FRANCES POWER ROWAN

THE CHRONICALLY DISTRESSED CLIENT

A model for intervention in the community

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THE CHRONICALLY DISTRESSED CLIENT

A model for intervention in the community

To my mother

Theresa Foley Power

whose caring continues to unfold growth,
whose strength continues to adapt to life's demands,
and who finds fun in living for the moment.
She stands in testimony to the polarization of
true ego integrity and the flowering of wisdom.

FOREWORD

Although much has been written describing the science and art of nursing, there is little in the nursing literature illustrating how the two blend to become nursing practice. Frances Power Rowan does that in this book.

But she does more than that. In the preface and the first two chapters the reader is given a clear, understandable, explicit statement of nursing philosophy, nursing process, nursing practice, and the variables used to determine and evaluate care. The case studies in the next eight chapters illustrate the consistent application of that framework in practice.

Those who claim that psychiatric nursing is basically just process will find that position challenged. The content of practice is emphasized along with the continual evaluation and reevaluation of the client's response to explicit nursing interventions.

Those who minimize the importance of nursing process will also find that position challenged. Characteristics of the effective nurse are emphasized. The concept of a professional relationship is discussed. And a four-step nursing process is identified as the structural framework for practice.

The listing of variables and the use of the data base to determine and evaluate nursing care will stimulate considerable thought. Although additional testing is required to assure the validity and independence of the variables and to create a sound psychometric scale, a good beginning is here. The author has avoided premature claims about scaling and scoring, and this, too, is commendable.

What is most exciting to me is that as the author agonized intellectually over her own practice, doing a critical analysis and scholarly synthesis, she produced a book that is more than a contribution to the psychiatric nursing literature. Frances Power Rowan, through an inductive analysis of her practice, has helped define the very scope and nature of nursing knowledge and nursing practice.

Carol A. Lindeman, R.N., Ph.D., F.A.A.N.

PREFACE

In practice settings, nursing and nurses are in a special position. The clinician is placed by time, space, and skill most closely to the client's inner self. The pivot of any nurse's practice, especially in the psychosocial area, is to assist this inner self to cope in a healthy manner with traumatic experiences and to adapt to the living situation. All people cope in some way with life, its various predictable and unpredictable crises, the suffering and enjoyment of daily living, and all experiences, both positive and negative, that life provides. Unhealthy coping patterns are attempts to struggle with life and to protect the self from further pain. Healthy coping mechanisms are attempts to resolve conflicts and problems and to reach a relative level of equilibrium and emotional healing. Nurses willing to develop their communication skills and risk displaying a caring posture have within their grasp the ability to motivate or influence another human being's coping behaviors and coping patterns and thus affect human life.

Caring for individuals with long-term coping difficulties and chronic life disruptions can be a challenge. The attitude of the nurse within this relationship—sensitivity, empathy, flexibility, professional competency, proficiency, accountability, knowledge, care and concern, and self-investment—is crucial to help modify patterns of coping behaviors in the dilemma-filled lives of clients who receive the indelible label of "chronic." One does not readily adjust to the slow, deliberate stride called for in these situations. The fast-paced challenge of critical or crisis situations often has a more mobilizing effect on the nurse. The invitation of involvement with extended care clients lies in grappling with dilemmas and confronting the intricate entanglements of lives rooted in anxiety, dependence, and low self-concept. One perceives the confrontation as an uphill struggle and the task as toilsome. The conclusions from application of nursing process evaluation demand constant assessment with an expanded data base and increased validation. These vulnerable clients seem to live in a maze of self-defeat. The nurse must be keenly insightful and flexible if this maze is to resolve into a durable and renewed existence for the client. Often the evaluation mandates for the nurse frequent and increasingly innovative and creative use of self rather than a continuous butting against the already floundering client. The puzzled life of a person with the label "chronic" can often be given a more even tenor with fewer limitations through the persistent practice of nursing within a durable, solid relationship. Growth is possible for all human beings. Reliance on the potential of human growth can be the mainstay of the nurse.

