 - (c) Implementing the budget
 - (d) Monitoring and reviewing the budget
- d. Organizing nurse and client empowerment
- (1) Empowerment is a process that changes the distribution of power and enables others to recognize and use their talents and contributions so that they experience their own personal power.
 - (2) Nursing empowerment is creating an empowering climate for nurses and staff (Gunden & Crissman, 1994). Empowerment is created by:
 - (a) Fostering trust—manager needs to demonstrate constancy, congruity, reliability, and integrity.
 - (b) Feedback—manager needs to receive and give realistic feedback including fostering opportunities for staff to make decisions, and by providing inspiration.
 - (c) Communication—manager needs to encourage openness in organizational communication.
 - (d) Goal setting—manager needs to work with staff to set goals for their work and for their professional development.
 - (e) Positivity—manager needs to create a positive climate so that the staff can accomplish their goals.
 - (3) Client empowerment creates an empowering climate for patients.
 - (a) Nurses should assist all vulnerable groups to achieve a greater sense of empowerment.
 - (b) Clients who are empowered have a greater sense of hope and are more able to make autonomous decisions about health care that may increase their level of health.
 - (c) Nursing interventions for assisting clients to feel more empowered include: active listening, letting clients know their rights, initially acting as an advocate for them if needed, reassuring them that fears are normal, mutually

- setting reasonable goals, helping them identify their strengths, being culturally sensitive, and teaching health promotion and disease prevention.
- (d) The empowerment model of recovery is a health promotion model in which individuals define their own needs and are active collaborators with a variety of people in their own healing (Fisher, 1994).
 - (e) The empowerment model of recovery is based on experiences of consumers in recovery and on the independent living movement, which is a grass-roots movement for social justice and civil rights led by people with disabilities.
 - (f) Nurses can apply the principles of the empowerment model of recovery by using the following methods (Fisher, 1994):
 - i. Facilitating recovery through education and instilling hope
 - ii. Developing alternatives to hospitalization
 - iii. Providing state funding for involuntary admissions under the public safety budget rather than the healthcare budget
 - iv. Maximizing consumer involvement in all aspects of treatment; establishing self-help and consumer-run services
 - v. Ensuring that consumers are genuinely and effectively involved in activities to protect human rights and improve the quality of services
 - vi. Favoring the role of personal care attendants rather than case managers (who are too controlling)
 - vii. Viewing the life experience of recovery from a serious psychiatric disability as an asset in hiring, not a liability
 - viii. Promoting consumer control and choice in housing and financial, educational, vocational, and social services
 - ix. Providing staff training based on the needs of consumers
 - x. Basing quality improvement of mental health services on outcome measures designed by survivors and consumers
4. Evaluating
 - a. Evaluation is the systematic attempt to assess worth and value for decision-making purposes.
 - b. Program management and evaluation
 - (1) For program improvement, use formative evaluation or receive intermittent feedback throughout the program's performance.
 - (2) For program judgment at the end of program, use summative evaluation.
 - c. Types of measurement in evaluation
 - (1) Resources for program—structure of people, equipment, and setting
 - (2) Judgments of process performance
 - (3) Concerns and issues of all stakeholders or those having an interest in the program
 - (4) Goals and objectives of program and whether goals and objectives were met
 - (5) Intended and unintended program outcomes
 - d. Methods of measurement.
 - (1) Empirical research designs with statistical analysis
 - (2) Questionnaires and surveys of stakeholders for attitudes, satisfaction, and goal attainment
 - (3) Comparison to other similar programs
 - (4) Review of documents, policies, and procedure manuals
 - (5) Cost analysis for effectiveness, benefits, feasibility
 - (6) Interviews of individuals or focus groups
 - (7) On-site observation of process and structure
 - e. Quality in health care
 - (1) Continuous quality improvement (CQI) is a philosophy for evaluating and managing the quality of health-care services.
 - (2) To successfully integrate a philosophy of quality into a mental health setting, staff must understand the philosophy and processes of improving quality in a collaborative, multidisciplinary setting.
 - (3) Total Quality Management is a management philosophy that incorporates the concept of continuous quality improvement by involving all levels

