Compensation: Overachievement in one area to offset real or perceived deficiencies in another area

Conversion: Expression of an emotional conflict through the development of a physical symptom, usually sensorimotor in nature

Denial: Failure to acknowledge an unbearable condition; failure to admit the reality of a situation or how one enables the problem to continue

• Person who cheats on a spouse brings the spouse a bouquet of roses.

• Woman who would like to have her own children opens a day care center.

• Person goes for a 15-minute walk when tempted to eat junk food.

• Person who has quit smoking sucks on hard candy when the urge to smoke arises.

• Nurse is too busy with tasks to spend time talking to a dying patient.

• Woman has no memory before age 7, when she was removed from abusive parents.

• Napoleon complex: diminutive man becoming emperor.

• Nursing student becoming a critical care nurse because this is the specialty of an instructor she admires.

• Man who despises the boss tells everyone what a great boss she is.

• Student blames failure on teacher being mean.

• Never learning to delay gratification

Psychoanalytic theory supports the notion that all human behavior is caused and can be explained (deterministic theory). Freud believed that repressed (driven from conscious awareness) sexual impulses and desires motivate much human behavior. (Videbeck 43)

Transference and Countertransference

• Transference occurs when the client displaces onto the therapist attitudes and feelings that the client experienced. Transference patterns are automatic and unconscious in the therapeutic relationship. For example, an adolescent female client working with a nurse who is about the same age as the teen’s parents might react to the nurse like she reacts to her parents. She might experience intense feelings of rebellion or make sarcastic remarks; these reactions are actually based on her experiences with her parents not the nurse.

• Countertransference occurs when the therapist displaces onto the client attitudes or feelings from his or her past. For example, a female nurse who has teenage children and who is experiencing extreme frustration with an adolescent client may respond by adopting a parental or chastising tone. The nurse is countertransference her own attitudes and feelings toward her children onto the client. Nurses can deal with countertransference by examining their own feelings and responses, using self-awareness, and talking with colleagues. (Videbeck 44-45)

Five Stages of Psychosexual Development

• Oral: Birth -18 mos
• Anal: 18-36 mos
• Phallic: 3-5 years
• Latency 5-11 years
• Genital : 11-13 years
Psychosocial Theories

Erikson's eight stages of development

❖ **Trust vs. mistrust (infant):** Hope
Viewing the world as safe and reliable; relationships as nurturing, stable, and dependable

❖ **Autonomy vs. shame and doubt (toddler):** Will
Achieving a sense of control and free will

❖ **Initiative vs. guilt (preschool):** Purpose
Beginning development of a conscience; learning to manage conflict and anxiety

❖ **Industry vs. inferiority (school age):** Competence
Emerging confidence in own abilities; taking pleasure in accomplishments

❖ **Identity vs. role confusion (adolescence):** Fidelity
Formulating a sense of self and belonging

❖ **Intimacy vs. isolation (young adult):** Love
Forming adult, loving relationships and meaningful attachments to others

❖ **Generativity vs. stagnation (middle adult):** Care
Being creative and productive; establishing the next generation

❖ **Ego integrity vs. despair (maturity):** Wisdom
Accepting responsibility for one’s self and life

1902-1994
Believed that human intelligence progresses through a series of stages based on age, with the child at each successive stage demonstrating a higher level of functioning than at previous stages. In his schema, Piaget strongly believed that biologic changes and maturation were responsible for cognitive development. (Videbeck 47)

Piaget’s theory is useful when working with children. The nurse may better understand what the child means if the nurse is aware of his or her level of cognitive development. Also, teaching for children is often structured with their cognitive development in mind. (Videbeck 47)

Piaget placed great importance on the education of children. As the Director of the International Bureau of Education, he declared in 1934 that “only education is capable of saving our societies from possible collapse, whether violent, or gradual.” His theory of child development is studied in pre-service education programs. Educators continue to incorporate constructivist-based strategies.

Piaget defined himself as a ‘genetic’ epistemologist, interested in the process of the qualitative development of knowledge. He considered cognitive structures development as a differentiation of biological regulations. When his entire theory first became known – the theory in itself being based on a structuralist and a cognitivist approach – it was an outstanding and exciting development in regards to the psychological community at that time.
Milieu Therapy

The concept of milieu therapy, originally developed by Sullivan, involved clients’ interactions with one another, including practicing interpersonal relationship skills, giving one another feedback about behavior, and working cooperatively as a group to solve day-to-day problems. (Videbeck 49)

In the concept of therapeutic community or milieu, the interaction among clients is seen as beneficial, and treatment emphasizes the role of this client-to-client interaction. (Videbeck 49)

Sullivan and later Jones observed that interactions among clients in a safe, therapeutic setting provided great benefits to clients. (Videbeck 48)

Five Life Stages. Sullivan established five life stages of development—infancy, childhood, juvenile, preadolescence, and adolescence, each focusing on various interpersonal relationships. He also described three developmental cognitive modes of experience and believed that mental disorders are related to the persistence of one of the early modes. (Videbeck 48)

Sullivan believed that one’s personality involves more than individual characteristics, particularly how one interacts with others. He thought that inadequate or non satisfying relationships produce anxiety, which he saw as the basis for all emotional problems. (Videbeck 47)

Therapeutic Community or Milieu. Sullivan envisioned the goal of treatment as the establishment of satisfying interpersonal relationships. The therapist provides a corrective interpersonal relationship for the client.

