Mental Health Nursing

A Holistic Approach

THIRD EDITION

PASQUALI ARNOLD · DeBASIO

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To our families with love, affection, and appreciation.

Elaine Anne Pasquali
Helen Margaret Arnold
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Preface

What is mental health? What is mental illness? When is a person ill enough to require treatment? These questions have long concerned society in general and mental health practitioners in particular. Of all mental health workers, nurses are in the best position to become actively involved in a broad range of mental health care activities. In primary prevention roles, nurses provide health education and perform health promotion activities. In secondary prevention roles, nurses play an important and integral part in identifying health care needs and providing therapeutic care. In tertiary prevention roles, nurses help reduce the severity and limitations of disabilities and are actively involved in rehabilitation.

The concepts and skills of mental health nursing are not limited to any particular practice setting. Staff nurses, nurse practitioners, community health nurses, industrial nurses, and nurse educators may all actively participate in the promotion of mental health. The health education and emotional support that nurses offer to persons facing maturational and situational stress help these persons mobilize resources, resolve crises, and maintain emotional stability. When mental illness does develop, it is often these same nurses who recognize the early signs of maladaptive behavior or emotional distress and help the involved individuals obtain early treatment. At this point, these clients may come into contact with psychiatric nurses, who may then assume a vital role in all aspects of treatment. Later, community mental health nurses may help the clients reestablish family and social networks and reassume social roles. Regardless of whether nurses function in psychiatric settings or other health care settings, they may be engaged in a variety of activities that serve to promote and restore mental health.

PHILOSOPHICAL APPROACH

This book advocates an eclectic and holistic systems approach to mental health nursing. It is our belief that no one theory or model can provide a complete basis for understanding all aspects of human functioning or the complexities of human behavior. We believe further that anyone practicing mental health nursing must acknowledge, identify, and explore the many interrelationships among biological, psychological, intellectual, spiritual, and sociocultural dimensions of behavior.

Although many nurses conceptually agree with this approach, most textbooks and many nurses in practice tend to emphasize a particular dimension to the minimization or exclusion of others. To fail to recognize all the dimensions of behavior and their interrelationships, however, is to fail to address the primary objectives of mental health nursing

1. Promotion of mental health
2. Intervention in mental illness
3. Restoration of mental health

Drawing on a variety of theories and concepts from a number of sources, this book develops a theoretical framework that examines and integrates concepts and skills involving all the dimensions of behavior.

Rather than emphasizing only theory, however, this holistic systems approach focuses on *people* and on the myriad interrelated factors that both affect and are affected by them. Nursing should not be hospital oriented or community oriented but *people oriented*. Because people—their behavior

and the reasons for their behavior—are the focus of mental health nursing, nurses must learn to view and understand the ways in which people interrelate within a wide social field. By using the nursing process, nurses can endeavor to promote healthy behavior, sustain people during stress-producing situations, intervene during maladaptive behavior, and restore adaptive behavior.

The major objectives of this book are to provide a theoretical background for the understanding of human coping with stress and crisis and to present a basis for therapeutic intervention designed to promote, maintain, or restore mental health. In keeping with the holistic, humanistic philosophy of nursing and the belief that mental health nursing is an integral part of all nursing as well as a specialized area of professional practice, this book emphasizes nursing interventions both for persons who are coping with physical illness and injury and for individuals with psychiatric disorders. Attention is also given to the functions of the nurse as a collaborative member of the mental health team and to the social forces of power and politics as they relate to mental health nursing.

ORGANIZATION AND COVERAGE

Building on the strengths of the first and second editions, this book has been logically and cohesively organized to provide

1. A theoretical framework for understanding human behavior
2. A historical perspective on mental health nursing
3. An understanding of political and other forms of power inherent in the health care system and the nursing profession
4. A theoretical foundation for understanding and practicing psychiatric nursing
5. An understanding of how people cope with stress
6. A framework and methods for the implementation of the nursing process in primary, secondary, and tertiary prevention

An introduction and three new chapters have been added to expand the book's coverage and provide for a more in-depth exploration of pertinent issues and topics in mental health nursing. The following is a brief description of the organization, the new chapters, and other expanded coverage.