- of personnel within an organization to actively participate in decision making.
- (4) The definition of “quality” has broadened from a property of the product to being defined by the customer, which focuses mental health care on the customer.
 - (5) Deming (1986) wrote that to increase quality, management should:
 - (a) Create an organizational culture that embraces opportunities to improve services.
 - (b) Eliminate quotas, slogans, and awarding contracts based on price alone.
 - (c) Promote self-improvement of workers and management.
 - (6) To be effective over time, quality improvement involves:
 - (a) Staff working together to improve the work process. Employees can only be as productive as their work process is organized.
 - (b) All staff using a continuous, rational approach for problem solving over time. It involves every employee on every level working together.
 - (c) Feedback mechanisms built into work processes so that work can be monitored and improved. When quality is improved, mistakes occur less often, resulting in less cost.
 - (d) A plan systematically attacking problems identified by staff and patients.
- f. Peer evaluation
- (1) Peer evaluation has been shown to be a valuable part of a total performance evaluation plan and can include multiple ratings of different peers.
 - (2) Peer evaluation identifies strengths and weaknesses of an employee, identifies competency, increases self-awareness, improves and evaluates the enactment of professional roles.
 - (3) The three phases of peer review
 - (a) Employees become familiar with peer review.
 - (b) Objectives are defined; employees try different peer review techniques; objectives are further refined.
 - (c) Peer evaluation becomes fully operational.
- g. Self-evaluation
- (1) Nurses should be continually involved in self-evaluation or identifying their own strengths and weaknesses in a professional role. Nurses are accountable to the public and profession.
 - (2) Self-evaluation has been found to be threatening if an employee must discuss findings in a group of other employees.
 - (3) Advanced practice nurse self-evaluates practice based on client outcomes (ANA, 1996).
- h. Evaluation of care and legal issues (Fontaine & Fletcher, 1995; Stuart & Sundeen, 1996)
- (1) Nurses’ ability to provide safe care is enhanced by knowledge of the law, particularly legislative decisions affecting the state’s nurse practice act, ANA Code of Ethics for Nurses, and Standards of Psychiatric Practice.
 - (2) An important concept in psychiatric nursing is understanding the legal framework for the delivery of mental health care in the state in which the nurse practices.
 - (3) State law may also vary regarding admissions, discharges, patient rights, and informed consent.
 - (4) Types of admissions to psychiatric units
 - (a) Voluntary admission—signed standard admission form indicating patient voluntarily seeks help.
 - (b) Involuntary admission or commitment—patient did not request hospitalization and admission was initiated by hospital or court.
 - (c) Emergency involuntary admission
 - i. State laws differ as to procedures for petitioning for admission, psychiatric evaluation of the client, treatment available, and length of detainment (usually 2–3 days).
 - ii. Clients are restricted from leaving and may be forced to take psychotropic medication.
 - iii. Clients’ right to consult with attorney to prepare for hearing must be enforced.
 - (d) Indefinite involuntary admission
 - i. Civil hearing is convened to determine need for continuing involuntary treatment.