The long-term nursing situation leaves no room for self-doubt. Commitment to growth through care, concern, nurturance, and applied theoretical knowledge is the core component in helping others in difficulty disentangle their lives.

Mental health is an individual asset; it fluctuates with new situations and new insights in each person's life.

Stress can alter an individual's functioning, adjustment, and adaptation, calling forth new methods of coping with situations that rely on old strengths.

Perception and integration of messages when high stress is present can alter functioning. A client can feel pushed under, unable to function properly, unable to rely on old methods, and needing new strength.

Mental health is a dynamic process. It is built with care and love and is sustained by love and care from within and without. It is tested in life by the process of living. One may fumble in reaching or grasping for a way to protect the self, and in so doing can usually find new strengths and a firmer base of mental health.

It is the application of one's personal and nursing philosophy that engenders the tremendous power to assist another human being cope on a level of increased health that makes the difference among nurses. All nurses have learned how to help clients cope; all nurses can choose to practice this client-centered skill. The nurse who assists clients to cope with life's realities is truly a practitioner of nursing.

If one wishes to make a change or support a transition, if one wishes to do something new, one must have commitment to an idea. One must be willing, whether it is comfortable or uncomfortable to demonstrate one's skills, to be responsible for one's actions, to try not to feel threatened or be threatening, and to have objective theory and data to support one's method of operation.

Several years before I was granted privileges (individual practice privileges in a health care organization), I learned that in order to be of any value to my patient/client, I had to be able to forget totally about myself when I exercised my professional skills. This was difficult for me to learn, but I have learned it so well that when I am in a professional relationship with a patient/client, I first of all turn all my thoughts to the patient/client and off myself. When I turn to my client and give nursing care, I make every effort to remain open to questions or peer evaluation. If I've done well, or done poorly, I can evaluate with ease because my concern has not been for me but for my patient/client. My concentration level and listening ability have increased with this "other centeredness."*

The often missed beauty of nursing process is its built-in reinforcement for one's self both personally and professionally while offering an objective umbrella of "other centeredness." Nursing process is a thinking, action-oriented, professional activity leading to observable behavioral outcomes. For purposes of this book I subscribe to the four-step method of nursing process. Nursing process is implemented as *assessment* of the client, *diagnosis* of the problem areas, *intervention,* or actual nursing care planned and administered, and *evaluation* of concrete outcomes.

The essence of the material presented here assumes the reader's extensive knowledge base and theoretical foundation. The substance of the case format is intervention strategy and implementation requiring basic philosophy and principle supplementary to nursing formulation and action.

I wish to express my sincere appreciation to numerous colleagues, students, and clients, both past and present, and to devoted family and friends whose encouragement, insights, and collaboration have inspired and fortified me to

*From Rowan, F. P.: The privileged nurse. In American Nurses' Association: Power nursing's challenge for change, Kansas City, Mo., 1979, The Association. Reprinted with permission of the American Nurses' Association.

complete my task. I am especially indebted to Bernard A. Schultz, my mentor for this project, who not only inspired growth but insisted on development and maturation of my written communication skills. The conscientious support of Frances M. Ludwig, R.N., M.S.N., urged persistence and validated my commitment to the value of this book. Cynthia Braem, secretary-typist, adjusted her time to my needs and to the completion of the task not only without complaint, but with a smile and words of encouragement. Christine M. Wolohan, R.N., B.S., provided reliable, organized reference research in a limited time period.

Frances Power Rowan

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CHAPTER 1

NURSING PHILOSOPHY, CONCEPTUAL HYPOTHESIS OF PRACTICE, AND A PERSONAL CONTEMPLATION

Nursing process is a systematized thinking and action-oriented method that lends credence and refinement to nursing practice. For the methodology of nursing process to be learned effectively, it must be broken down into segments of the whole. All the pieces can be then viewed by the nurse as separate entities. Data collection, for example, is done to obtain pertinent information. Later, these data become part of the assessment, and much later, the assessment becomes part of the whole or total of nursing process. Many of the segments of nursing process are learned as paper-and-pencil exercises and must be transferred to a flowing-thinking exercise executed in one's mind and delivered through one's nursing skills. The quality of one's nursing practice should be measured through the individual application of nursing process to one's practice.