Sulllivan’s Life Stages

❖ Infancy: Birth to onset of language
Primary need exists for bodily contact and tenderness. Prototaxic mode dominates (no relation between experiences). Primary zones are oral and anal. If needs are met, infant has sense of well-being; unmet needs lead to dread and anxiety.

❖ Childhood: Language to 5 years
Parents are viewed as source of praise and acceptance. Shift to parataxic mode: experiences are connected in sequence to each other. Primary zone is anal. Gratification leads to positive self-esteem. Moderate anxiety leads to uncertainty and insecurity; severe anxiety results in self-defeating patterns of behavior.

❖ Juvenile: 5–8 years
Shift to the syntaxic mode begins (thinking about self and others based on analysis of experiences in a variety of situations). Opportunities for approval and acceptance of others. Learn to negotiate own needs. Severe anxiety may result in a need to control or in restrictive, prejudicial attitudes.

❖ Preadolescence: 8–12 years
Move to genuine intimacy with friend of the same sex. Move away from family as source of satisfaction in relationships. Major shift to syntaxic mode occurs. Capacity for attachment, love, and collaboration emerges or fails to develop.

❖ Adolescence: Puberty to adulthood
Lust is added to interpersonal equation. Need for special sharing relationship shifts to the opposite sex. New opportunities for social experimentation lead to the consolidation of self-esteem or self-ridicule. If the self-system is intact, areas of concern expand to include values, ideals, career decisions, and social concerns. (Videbeck 48)

Sullivan’s developmental cognitive modes

❖ Prototaxic: occurs in infancy and childhood. Involves short, unconnected experiences that have no relation. Schizophrenics can exhibit this.

❖ Parataxic: Onsets in early childhood, the child begins to make connections between experience and sequence. The child may not understand logic but may see coincidence in events. Paranoid ideas or slips of the tongue are associated with this mode.

❖ Syntaxic: Occurs in school aged children. The person begins to perceive themselves within the world and their environment and can analyze experiences.
Nursing theorist and clinician who built on Sullivan’s interpersonal theories and also saw the role of the nurse as a participant observer. Peplau developed the concept of the therapeutic nurse–patient relationship, which includes four phases: orientation, identification, exploitation, and resolution (Videbeck 49).

**Therapeutic Nurse–Patient relationship stages**

**Orientation**
- Patient’s problems and needs are clarified.
- Patient asks questions.
- Hospital routines and expectations are explained.
- Patient harnesses energy toward meeting problems.
- Patient’s full participation is elicited.

**Identification**
- Patient responds to persons he or she perceives as helpful.
- Patient feels stronger.
- Patient expresses feelings.
- Interdependent work with the nurse occurs.
- Roles of both patient and nurse are clarified.

**Exploitation**
- Patient makes full use of available services.
- Goals such as going home and returning to work emerge.
- Patient’s behaviors fluctuate between dependence and independence.

**Resolution**
- Patient gives up dependent behavior.
- Services are no longer needed by patient.
- Patient assumes power to meet own needs, set new goals, and so forth.
- Adapted from P (Videbeck 49)

**Expected outcomes of Nurse–Patient relationship stages**
1. The orientation phase is directed by the nurse and involves engaging the client in treatment, providing explanations and information, and answering questions.
2. The identification phase begins when the client works interdependently with the nurse, expresses feelings, and begins to feel stronger.
3. In the exploitation phase, the client makes full use of the services offered.
4. In the resolution phase, the client no longer needs professional services and gives up dependent behavior. The relationship ends. (Videbeck 49-50)

**Roles of the Nurse in the Therapeutic Relationship.**
- **Stranger**—offering the client the same acceptance and courtesy that the nurse would to any stranger,
- **Resource person**—providing specific answers to questions within a larger context,
- **Teacher**—helping the client to learn formally or informally,
- **Leader**—offering direction to the client or group,
- **Surrogate**—serving as a substitute for another such as a parent or sibling,
- **Counselor**—promoting experiences leading to health for the client such as expression of feelings.