- ii. “Clear and convincing evidence” of “mentally ill and dangerous to self and others” must be demonstrated.
- (5) Clients do not lose their legal rights because they are admitted to a psychiatric facility.
- (6) Malpractice is the failure of professionals to provide the proper and competent care resulting in harm to the patients, judged by national standards of care by other members of their profession.
 - (a) Nurses should be familiar with the following resources that help define standards of care:
 - i. Code of Ethics for Nurses with Interpretive Statements
 - ii. Scope and Standards of Psychiatric Nursing Practice
 - iii. Nurse practice statutes of the state
 - iv. Evidence-based practice/ treatment guidelines
 - v. Documents published by the Joint Commission on Accreditation of Health Care Organizations (JCAHO)
 - vi. Federal Agency Guidelines (USPHS) (AHCPR)
 - vii. Statements from the American Hospital Association
 - viii. Policies and Procedures of the employing agency
 - (b) If standards are not clear in a particular instance, a lawyer should be consulted.
 - (c) Malpractice suits usually come from angry patients who have had poor results from treatment.
 - (d) Malpractice lawsuits involving nurses usually include administration of medications or treatment, communications, and supervision of patients.
 - (e) Most malpractice suits are filed under the law of tort, which is a private civil wrong committed by one individual against another for which money damages are collected by the injured party from the wrongdoer.
- (7) Battery is a harmful or offensive touching of another’s person.
- (8) Assault is a threat to use force without actual bodily contact, although the person must have the opportunity and ability to carry out the threat immediately (words alone are not enough).
- (9) Negligence is an act or an omission to act that breaches the duty of due care and results in or is responsible for a person’s injuries.
- (10) For psychiatric mental health nurses, the most common causes of negligence are implementation of suicide precautions and assisting in electroconvulsive therapy.
- (12) Informed consent is the client’s right to receive enough information to make a decision about treatment and to communicate the decision to others.
 - (a) In an absence of consent, a healthcare provider can be held liable in a civil lawsuit for battery, assault, and professional negligence.
 - (b) In the case of an emergency situation, consent may not be obtained because a delay would endanger the client’s health and/or safety, and the client may be treated without legal liability.
 - (c) To give informed consent, the patient should be told the diagnosis, differential diagnosis, nature of diagnostic and therapeutic procedures to be performed, the prospect of success from the treatment, prognosis or expectations, and alternative courses of treatment if available.
- (13) Clients must be informed of the potential risks of medications and have the right to refuse medications. If the physician or nurse believes the patient needs the refused medication, the physician can take the decision to the courts to rule whether client is incompetent.
- (14) Competency is a legal determination that a client can make reasonable decisions about treatment and other areas of his/her personal life.
- (15) Communication, both written and oral, is a legal responsibility. Specific charting, e.g. on suicide precautions, documents the nurse’s actions.
- (16) There are federal rules regarding chemical dependence confidentiality so that staff members cannot disclose any admission or discharge information.

- (17) All 50 states have enacted child abuse reporting statutes that generally include a definition of child abuse, a list of persons required or encouraged to report, and the governmental agency designated to receive and investigate the reports.
 - (18) Some states have enacted adult abuse laws.
 - (19) Duty to warn or disclose (*Tarasoff v. The Regents of University of California*, 1976) ruled that a psychotherapist had the duty to warn his or her client's potential victim of potential harm. In 1983, the court stated that the duty to warn was composed of two elements: (1) the duty to diagnose and predict the client's danger of violence, (2) the duty to take appropriate action to protect the identified victim. The duty to warn supercedes the client's right to confidentiality.
 - (20) Some general areas of healthcare litigation in multidisciplinary psychiatric/mental health private practice—*informed consent, faulty diagnosing resulting in wrong treatment, physical restraint and bodily harm, confidentiality and defamation, failure to warn those threatened by clients, limitation of ability to perform a needed service and failure to refer to another professional, misuse of therapy, and inappropriate termination and abandonment of client.*
- The consultative liaison role
 1. This advanced practice nursing role evolved from consultative roles and requires the ability to integrate expert psychiatric-mental health knowledge into all healthcare settings (ANA, APNA, & ISPN, 2007).
 - a. PMH consultant-liaison activities occur in nonpsychiatric care settings such as hospitals, outpatient clinics, rehabilitation settings, and extended care facilities in which the advanced practice PMH nurse provides specialized consultation or direct care.
 - b. A variety of services can be provided by the PMH consultant-liaison nurse including client-centered consultation (to treat or advise treatments for identified mental health needs) and providing nurses and other care providers information, support, and training about identified mental health issues/concerns (consultee-centered consultation—See next section) (ANA et al., 2007).
 2. In the community mental health model, Caplan (1970) defines consultation as a specific professional process between two systems. The consultee system has a problem and requests assistance. The consultant system gives the assistance.
 3. Role characteristics include collaborative professional relationships, not supervisory relationships, where the users/consultees choose whether or not to accept professional advice.
 4. The psychiatric liaison nursing role provides and coordinates psychiatric care and maintains a therapeutic environment for clients admitted with a physical symptom or dysfunction.
 5. Psychiatric liaison nurses, as members of the healthcare team, provide direct care, including psychotherapy, health teaching, anticipatory guidance, and somatic therapy to individuals, groups, and families.
 6. Psychiatric consultation liaison nurses may provide indirect care such as consultation, education, maintenance of a therapeutic environment, systems evaluation, and program development for work unit and/or organizational issues.
 7. The consultation liaison nurse provides support and guidance in assisting the user/consultee to solve the problem and gain more understanding of the issues.
 8. Consultation liaison nurses may fill roles in a variety of settings—*independent private practitioners who are self-employed, nurses who are contracting out services to an organization based on a fee-for-service arrangement, and/or staff members of an organization.*
 9. In general, the nurse consultant will deal with the following three problem areas:
 - a. A problem with a specific patient
 - b. A specific service program problem
 - c. An organizational problem
 10. Phases of the interactive consultative liaison process (Lehmann, 1996)
 - a. Orientation phase
 - (1) Identifying the overt and covert expectations of the consultee
 - (2) Clearly defining the problem so that the staff have realistic expectations for the consultation
 - (3) Communicating confidentiality
 - (4) Writing a written contract
 - (a) Represents an exchange between the consultee and consultant.
 - (b) Clearly writes services expected and method of payment signed