Introduction: The Student Experience, new to this edition, has been added in an effort to acknowledge and allay students' fears as they begin their mental health experience. Unit 1, The Domain of Mental Health Nursing, consists of three chapters that provide the reader with an orientation to mental health nursing. Chapter 1, Framework for Mental Health Nursing Practice, defines mental health, mental illness, and mental health nursing and presents the holistic and eclectic theoretical framework used and further developed throughout the book. Selected nursing theories with a systems focus and their application to mental health nursing are explored. The concepts of primary, secondary, and tertiary prevention are also presented—as part of a systems-theory approach—along with a discussion of how these concepts can be used as an organizing framework for nursing intervention. Discussion of the biological basis for mental illness has been expanded, reflecting the most current research and focus in both psychiatry and mental health nursing. Chapter 2, Historical Overview of Psychiatric Nursing, examines historical aspects of psychiatry and psychiatric nursing and considers their influence on contemporary nursing practice. Focusing on contemporary nursing practice, Chapter 3, Power, Politics, and Psychiatric Nursing, provides both a theoretical and a practical basis for understanding the political forces that are inherent in any situation in which groups of people work together. Describing strategies for utilizing power and political action to promote mental health, this chapter also discusses the roles of the nurse as client advocate and change agent.

Unit 2, Concepts Basic to Understanding Behavior and to Nursing Intervention, explores in depth the fundamental concepts of mental health nursing. Because the ways in which people perceive and respond to stress and to health problems are culturally influenced, Chapter 4, The Sociocultural Context of Behavior, introduces theories that provide a foundation for understanding enculturation and acculturation. Sociocultural influences related to stress and coping are explored, as are theories that provide approaches to understanding and assessing ethnic or cultural factors in relation to health care.

The discrepancies that may exist between the cultural values of a client and those of a health care provider are also discussed. A section on attitude clarification explores how a professional nurse's own cultural and ethnic values may affect the nurse-client relationship. This section also explores the influence of the nurse's self-awareness and self-understanding on the therapeutic interpersonal process between nurse and client.

Chapter 5, The Family, investigates the many factors that influence the composition, form, and dynamics of the family. The family is viewed as a social system whose effective functioning depends not only on internal variables but also on the family's relationship with the social, cultural, emotional, and physical environment.

Experiences early in life have a major influence on the ways in which each of us perceives and copes with the stress caused by anxiety, fear, frustration, loss, and other threats to emotional and mental well-being. Chapter 6, Human Development, discusses the processes of human development from biological, psychological, and sociocultural perspectives. A variety of theories are presented and integrated to provide a comprehensive understanding of this important topic, which continues as a conceptual strand throughout the book. This chapter provides the theoretical basis for nursing interventions for clients at all stages of the life cycle and aids in understanding behavioral responses that may have their origins in early developmental experiences. New to this edition, Chapter 7, Human Sexuality, explores human sexual response patterns, alternative lifestyles, and sexual dysfunction and treatment, acknowledging how this aspect of the client affects mental health and illness.

Because dealing with stress is an ongoing process throughout life, it is a theme that recurs throughout the book. However, this theme serves as the focus for Chapter 8, Stress and Anxiety. Concepts such as biological, psychological, spiritual, intellectual, and sociocultural stressors are explored. Responses to stress are discussed in relation to mechanisms for adaptation in mental health and mental illness. In Chapter 9, Commonly Encountered Stressors, such stressors as pain, threats to body image, loss, and immobilization are described and explored. Primary, secondary, and tertiary prevention in cases involving these threats to mental health are discussed in terms of the nurse-client interpersonal process as a tool of nursing practice.

The therapeutic interpersonal process is fundamental to all areas of practice in mental health nursing. A knowledge of communication theory and the ability to use therapeutic communication processes with individuals and groups are at the heart of psychiatric nursing. Chapter 10, Basic Concepts of Communication, provides a theoretical basis for understanding communication. Theories of verbal, kinesic, and proxemic communication are discussed. Communication theory and the relationships among different levels of communication are discussed to promote an understanding of the use of the therapeutic interpersonal process with clients from various ethnic backgrounds. Chapter 11, Therapeutic Communication and the Nursing Process, specifically addresses the nurse-client relationship and the application of the nursing process to mental health nursing.