Nursing process is an intellectual method that nurses are educated and disciplined to apply to the practice of client care. In-service education, continuing education programs, and current professional literature regularly provide refinements and perspectives on nursing process. Hypothetically, the currently accepted information and application of nursing process will always be necessary to nursing practice. Presumably access to and knowledge of all current nursing process information *can affect* one's nursing practice, *but it does not necessarily or automatically* do so. It is the implementation and skillful application of nursing process that refine and give credibility to one's nursing practice.

Nursing process *is not* choosing to follow a memorized one-, two-, three-, four-step procedure or a five-step procedure, or is it the implementation of an eight-step procedure. Nursing process is a circular, ongoing thinking and doing process activated by extensive, applied specific and general knowledge of one person toward another person or persons within the confines of an interpersonal relationship. It produces growth if the elements of caring, discriminating communication techniques, and scientific skills are employed by the caregiver-nurse.

The total objective application of nursing process allows the nurse to review actual practice with immediate answers or explanations for

the outcomes of the given care. Evaluation and continual assessment remove ambiguity about the whys and wherefores of the nursing outcomes. The answers are evident to the open, questioning, and evaluating mind. Mistakes, wrong conclusions, and misinformation are readily corrected when nursing process is continually and systematically applied. Renewed nursing efforts are methodically practiced until the end goals or outcomes of nursing action are assured, objectively aborted, or redirected.

Evaluation lends objectivity to limited progress in the long-term client relationship and the slow-paced therapy movement that the clinician confronts daily in routine encounters with long-term psychiatric clients. This phase of nursing process monitors nursing action to aid in preventing stagnation and feelings of helplessness. The use of the methodology itself provides a control over one's practice. A mode of regulation gives power to the clinician in preventing or dispersing the apathy and helplessness that can cripple both clinician and client.

Proficient, ongoing assessment as part of nursing process is a highly functional key to progress in long-term psychosocial nursing situations. The umbrella-like nature of continual assessment ensures an active process that is always alert to new behavior, change, and growth whether it be toward or away from health. Assessment does not stop once all apparent data have been collected by the clinician or when nursing diagnosis is concluded. It brings continuity accompanied by growth, productivity, and a more holistic quality to the client care. With long-term psychosocial nursing situations it can prevent stagnation and entrenchment in unhealthy behavior and reliance on ineffective coping patterns. The constant assessment factor unearths new, relevant data. Validation of coping styles, interacting manners, and behavior patterns is derived through steady, repeated, and persistent appraisal of the observable data, client and nurse perception, and the execution of the client's life stance.

Psychosocial nursing diagnosis is a statement of essential groupings or a compilation of significant assessed data, both objective and subjective, obtained from a relevant investigation of the client. Nurses obtain these data within the scope of the established interpersonal relationship from both verbal and nonverbal communications. Other pertinent facts are gathered from available records, collaboration with other reliable professionals involved with the client, family members, and other significant relationships. Relevant, significant data are then converted to short, descriptive, identifying themes on which nursing intervention is based. Nursing diagnosis may be viewed as the core of nursing interventions. Colloquially, nursing diagnosis is a "springboard" to nursing intervention.

Three nursing diagnoses consistently applied in each case are essential components of the fundamental dilemma of the chronically distressed client. They are anxiety, dependence/independence struggle, and low self-concept. Intrinsic and extrinsic conflicts produce an unremittingly high anxiety level that is intensified by lack of conflict resolution, uncertainty, and discomfort. In the client a relentless life quandary between dependence and independence with a usual nonautonomous stance is reinforced by an essentially reliant nature, supported by negative and uncertain feedback and a diminished level of functioning. Low self-concept is a perceptual disturbance that is strengthened and replenished by the process of chronicity, the nonautonomy, perplexing and irresolute life stance, and lack of significant person associations. The nurse's relationship with the client must facilitate differentiation of the self while fostering healing and growth, adaptation, and change.