- by each party. It is not so much a legal document but an agreement between two professional systems.
- (c) Contains a brief description of problem, expected outcomes or goals, estimated time to be devoted to project, amount of compensation for consultant's time, key department and personnel related to consultant, and name of contact person from consultee agency.
- b. Working phase
 - (1) After contract is formalized, further assessing the problem.
 - (2) Selecting interventions for the problem. At this point, the nurse consultant may have completed the consultation depending upon the terms of the contract.
 - c. Termination phase
 - (1) Writing a formal summary written report
 - (2) Including in the written report—purpose, dates, time, and activities of consultation; statement of identified problem; assessment and diagnoses of problem; proposed interventions for problem resolution; alternative problem-solving approach; and evaluation criteria and findings, if available

■ QUESTIONS

Select the best answer

1. Today, the goal of most inpatient hospitalizations is:
 - a. Assessment
 - b. Rehabilitation
 - c. Psychotherapy
 - d. Crisis stabilization
2. The main difference between inpatient and outpatient treatment is:
 - a. Therapeutic milieu
 - b. Caregiving activities
 - c. Integrating and coordinating care
 - d. Evaluating outcomes
3. In the last 30 years, public mental hospital settings':
 - a. Inpatient census and admissions have increased over 75%.
 - b. Inpatient census has declined over 75%; admissions have doubled.
 - c. Admissions of younger, violent patients have declined.
 - d. Inpatient census has increased by 50%; admissions have decreased.
4. In 1963, a fundamental change in the mental health delivery system occurred because of the following mental health legislation:
 - a. Omnibus Reconciliation Act
 - b. Community Mental Health Center Act
 - c. Social Security Act
 - d. Americans with Disabilities Act
5. In general, discharged public mental health patients had the following problem *most* frequently in working with community mental health centers:
 - a. Had difficulty working in family therapy
 - b. Wanted to immediately live independently in the community
 - c. Had difficulty keeping appointments
 - d. Became involved in a revolving door with long jail times
6. In working with discharged public mental health patients, the community mental health program that was most essential was:
 - a. An inpatient unit
 - b. Geriatric services
 - c. Drug abuse treatment
 - d. 24-hour crisis intervention
7. Mobile crisis services, including services in private homes, hospital emergency rooms, and residential programs, help provide:
 - a. Group therapy
 - b. Improved access to care
 - c. Family psychotherapy
 - d. Long-term rehabilitation of chronic patients
8. One important function of a partial hospitalization program is to:
 - a. Stabilize the patient in an inpatient setting
 - b. Transition patients from the inpatient to outpatient setting
 - c. Provide 24-hour 7-day-a-week crisis intervention
 - d. Provide mobile crisis services at the patient's home
9. For maximum treatment effectiveness, partial hospitalization nurses should consider the following group therapy issue:
 - a. Acutely ill patients need an intensive group-orientated psychotherapy.
 - b. Low-level and high-level patients have the same group needs.