Peplau also believed that the nurse could take on many other roles, including consultant, tutor, safety agent, mediator, administrator, observer, and researcher. These were not defined in detail but were “left to the intelligence and imagination of the readers” (Peplau, 1952, p. 70).

**Levels of Anxiety**
- **Mild anxiety** is a positive state of heightened awareness and sharpened senses, allowing the person to learn new behaviors and solve problems. The person can take in all available stimuli (perceptual field).
- **Moderate anxiety** involves a decreased perceptual field (focus on immediate task only); the person can learn new behavior or solve problems only with assistance. Another person can redirect the person to the task.
- **Severe anxiety** involves feelings of dread or terror. The person cannot be redirected to a task; he or she focuses only on scattered details and has physiological symptoms of tachycardia, diaphoresis, and chest pain. A person with severe anxiety may go to an emergency department, believing he or she is having a heart attack.
- **Panic anxiety** can involve loss of rational thought, delusions, hallucinations, and complete physical immobility and muteness. The person may bolt and run aimlessly, often exposing himself or herself to injury. (Videbeck 50)
Abraham Maslow: Maslow’s Hierarchy of Needs

- Do not forget this, you will use it the rest of your life!
- Studied the needs or motivations of the individual. He differed from previous theorists in that he focused on the total person, not just on one facet of the person, and emphasized health instead of simply illness and problems (Videbeck 51)

- formulated the hierarchy of needs, in which he used a pyramid to arrange and illustrate the basic drives or needs that motivate people. The most basic needs—the physiological needs of food, water, sleep, shelter, sexual expression, and freedom from pain—must be met first. The second level involves safety and security needs, which include protection, security, and freedom from harm or threatened deprivation. The third level is love and belonging needs, which include enduring intimacy, friendship, and acceptance. The fourth level involves esteem needs, which include the need for self-respect and esteem from others. The highest level is self-actualization, the need for beauty, truth, and justice. (Videbeck 51)

- Maslow hypothesized that the basic needs at the bottom of the pyramid would dominate the person’s behavior until those needs were met, at which time the next level of needs would become dominant. For example, if needs for food and shelter are not met, they become the overriding concern in life: the hungry person risks danger and social ostracism to find food. (Videbeck 51)
CARL ROGERS: Client centered therapy

was a humanistic American psychologist who focused on the therapeutic relationship and developed a new method of client-centered therapy. (Videbeck 51)

Rogers was one of the first to use the term client rather than patient. Client-centered therapy focuses on the role of the client, rather than the therapist, as the key to the healing process. (Videbeck 51)

According to Rogers, clients do “the work of healing,” and within a supportive and nurturing client–therapist relationship, clients can cure themselves. Clients are in the best position to know their own experiences and make sense of them, to regain their self-esteem, and to progress toward self-actualization. (Videbeck 51)

**Rodgers three central concepts**

❖ **Unconditional positive regard**—a nonjudgmental caring for the client that is not dependent on the client’s behavior

❖ **Genuineness**—realness or congruence between what the therapist feels and what he or she says to the client

❖ **Empathetic understanding**—in which the therapist senses the feelings and personal meaning from the client and communicates this understanding to the client.

(Videbeck 51)

Rogers also believed that the basic nature of humans is to become self-actualized, or to move toward self-improvement and constructive change. We are all born with a positive self-regard and a natural inclination to become self-actualized. If relationships with others are supportive and nurturing, the person retains feelings of self-worth and progresses toward self-actualization, which is healthy. If the person encounters repeated conflicts with others or is in unsupportive relationships, he or she loses self-esteem, becomes defensive, and is no longer inclined toward self-actualization; this is not healthy. (Videbeck 52)
Behaviorism is a school of psychology that focuses on observable behaviors and what one can do externally to bring about behavior changes. It does not attempt to explain how the mind works. (Videbeck 52)

Behaviorists believe that behavior can be changed through a system of rewards and punishments. For adults, receiving a regular paycheck is a constant positive reinforcer that motivates people to continue to go to work every day and to try to do a good job. It helps motivate positive behavior in the workplace. If someone stops receiving a paycheck, he or she is most likely to stop working. (Videbeck 52)

Laboratory experiments with dogs provided the basis for the development of Ivan Pavlov’s theory of classical conditioning: Behavior can be changed through conditioning with external or environmental conditions or stimuli. (Videbeck 52)

Pavlov’s experiment with dogs involved his observation that dogs naturally began to salivate (response) when they saw or smelled food (stimulus). Pavlov (1849–1936) set out to change this salivating response or behavior through conditioning. He would ring a bell (new stimulus), then produce the food, and the dogs would salivate (the desired response). Pavlov repeated this ringing of the bell along with the presentation of food many times. Eventually, he could ring the bell and the dogs would salivate without seeing or smelling food. The dogs had been “conditioned,” or had learned a new response—to salivate when they heard the bell. Their behavior had been modified through classical conditioning, or a conditioned response. (Videbeck 52)
B. F. Skinner: Operant conditioning

People learn their behavior from their history or past experiences, particularly those experiences that were repeatedly reinforced. Although some criticize his theories for not considering the role that thoughts, feelings, or needs play in behavior, his work has provided several important principles still used today. Skinner did not deny the existence of feelings and needs in motivation; however, he viewed behavior as only that which could be observed, studied, and learned or unlearned. He maintained that if the behavior could be changed, then so could the accompanying thoughts or feelings. Changing the behavior was motivating what was important (Videbeck 52).