The term "nursing diagnosis" in long-term psychosocial nursing situations is extremely relevant to practice. Psychosocial nursing is a broad area that reaches from the heights to the depths of human behavior. Nursing diagnosis in

the case material encompasses symptoms of emotional distress such as anxiety; descriptions of the clients' prominent behaviors, such as lack of insight; and simplistic descriptions of core pathology, such as inability to grieve. (See Appendix A.) Simple, descriptive, recognizable terms that apply to a client's particular dilemma based in observable reality are a nursing diagnosis of choice. Nursing diagnosis must be relevant to the client's current situation, mandating nursing intervention. The application of nursing process is based on knowledge, theory, proficient and skillful communication, and practice experience. In addition, the knowledgeable application of nursing process methodology, professional and self-motivation, a care-concern quality for other individuals, a refined innate sensitivity (or "gut-level" instinct), and the courage to apply one's proficiency with discretion to another human being are all germane components to the nursing process. This task often looms as formidable. The risk lies in daring to begin, to evaluate, and to stay with the process until the outcome is satisfactory to both practitioner and client. The level and objectivity of commitment help to differentiate and identify nursing practice as a professional alliance.

In the case examples of intervention in psychiatric nursing, the process is a continuously applied, four-step method of assessment, diagnosis, intervention, and evaluation to assist an individual to cope with life as evidenced in behavioral outcomes. Additionally, the nursing process is further implemented *at selected points* in a step-by-step procedure, *beginning with* evaluation, renewed assessment, diagnosis, and intervention. The format of the application of the process is elaborated in Table 1.

Table 1. Psychosocial nursing process methodology (adapted from four-step nursing process format and problem-oriented medical record format)

Nursing process step	Methodology
IV Evaluation	**1**—Evaluation yields the following data: Nursing diagnosis (N.D.) Subjective component (S) Objective component (O) Actual outcome evaluation
I Assessment	**2A**—Continual assessment yields additional data: Nursing diagnosis (N.D.) Subjective component (S) Objective component (O) **2B**—Continual assessment yields data validated by repetition of behavior: Nursing diagnosis (N.D.) Subjective component (S) Objective component (O)
II Diagnosis	**3**—Additional nursing diagnosis conclusions
III Intervention	**4A**—Intervention is predicated on nursing judgment of the following: 1. Evaluation data 2. Assessment data 3. Selected nursing diagnosis

Continued.

Table 1. Psychosocial nursing process methodology (adapted from four-step nursing process format and problem-oriented medical record format)—cont'd

Nursing process step	Methodology
III Intervention— cont'd	4. The presence (positive) or absence (negative) of the influence of the following client variables: Reality timing +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Relationships +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Stressors and/or crisis +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Coping resources +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Significant emotional strength +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Significant emotional limitations +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Therapy relationship +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Physical health status +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Physical and emotional readiness dimension +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Available support systems +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Meaning significance +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Values and beliefs impact +5 +4 +3 +2 +1 0 −1 −2 −3 −4 −5 Other, if applicable 5. Additional knowledge Nursing diagnosis (N.D.) 6. Analysis and synthesis Nursing diagnosis (N.D.) **4B**—Intervention activity is supported by nursing judgment conclusions resulting in a design of action: Nursing diagnosis (N.D.) 1. Plan 2. Strategy 3. Expected outcomes 4. Criteria

Measurement scale

Positive, or presence of health potential ← Negative, or absence of health potential

+5	+4	+3	+2	+1	0	−1	−2	−3	−4	−5
strongest		stronger		strong		weak		weaker		weakest

Fluid line

In the left-hand column the Roman numerals indicate the more usual order of the four-step methodology. It is underscored that the initial *implied* case application of nursing process was the more usual order of assessment, diagnosis, intervention, and evaluation. The case material focuses on intervention, and it is after initial assessment, diagnosis, and intervention that the methodology is first elaborated at selected points. Assessment is basic to intervention, but it is not the focal point of the client's case study when life stance modification is germane to health and growth. Initial assessment content includes all data described prior to the point of stated nursing diagnosis. Furthermore, assessment is a continuous core element of all psychosocial nursing. In the actual application of nursing process over extended periods, the resumed intellectual implementation of the nursing process occurs during the evaluation step, then proceeds to a renewed assessment, diagnosis, and intervention effort by the nurse. Skilled nursing activity is rooted in this refined intellectual methodology called nursing process. The case studies have been constructed to portray this circular, *ongoing thinking/action* methodology *focusing* on restorative, replenishing, *intervention* endeavors.