Unit 3, Therapeutic Settings and Modalities, focuses on the application of theory and explores a variety of treatment settings and the more common forms of treatment in conjunction with the many roles of the psychiatric nurse. The material in this unit, much of which is new to this edition, provides the reader with an opportunity to examine and explore new and expanding roles and responsibilities in mental health nursing. Chapter 12, The Therapeutic Milieu, introduces a wide range of therapeutic modalities and the concepts and realities of the therapeutic milieu. The client is considered an integral part of the health care team. The role of the nurse is emphasized.

Chapters 13, 14, and 15 focus on nursing functions in relation to group therapy, crisis intervention, and family therapy. Chapter 13, Group Therapy, has been strengthened, exploring group processes and dynamics along with a variety of approaches to group therapy. Chapter 14, Family Dysfunction and Family Therapy, discusses the stressors that may contribute to family dysfunction and their impact on the dynamics of the family and the role of the nurse. Chapter 15, Crisis Intervention, defines and describes both maturational and situational crises and examines the role of the nurse in this important short-term form of therapy.

Chapter 16, Community Mental Health, focuses on mental health services that are oriented toward defined communities or catchment areas. Characteristics of the community mental health movement are described, as are the scope of mental health problems and the current status of community mental health services. The organization of community mental health services is considered in terms of primary, secondary, and tertiary prevention, and in relation to the roles and functions of community mental health nurses.

Unit 4, Client Behavior and Nursing Practice, identifies and discusses major psychogenic and psychiatric conditions of children, adolescents, and adults. Although most of these chapters consider the development and implications of particular disorders throughout the life cycle, Chapter 17, Patterns of Conflict and Stress in Childhood and Adolescence, explores in depth and within a family context selected disorders specific to children or adolescents. An important new addition to this text is Chapter 18. Patterns of Conflict and Stress in the Elderly . The elderly represent the fastest growing segment of the population, and they have special needs that must be met by health care professionals. Psychiatric nurses are in a unique position to meet these needs and therefore must be knowledgeable about developmental tasks, biopsychosocial influences, and specific problems afflicting this group.

In Chapters 19 through 26, patterns of coping with stress are discussed. The earlier chapters concern conditions that involve relatively little interference with psychosocial functioning, such as the psychophysiological and neurotic disorders. The later chapters concern conditions, such as schizophrenia, affective disorders, and organic brain disorders, in which there may be great interference with psychosocial functioning. A new chapter, Patterns of Human Abuse, has been added to address domestic and criminal violence. The chapter on substance and practice abuse, virtually all of which is new to this edition, examines these widespread problems in today's society. Chapter 24, Patterns of Emotional Turbulence and Primitive Defenses, explores disruptive, borderline personality disorders and the role of the nurse in helping affected clients maintain psychological equilibrium.

A new appendix, Selected Psychotropic Drugs, discusses common psychotropic drugs, their indications and side effects, and implications for the nurse's role in administration.

PEDAGOGY

To facilitate the teaching-learning process, we have included a number of pedagogical aids. Each unit opens with a brief introduction, with an overview of chapters within that unit. Each chapter begins with an outline of its contents and a brief statement of chapter focus. These tools should help orient the reader to the logical progression in subject matter as well as the purposes and coverages of individual chapters.

Throughout the text, many new case studies have been added to help the reader understand and apply the theoretical concepts to practical situations. Sample interaction boxes have also been included throughout, providing realistic communication examples to help students better interact with clients.

The five-step nursing process has been used in the secondary prevention sections of chapters, and care plans have been added that reflect the latest 8th NANDA approved diagnoses with corresponding DSM-III-R classification codes.

Many new summary tables and boxes have been created to synthesize important information in an easy-to-use format and to aid student learning. A new section at the end of each chapter, Self-Directed Learning, features sensitivity awareness exercises that help students better understand themselves so that they may intervene effectively with clients. Also included in this section are Questions to Consider, featuring multiple-choice and matching questions that help students review concepts presented in the chapter.