- c. High-level patients may dilute intensive group-orientated psychotherapy for low-level patients.
- d. Low-level patients may dilute intensive group-orientated psychotherapy for high-level patients.
10. Managed care has created the following health-care change:
- Separating treatment plans for inpatient and outpatient providers
 - Shifting from capitated to fee-for-service reimbursement
 - Evaluating quality and patient outcomes
 - Longer and more intense psychiatric inpatient stays
11. Which of the following is NOT a goal of deinstitutionalization?
- To save clients from debilitating effects of long, restrictive hospitalization
 - To return the client to community after discharge
 - To maintain the client in the community for as long as possible
 - To increase revenue resulting from revolving-door/multiple hospitalizations
12. The most prevalent ethical dilemma in managed care is that managed care providers:
- Prolong inpatient stays
 - Limit patient treatments and options
 - Prescribe too many patient treatments given by too many providers
 - Prolong life-saving measures in intensive care units
13. For an advanced practice nurse to work competitively in a managed care setting, the nurse should:
- Provide cost effective care
 - Focus exclusively on self-care
 - Expect referrals from providers providing similar services
 - Focus on decreasing case load
14. In therapy, the nurse should be aware of gender role stereotypes. Which of the following is *least* influenced by gender role stereotypes?
- A person's self-esteem and prescribed role in society
 - The nurse-client therapy relationship
 - Nursing roles with other disciplines
 - Lateral peer nursing roles
15. When a staff nurse assumes a nurse manager's position, the nurse assumes the following type of power:
- Referent
 - Expert
 - Legitimate
 - Coercive
16. A nurse can use which of the following strategies for acquiring power in an organization?
- Increase visibility.
 - Inform patients about their rights.
 - Write letters to the media about the organization.
 - Complain about management to other staff members.
17. The most effective strategy for psychiatric-mental health nurses to use as change agents in mental health policy is to:
- Serve on a legislative committee
 - Write the media about mental health issues
 - Advocate for patients in the hospital
 - Notify the patient of his/her rights
18. A continuing mental health coverage issue involves:
- Giving parity of insurance coverage to mental health clients
 - Creating Medicaid coverage to include wrap-around services
 - Restricting hospital reimbursement
 - Caring for the elderly
19. The most influential legislation to give patients access to health care was the:
- Omnibus Reconciliation Act
 - Community Mental Health Center Act
 - Social Security Act
 - Americans with Disabilities Act
20. Healthy People 2010 focuses the United States on the following mental health promotion:
- Decreasing polypharmacy in mental health care
 - Reducing child and adolescent suicide
 - Promoting deinstitutionalization
 - Increasing social supports for the indigent
21. The *most* significant barrier for advance practice psychiatric-mental health nurses in practicing within healthcare organizations is:
- Preferred Provider Organizations' (PPOs) restrictive hiring policies
 - Lack of clients
 - Limited autonomy in organized practice settings
 - Limited liaison roles