The intellectual component of nursing process is implemented at selected points in the case material with emphasis on assessment and planning, but in no way do these points represent the only appropriate or significant periods of intervention. Both the depth and breadth of the implementation could be increased. Methodology applications were selected to demonstrate initial, intermediate, and extended progression in the therapy. Selection criteria were also the intensity of an interaction, the duration of the relationship, and the repetition of the intervention needed to achieve an end goal. The final implementation of the selected methodology does not include evaluation. It is suggested that enough data have been provided to complete this element. A paper-and-pencil approach would be most useful. An additional suggested exercise would be the selection of a new or alternate area in the case to apply the espoused methodology. Performance of this intellectual task in a simulated situation extends proficiency and skill into the actual nursing situation requiring practitioner action.

The client variables identified in Table 1 are instruments of nursing judgment. They are elements of change that alter the essence of a situation and apply to the predictability of a psychosocial nursing intervention. There is a subjective element in judging or qualifying these variables. Objectivity can be acquired and refined through practice. The proficiency of observation skills and the intensity, duration, and quality of the helping relationship refine the clinician's impersonal, unbiased judgmental abilities.

The selected variables are chosen as factors that influence and complicate one's nursing intervention in long-term psychosocial nursing but do not have scientific validity or reliability. The need for refinement of the variables as a tool for psychosocial assessment is acknowledged. Distinct, discriminating definitions of the terms in ascending and descending order need to evolve. The elementary identification of relevant areas is hypothesized as a baseline in need of standardization.

A rating scale of both positive and negative scores was chosen to show the actual deficits as well as positive force factors in operation within the client's life. The *individual score* of each variable *is significant* in itself. Each area represents one influencing life factor. The standardization of terms, definitions, and measurement would clarify more clearly the interdependence of the variables themselves.

An overall balance score of positive, negative, or balance indicates the presence or absence of potential for change or adaptation. A composite numerical score is not applicable in the present form of the instrument. The tool has not been tested for reliability or validity. Other

rating scales might lend themselves better to standardization; however, it is important to acknowledge that clients have both positive and negative forces affecting their functioning. Therefore an alternate choice of the sole criterion of a plus scale or minus scale may not portray the actual life position of the client.

In addition, the variables have value only at the point in time of judgment. A quantitative composite of several numerical scores over time would not necessarily indicate growth or lack of growth. For example, a lower quantitative composite score after 2 years of therapy when crisis factors are prominent does not preordain a decrease in coping ability or interacting manner or an increase in reliance on negative behavior patterns. It may only represent the presence of increased stress factors activating pathology. The client may be ready to experience the learning of new, more effective coping, open interacting methods, and new positive behaviors to alleviate the stress. A lower composite score may also suggest a new or increased willingness to engage in life struggles and not retreat to a state of negative polarization. This client willingness may not be accompanied by functioning ability. The nursing intervention plan and activity become the map to experience positive outcomes. The identified variables are road signs to help chart the chosen course of action for a unique client, with a particular set of circumstances, at a specific point in time.

The necessary nursing judgments can be defined as follows:

1. Reality timing—selecting the proper moment for doing a task or beginning an intervention to achieve the desired objective. An example of reality timing at a −3 level is choosing a point to begin a therapy goal when some objective data exist that will interfere with goal initiation or achievement.

2. Relationship—an association or connection between people. Such an alignment, if positive, usually has a quality of supportiveness and emotional involvement. An example of a relationship at a +5 level is a select number of people in one's personal territory, both familial and nonfamilial. Such a relationship is of an emotionally intimate nature. Several associate or comrade relationships exist that are of a social nature.