As in the first edition, references, annotated suggested readings, and further readings are included for all chapters to provide the reader with a basis for further exploration of the topics presented.

Package

To enable nurse educators and students to benefit optimally from use of this text, we have provided

an instructor's manual, which includes learning objectives, lists of terms and concepts introduced in each chapter, topical lecture outlines, suggested course syllabi, classroom discussion/questions, and lists of audiovisual aids. At the end of this manual, instructors will find a testbank consisting of over 200 multiple-choice questions from which they can construct examinations.

Also for use by instructors or students are two interactive CAI software disks covering crisis intervention and psychiatric assessment. The menu for both disks includes a pretest, review of concepts, clinical simulations, and posttest. Software is available for Apple II+, Apple IIe, and IBM-PC microcomputers.

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We believe that people should be actively involved in their own health care. Since the term *client* denotes such a participatory role, this term is used predominantly in this book. However, there are times in the delivery of health care when people are (or have historically been) acted upon, when they are forced by illness or other circumstances to assume a submissive, dependent role—the role of patient. Thus, in appropriate instances we have used the term *patient* instead.

The terminology in many of the chapter titles in Unit 4 reflects patterns of coping with stress rather than psychiatric diagnostic categories. Psychiatric terminology is used in the text, however, when it is appropriate to learning objectives and when it facilitates communication.

We would like to take this opportunity to thank a number of people who have contributed in various ways to the development of this book. We are indebted to the hundreds of students who have taken our courses. Their learning needs have motivated us to write the book, and their learning experiences have formed the basis for much that appears in it.

We would also like to acknowledge the original contributions of the late Eleanore Alesi. We remember Eleanore with love, affection, and admiration.

Finally we want to thank our friends and families, who have patiently lived with the development of the book and who have offered constant encouragement. Without their support this book might never have been written.

Elaine Anne Pasquali
Helen Margaret Arnold
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Introduction: the student experience

Any new clinical experience generates a certain amount of anxiety, concern for one's own skills, and lack of confidence in the ability to meet client needs effectively. The psychiatric nursing experience, however, is most often looked upon with much trepidation—preconceived ideas and past negative experiences of other students influence students' perceptions. Often students consider the psychiatric experience to be "just talking" with the implication that goals cannot be set; thus, nothing can be achieved with the client. Unrealistic expectations of what can be accomplished may be deterministic in the perceived value of the experience as well. The goals of the psychiatric clinical experience may also be framed differently from other clinical experiences. Goals that reflect an increased awareness of self as a therapeutic tool may initially be threatening. Students are accustomed to performing specific skills, which can then be measured by direct observation. The therapeutic use of self may befuddle students who generally come to the bedside with all types of equipment.

Fears and concerns about the ability to function competently in the psychiatric clinical area are normal. The purpose of this introduction is to reduce the sense of "pluralistic ignorance," better known as "I must be the only student who has felt this way—I must be a terrible person!" Through our shared experiences as faculty working with these students, we can hope to minimize those fears as well as enhance students' ability to function effectively and to experience satisfaction in the psychiatric clinical setting. Students must be encouraged to utilize their listening and communicating skills—those same skills they have utilized with friends and family. Respect, honesty, and a genuine commitment to listen and to care for another human being are critical variables in the development of therapeutic relationships. Satisfaction for the student may be gained by enabling a client to express himself to a willing listener or by returning again and again to a client who does not believe he is capable of another individual's caring. Students may lose sight of the fact that psychiatric clients are human beings—the fear of "who" they are and "what" they might do may preclude this important premise. Validation of feelings experienced in the psychiatric clinical area is vital. Concurrently, developing an understanding of one's self within the context of the therapeutic relationship as having an affect on and being affected by another individual is also necessary.

Common fears and issues arise in the psychiatric experience. The following discussion will explore these issues and possible reasons for these feelings.

Will I be hurt?