22. Of the following, which action does NOT demonstrate the nurse as change agent?
 - a. Voicing concerns and solutions to legislative bodies and the media
 - b. Seeking membership on community committees that formulate policy
 - c. Voting for a candidate who supports mental health legislation
 - d. Familiarity with the legislative process and making presentations about pending legislation at scheduled hearings
23. Paying a set amount of money for mental health services for a defined group of people is referred to as:
 - a. Fee-for-service reimbursement
 - b. Capitation
 - c. Prospective payment reimbursement
 - d. Sliding scale reimbursement
24. Which role should be performed by an advanced practice nurse with a graduate degree?
 - a. Case management
 - b. Consultation
 - c. Budgeting
 - d. Coordinator of patient care
25. Which nursing activity demonstrates an indirect nursing care function?
 - a. Teaching patients
 - b. Supervising staff
 - c. Crisis intervention
 - d. Group therapy
26. To consider beginning a solo private practice, what factor would be most important?
 - a. Experience as an advanced practice nurse
 - b. Survival with the economic uncertainties of private practice
 - c. An intensive personal support system
 - d. Total responsibility for professional accountability
27. Which of the following are key factors in establishing a viable private practice?
 - a. Adapting a financial management system, obtaining insurance, marketing successfully
 - b. Creating support groups, establishing criteria for using consultants, successful marketing
 - c. Establishing criteria for using consultants and employees, adapting a financial management system
 - d. Creating professional support groups, paying courteous attention to referrals
28. The strongest predictor of private practice charges for psychiatric-mental health clinical specialist is:
 - a. Charges of a private practice psychologist who has comparable experience
 - b. The price just above what your clientele is willing to pay
 - c. Charges of a private practice social worker who has equal education requirements
 - d. The charges that third-party payers are saying are "reasonable and customary"
29. In mental health care, parity:
 - a. Encourages capitation of services to help reduce healthcare costs
 - b. Restricts legislators from adding unrelated legislation to bills; paring them down
 - c. Levels/equalizes mental health benefits as compared to nonpsychiatric benefits
 - d. Pairs mental disorders that are common dual disorders for the purpose of billing
30. Which of the following are NOT leaders' tasks?
 - a. Renewing
 - b. Distracting members from goals
 - c. Envisioning goals
 - d. Serving as a symbol
31. According to Hersey and Blanchard's Leadership Theory, leadership strategies are based upon:
 - a. The ability of the leader
 - b. The level of readiness of the follower
 - c. The leader's charisma
 - d. The organization's goals and objectives
32. The four classical functions of managers are:
 - a. Planning, organizing, leading, and evaluating
 - b. Visioning, planning, leading, and supervising
 - c. Planning, directing, organizing, and evaluating
 - d. Changing, visioning, bargaining, and supervising
33. Epidemiology is useful in mental health care because it:
 - a. Shows that the relationship between physical and psychiatric disorders does not vary in different populations
 - b. Allows attention to be focused on identifying causes of mental illnesses
 - c. Allows attention to be focused on giving different populations different levels of social support
 - d. Shows that the relationship between patterns of diseases varies in human beings and animals

34. An example of developmental risk is:
- Age
 - Ethnicity
 - Population density
 - Social support
35. An example of a situational risk is:
- Family history
 - Age
 - Genetics
 - Unemployment
36. An example of an environmental risk is:
- Religion
 - Bacteria
 - Housing
 - Ethnicity
37. Which combination gives the most complete community assessment?
- Community's educational level, safety, and social support
 - Community's politics, recreation, and safety
 - Community's physical environment, social support, and economics
 - Community's transportation, safety, and communication channels
38. Nurses who screen workers for depression are using which type of intervention?
- Primary intervention
 - Secondary intervention
 - Tertiary intervention
 - Quality intervention
39. Nurses are creating and implementing a plan to assist nursing home residents in dealing with homesickness. They are using which type of intervention?
- Primary intervention
 - Secondary intervention
 - Tertiary intervention
 - Quality intervention
40. Which of the following populations is often in need of mental health services, but is neglected because of lack of programs?
- Geriatric population
 - Adolescents and children
 - Substance abusers
 - Mentally ill in jail
41. Two criteria for home visits by psychiatric nurses are:
- Need for treatment and geographical location of patient
 - Type of diagnosis and family services resources available
 - Need for treatment and homebound status of patient
 - Patient's ability to pay and need for treatment
42. Which population is at high risk because members ignore warning signals and engage in risk-taking behaviors?
- Children
 - Women
 - Men
 - Elderly
43. The following is important to consider in planning women's issues and mental health?
- Women are more likely to make a serious attempt to kill themselves than cry for help
 - Women have a depression rate twice that of men.
 - Major health problems include accidents and acute illness.
 - Women's suicide rate is four times higher than men.
44. The "new" revolving door with mental health patients is:
- Community mental health centers
 - The public mental hospital
 - The acute care inpatient unit
 - The jail
45. The following type of planning is 3–5-year long range planning:
- Strategic
 - Operational
 - Functional
 - Capital
46. The following type of planning addresses everyday work management:
- Strategic
 - Operational
 - Functional
 - Capital
47. In preparing a proposed plan for a new program, the *most* important factor the nurse should consider is:
- The evaluation plan containing both quality and patient outcomes measures
 - The need for the program
 - Marketing strategies for the program
 - The fit of the program into the organizational chart