3. Stressors and/or crisis—equilibrium factors that are both intrinsic and extrinsic to the balancing of life forces. Crisis is a condition of instability in the life factors. Crisis can be considered a turning point in life, leading to a new direction that can be either positive or negative in nature. An example of stressors and/or crisis at a 0 level is a balance in the presence of life pressuring forces, not causing undue anxiety. The lack of current or impending crisis in one's life is also an example of a judgment at 0 level.

4. Coping resources—available capabilities to contend with the life problem at hand. An example of coping resources at a −3 level is when few adequate supports are available to meet the continual demands or pressures of life over an extended time.

5. Significant emotional strength—prominent feelings of affective force or energy or the deficiency or a fragility of such energy or force. An example of significant emotional strength at a +5 level is an observable identified positive force in more than one area of living. The reverse, or a −5 level, is an observable identified deficiency of a positive force or emotional fragility in more than one area of living.

6. Significant emotional limitations—prominent lack of emotional capacity or an inability to feel; a restrictive affective weakness. An example of a significant emotional limitation at a 0 level is the absence of an observable identified obstacle or boundary to self-disclosure within the therapy relationship.

7. Therapy relationship—the essence of the bond between client and nurse. The association denotes an emotionally intimate level of connections. Overriding qualities of rehabilitation, a healing or curative nature, client self-disclosure, and clinician skill are apparent to the

observer. An example of the therapy relationship at a 0 level is one in which the identified qualities exist but the relationship lacks the quality of endurance over time and observable, measurable, objective progress in the client. No deterrents to the relationship are identified.

8. Physical health status—the soundness of the body; an indication of the lack or presence of a physical disease condition or process. An example of physical health status at a −2 level is the presence of a transient viral infection.

9. Physical and emotional readiness dimension—a synchronization of body and emotions. Somatic and psychic forces become involved in the task at hand and in the achievement of the desired objectives and identified goals. An example of the physical and emotional readiness dimension at a −4 level is the presence of identifiable physical health problems and of identifiable intrinsic and extrinsic anxiety.

10. Available support systems—the existence of or accessibility to methods or structures of sustenance, maintenance, assistance, or strength. An example of an available support system at a −5 level is the absence of an identifiable structure offering strength at a high point of stress.

11. Meaning significance—indicative interpretation or important implication of a life factor. Meaning is often subjective to the client and may be a covert element. An example of meaning significance at a −5 level is a client's pervading and unshakable perception or interpretation that originates in his psychopathology.

12. Values and belief impact—an intrinsic and extrinsic thrust of personal ideals and convictions and societal norms. The person holding these values and beliefs accepts them as authentic, factual, and basic to life. An example of values and belief at a +3 level is convictions founded in reason and realism that have a positive force toward the client's health. The degree of impact will change the level.

All nursing judgments are relative to the specific situation of each client. The degree of balance depends on the time, place, interdependence of the identified variables, and presence or absence of psychopathology.

One's use of nursing process comes from within oneself. One's talent, knowledge, and skills applied to each situation will provide a unique contribution for a nurse practitioner. The other-centered approach to nursing care is a communication tool applied to enhance the relationship through the nursing process by providing comfort and objectivity both to the nurse and to the client.

The implementation of nursing process as a decision-making tool allows for a broadness of one's nursing practice. The science of nursing has a comprehensive and diversified knowledge base requiring extensive practice skills for each individual nurse. Astute assessment of one's client allows for individualized treatment supported by data about a person or group at a specific point in the process that considers all of the applicable variables of a situation. The clinician's acute observation aptitude further validates the client's behavior by ongoing assessment of the dynamic client profile.

Frequently, in the treatment of clients for emotional problems or mental illness, the therapist employs only a narrow philosophy or one treatment modality in the expectation that it will improve the problem. Treatment goals and health outcomes for a client or group often depend on the therapist's astuteness, combined person and knowledge complexities, and skill rather than on the discipline, philosophy, or specific treatment modality. No amount of knowledge, no single philosophy, and no single treatment modality provide a panacea for a successful client outcome. Growth, change, and healing occur within the scope of a relationship. The relationship combined with proficient assessment and skilled intervention supercede the choice of professional discipline, treatment philosophy, and/or curative modality.

Nurse-psychotherapy is a broadly based,