Students have perceptions that crazy people are kept behind locked bars waiting to harm others. Such films as "One Flew over the Cuckoo's Nest" reaffirm the belief that psychiatric clients have no control over their behavior. In fact, clients in some cases do not have control over their behavior and require control from health care providers. Students feel vulnerable in the sense that they may not have the skills to provide necessary controls, thus leading to the fear of clients either physically or psychologically harming them. One student stated that she was told by the staff that she could no longer see her client because she had been transferred

to a maximum security unit, which would not be safe for her to visit. Another student shared that his client kept pacing back and forth and glaring at him. He felt that if he approached the client, the client would "haul off and whack" him. A group of students described their first day on a locked unit. A common thread of apprehension and dread was voiced upon being "left" on the unit without keys. Each identified a fear that they would be left with the clients and be unable to "get out."

Will I become crazy?

Students describe a fear of "catching" mental illness or becoming like their clients. One student shared in post-conference that he felt as though he was analyzing his own mood swings rather than viewing them as a normal part of his life. Another student stated that during the psychiatric rotation her roommate noticed that each day after clinical, the student would go back to her room and pull the cover over her head until dinner. Students in a private psychiatric hospital noted that "many of the clients looked just like them." There was a concern as to what actually separated "us" from "them." The use of street clothes in the psychiatric setting prevents separation by generally accepted symbols of authority: the uniform, the scissors, the stethescope. Students have described the need to find some symbol—a name pin, a lab coat—which will reduce the perceived dissonance and role blurring. Although the fear of mental illness is a real one, the issue can be utilized to demonstrate to students that clients are not "crazy" in all areas of their lives. Mentally ill individuals may utilize the same defense mechanisms healthy individuals do, but the degree and frequency of usage is different. This perspective often assists students to reframe their perceptions of the mentally ill.

What can I do to help clients?

Most students express an overwhelming sense of helplessness on initial entry into the psychiatric setting. Comments such as "I don't have anything to do," "The client is in activities all day; what does he need me for?" "I feel like an appendage; all I do is follow my client around," "How does talking help when someone is really depressed or delusional?" Each of these comments deserves merit, yet students are unaware of what they can potentially bring to the client's situation. Just as they learned skills to effect outcomes in other clinical settings so too can they develop effective use of their communication skills to develop a relationship with a client who is mentally ill. The reaffirmation that students' feelings are valid is most important, particularly in the early stages of the psychiatric clinical experience.

Will I hurt the client?

In conjunction with the above concern, students express a fear that they might say the wrong thing. For example, one student who was working with a suicidal client feared that he might say something that would "send the client over the edge." In this same situation, the student also feared that he might not pick up clues that would be indicative of impending suicidal activity. Students working with depressed clients shared the belief that they might make the client feel worse by saying the wrong thing. There is also a fear that clients might lose control and act out, precipitated by something the student said. Two factors must be identified in relation to this issue. First, clients have much more strength than we attribute to them. They are able to tolerate in many cases the clumsy attempts of students to intervene therapeutically. Secondly, there seems to be an inherent belief that students have the power or influence to cause clients to discuss subjects or behave in certain ways. This can be described as analagous to the discussion of suicide or birth control—students do not put thoughts into clients' heads but rather provide an environment where thoughts and feelings are accepted and encouraged.

Will I be rejected?

The fear of being rejected by the client is valid and quite commonly experienced among students. Students' feelings of incompetence lead them to believe they have little to offer; thus, why should a client want to establish a relationship with them? During a pre-conference, a student stated that his