48. The nurse manager knows that positive reinforcements for productive staff behaviors are important in the workplace. Which theory most supports this statement?
- Maslow's Need Theory
 - Skinner's Behavior Modification Theory
 - Herzberg's Two Factor Theory
 - Hersey and Blanchard's Life-Cycle Theory
49. Based on Herzberg's Motivation Theory, which is most important for the nurse manager in creating a motivating work environment for the staff?
- Physiology needs are lower level needs and are being met.
 - Consistent, clear rules guide the staff in producing the work.
 - The work itself should be interesting to the worker.
 - Staff must understand the mission of the work.
50. A nurse manager wants to create a motivating climate for staff. Which strategy best accomplishes this goal?
- Allow staff to create the budget for the department.
 - Allow staff input into decisions which affect their work.
 - Give all staff a 10% raise.
 - Allow staff more sick time.
51. Two staff members approach you and state that they are arguing over the upcoming political election. The best strategy for the nurse manager is:
- Bargaining, so that the argument will not escalate
 - Confrontation, so the issue can be resolved expeditiously
 - Redesigning the organization, because the work group needs to be more self-contained
 - Smoothing, because the issue is trivial and not related to work
52. The evening charge nurse complains repeatedly to you, the nurse manager, that day shift personnel do not complete admitting new patients who enter the unit late on day shift. What is the best conflict management approach?
- Redesigning the organization, because the conflict is within the work process
 - Avoidance, because the issue is trivial
 - Smoothing, because it gives people time to calm down
 - Structuring, because an objective third party is needed
53. When choosing an optimal patient care delivery system, desired outcomes include:
- Short length of stay, physician satisfaction, and least expensive nursing care
 - Cost effective nursing care and administration satisfaction
 - Patient, administration, and managed care satisfaction
 - Patient satisfaction, quality nursing care, and cost-effective nursing care
54. The clinic needs a new computer. This expense will come out of what type of budget?
- Technology
 - Capital
 - Personnel
 - Operating
55. For the nurse manager, the second stage of a budget is:
- Monitoring and reviewing the budget
 - Implementing the budget
 - Planning the budget
 - Reviewing and justifying the budget
56. The purpose of evaluating programs is to:
- Assess cost effectiveness
 - Assess community needs and desires
 - Assess stakeholders' involvement for decision making purposes
 - Assess worth and value for decision-making purposes
57. In evaluating a program, an essential component to measure is whether:
- Goals and objectives of program are met
 - Cost containment strategies are finished
 - Formative evaluation is used
 - Employees are motivated
58. Continuous quality improvement (CQI) can be defined as a philosophy for:
- Checking quality at set intervals
 - Evaluating and managing quality
 - Providing quality at the lowest possible cost
 - Determining quality over time
59. Which of these nursing interventions most exemplifies the CQI process:
- Interdisciplinary teams work together to solve patient discharge problems.
 - The nurse manager creates a plan to decrease costs over time.
 - Nursing administrators decide to give all staff raises.
 - The nurse management team collaborates to monitor sick-time usage.