client was described as withdrawn and noncommunicative, having not developed relationships with many people on the unit. The student had already determined that he would be rejected—prior to even entering the unit. Another student described an experience with a client she had been seeing for two weeks. The client was sitting in the dayroom when the student arrived for pre-conference. The student acknowledged the client with a brief wave and went with her peers to conference. At the scheduled time of their meeting, the client did not appear and was found in the recreation room with another staff member. She ignored the student. The student assumed the responsibility for the client's actions. It must have been something she did or did not do. Through processing the event in post-conference, the student became aware that the client's past experiences may have caused this specific response. It was known through the client's history that she had had little success with relationships. The student then utilized this experience to enable the client to explore her own feelings of rejection and to develop strategies to engage in successful relationships—initiated by a successful relationship with the student. In some instances, clients feel the need to have more space or distance between themselves and health care providers. The reasons for this may be unknown to the client on a conscious level and are acted out behaviorally. Clients may also reject students because a particular student may interact with a client similarly to a significant other with whom the client has had negative experiences. For example, an elderly depressed woman refused to engage in an initial interview with a young student. When evaluating this behavior in the supervisory relationship, the faculty member suggested that the student might remind the client of a significant person in her life with whom she has some conflictual feelings. The student was able to determine from staff input that the woman's granddaughter, a woman similar in age to the student, had recently committed suicide. The woman had not spoken to her granddaughter in several years because the grandmother had disapproved of her lifestyle. Clients often feel a low sense of self-worth, which generates feelings of "Why would anyone want to be with me?" which in turn leads to rejecting behavior on the part of the client. Other clients may use the rationale that they "talk" to too many other health professionals or that they "don't have time to talk to the student." In many cases, the client often fears rejection by the student so in turn rejects the student before he or she can reject the client. Through the exploration of this issue, students are able to understand the dynamics of rejection from the client's perspective. Students are also encouraged to give up the notion that they are personally responsible for the rejecting behavior of the client.

Am I using the client?

Often students feel that they are using clients as guinea pigs—attempting to get information from a client to write process recordings or a nursing care plan. Students have shared that they have nothing to offer clients or can't make them better as they can in other clinical settings. This feeling may be reaffirmed by psychiatric clients who may accuse students of doing just that in order to intimidate new students and empower themselves as important people. One student stated that his client shouted at him, "You don't like me; you just want to see what all the nuts look like!" Students need to be encouraged to be honest with clients, that is, to reiterate their desire to genuinely be involved with this person because of that person—not his or her information. Nonverbal messages are critical in conveying commitment to the individual. Clients are often astute enough to realize the student's lack of concern for them. Students may share their feelings of ineptness in this new situation yet convey a genuine sense of caring, of making a conscious choice to be with this individual in a therapeutic relationship.

Can I have feelings too?

Students are often not clear whether they should have feelings about their clients, and if they do, what do they do with them? One student explained after listening to a group of borderline clients who were trying to "one up" the other in their descriptions of their suicide attempts that she was so angry and frustrated that she had to leave the unit. She felt guilty for feeling angry. Later that day her

interaction with her client was described by the student as "disastrous." During post-conference, several students concurred that they weren't sure if they could be angry, frustrated, or disappointed. Sharing positive feelings was much easier. The process of the supervisory relationship between student and faculty member can facilitate the student's understanding of his or her feelings and how they can be utilized in a positive sense within the context of the student-client interaction. Once trust has been established between student and client, the client can learn more adaptive methods of coping with anger, frustration, and disappointment through the student's expression of how he or she copes with those same feelings.

What do I need to know before I see the client for the first time?

There are differing schools of thought as to whether students should have information prior to making the initial contact with the client. Generally in other clinical areas, students have access to charts and often preplan care the day before the clinical experience. Students share their concern that they feel little clinical competence; not having information prior to the initial contact is anxiety provoking and frustrating. On the other hand, some students feel that they would like to go in "cold" so as not to form preconceived ideas about their clients. It seems that there is no right or wrong answer but rather a consideration for the individual student and the individual client as to how their mutual needs are best met.

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In conclusion, several issues and fears that are common to the initial psychiatric clinical experience have been explored. Role dissonance in the psychiatric setting is expected. Validation by faculty and professional staff are critical in the facilitation of a positive psychiatric clinical experience. Students *do* bring something with them into this clinical arena: honesty, caring, respect, and the ability to listen. Small but significant goals such as the client's ability to sit with the student for ten minutes longer each session are viewed as equally important to changing a dressing or making a bed. The process of the therapeutic interaction between student and client is a mutual one where each influences and is influenced by the other. The analysis of this relationship through group conference or individual supervision provides a learning experience through which clients can learn more adaptive measures of coping. Students are encouraged to gain insight into their own behaviors as they relate to their clients, peers, and instructor. In some cases, the psychiatric clinical experience may elicit unresolved conflictual issues for students. The student may then choose to examine these issues further in a therapeutic relationship outside of the clinical setting.

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