60. PMH consultation-liaison nursing services occur:
- Exclusively in the emergency department
 - In any psychiatric setting
 - In any nonpsychiatric setting
 - Exclusively in outpatient settings
61. Psychiatric mental health nursing practice may vary from state to state because of laws governing:
- Child abuse reporting
 - Informed consent
 - Nurse practice acts
 - The ANA Code for Nurses
62. When a patient is an involuntary admission to the psychiatric unit, the nurse knows that the patient:
- Requested hospitalization
 - Can sign out against medical advice
 - Has his/her legal rights taken away
 - Has restricted freedom
63. Malpractice can be shown if the nurse:
- Gives a reasonable standard of care
 - Does not harm the patient
 - Fails to give competent care
 - Gives quality care but the patient has a poor outcome
64. Which patient right can be suspended with justified documentation?
- Right to treatment in least restrictive environment
 - Right to freedom from restraints and seclusion
 - Right to warn others of danger
 - Right to access courts and attorneys
65. In most states, the amount of time that a person can be under an emergency commitment is:
- 12 to 24 hours
 - 24 to 36 hours
 - 48 to 72 hours
 - 3 to 5 days
66. A healthcare worker telephones a substance abuse unit and asks the nurse if Mr. A. Smith is a patient there and can he talk with him. The nurse replies:
- "Here is Mr. Smith's telephone number, please call him."
 - "Mr. Smith is in a group and cannot talk with you now."
 - "No information can be given."
 - "Please talk to Mr. Smith's caseworker."
67. On an inpatient unit, the patient commits suicide because an intensive suicide watch was not continued throughout the shift. The nurse breached which legal concept?
- Informed consent
 - Negligence
 - Battery
 - False imprisonment
68. A therapist has a duty to warn. This involves informing:
- A patient about possible side effects of medications
 - A patient about tardive dyskinesia
 - A patient about their right to refuse treatment
 - A potential victim of potential harm
69. A nurse manager gives the staff the ability to create their own work schedules. This is an example of:
- Risk management
 - Goal setting
 - Self-realization
 - Empowerment
70. Nursing interventions that enable client empowerment include:
- Suggesting hospitalization if client does not comply with medication regime
 - Assisting patients in not disclosing their psychiatric hospitalizations
 - Promoting consumer choice in treatment
 - Promoting family therapy
71. A consultation liaison nurse's role includes:
- Supervision of staff
 - Support and guidance
 - Organization of patient care delivery
 - Monitoring the CQI process
72. A characteristic of a liaison contract is:
- A legally binding contract between two professional systems
 - Set-up for a 5-year period
 - A permanent document that can only be modified by the court
 - An agreement between two professional systems
73. The nurse manager wants to empower the staff and uses the following strategy:
- Creating staff committees with authority to resolve departmental problems
 - Creating staff committees to develop goals for other departments

- c. Providing education and training to create opportunity for advancement
 - d. Implementing employee suggestion program with monetary incentives
74. Which of the following is an indirect care intervention of a psychiatric consultation nurse?
- a. Health teaching
 - b. Psychotherapy
 - c. Anticipatory guidance
 - d. Systems evaluation
75. The nurse manager discovers that nurses on the substance abuse unit are using tissues rather than gloves when moving urine specimens. He/she immediately stops this practice because of violation of:
- a. Judgment
 - b. Risk management
 - c. Cost containment programs
 - d. Ethics

ANSWERS

- | | | |
|-------|-------|-------|
| 1. d | 26. b | 51. d |
| 2. a | 27. a | 52. a |
| 3. b | 28. d | 53. d |
| 4. b | 29. c | 54. b |
| 5. c | 30. b | 55. d |
| 6. d | 31. b | 56. d |
| 7. b | 32. c | 57. a |
| 8. b | 33. b | 58. b |
| 9. d | 34. a | 59. a |
| 10. c | 35. d | 60. c |
| 11. d | 36. c | 61. c |
| 12. b | 37. c | 62. d |
| 13. a | 38. b | 63. c |
| 14. d | 39. a | 64. b |
| 15. c | 49. d | 65. c |
| 16. a | 41. c | 66. c |
| 17. a | 42. c | 67. b |
| 18. a | 43. b | 68. d |
| 19. c | 44. d | 69. d |
| 20. b | 45. a | 70. c |
| 21. c | 46. b | 71. b |
| 22. c | 47. b | 72. d |
| 23. b | 48. b | 73. a |
| 24. b | 49. c | 74. d |
| 25. b | 50. b | 75. b |

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PSYCHIATRIC NURSING CERTIFICATION REVIEW GUIDE

FOR THE GENERALIST AND ADVANCED PRACTICE
PSYCHIATRIC AND MENTAL HEALTH NURSE

Third Edition

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