Principles of operant conditioning

❖ All behavior is learned.
❖ Consequences result from behavior—broadly speaking, reward and punishment.
❖ Behavior that is rewarded with reinforcers tends to recur.
❖ Positive reinforcers that follow a behavior increase the likelihood that the behavior will recur.
❖ Negative reinforcers that are removed after a behavior increase the likelihood that the behavior will recur.
❖ Continuous reinforcement (a reward every time the behavior occurs) is the fastest way to increase that behavior, but the behavior will not last long after the reward ceases.
❖ Random intermittent reinforcement (an occasional reward for the desired behavior) is slower to produce an increase in behavior, but the behavior continues after the reward ceases. (Videbeck 52)

Behavioral principles

❖ Behavior modification, which is a method of attempting to strengthen a desired behavior or response by reinforcement, either positive or negative.
❖ Positive reinforcement: Giving the client positive feedback and attention for positive behaviors.
❖ Negative reinforcement: involves removing a stimulus immediately after a behavior occurs so that the behavior is more likely to occur again. For example, if a client becomes anxious when waiting to talk in a group, he or she may volunteer to speak first to avoid the anxiety.
❖ Systematic desensitization can be used to help clients overcome irrational fears or anxiety.
Cognitive Therapy

Cognitive therapy, focuses on immediate thought processing—how a person perceives or interprets his or her experience and determines how he or she feels and behaves. For example, if a person interprets a situation as dangerous, he or she experiences anxiety and tries to escape. Basic emotions of sadness, elation, anxiety, and anger are reactions to perceptions of loss, gain, danger, and wrongdoing by others (Beck & Newman, 2005). Aaron Beck is credited with pioneering cognitive therapy in persons with depression. (Videbeck 53)

Existential theorists believe that behavioral deviations result when a person is out of touch with himself or herself or the environment. The person who is self-alienated is lonely and sad and feels helpless. Lack of self-awareness, coupled with harsh self-criticism, prevents the person from participating in satisfying relationships. The person is not free to choose from all possible alternatives because of self-imposed restrictions. Existential theorists believe that the person is avoiding personal responsibility and giving in to the wishes or demands of others. All existential therapies have the goal of helping the person discover an authentic sense of self. They emphasize personal responsibility for one’s self, feelings, behaviors, and choices. These therapies encourage the person to live fully in the present and to look forward to the future. Carl Rogers is sometimes grouped with existential therapists. Table 3.7 summarizes existential therapies. (Videbeck 53)

USES

Cognitive behavioral therapy (CBT) is the most widely-used therapy for anxiety disorders. Research has shown it to be effective in the treatment of panic disorder, phobias, social anxiety disorder, and generalized anxiety disorder, among many other conditions.

COGNITIVE BEHAVIORAL ASSESSMENT STEPS

Step 1: Identify critical behaviors

Step 2: Determine whether critical behaviors are excesses or deficits

Step 3: Evaluate critical behaviors for frequency, duration, or intensity (obtain a baseline)

Step 4: If excess, attempt to decrease frequency, duration, or intensity of behaviors; if deficits, attempt to increase behaviors
Cognitive Therapy

Albert Ellis, founder of rational emotive therapy, identified 11 “irrational beliefs” that people use to make themselves unhappy. An example of an irrational belief is “If I love someone, he or she must love me back just as much.” Ellis claimed that continuing to believe this patently untrue statement will make the person utterly unhappy, but he or she will blame it on the person who does not return his or her love. Ellis also believes that people have “automatic thoughts” that cause them unhappiness in certain situations. He used the ABC technique to help people identify these automatic thoughts: A is the activating stimulus or event, C is the excessive inappropriate response, and B is the blank in the person’s mind that he or she must fill in by identifying the automatic thought. (Videbeck 53)

ELLIS 11 IRRATIONAL BELIEFS

❖ It is a dire necessity for adult humans to be loved or approved by virtually every significant other person in their community.
❖ One absolutely must be competent, adequate and achieving in all important respects or else one is an inadequate, worthless person.
❖ People absolutely must act considerately and fairly and they are damnable villains if they do not. They are their bad acts.
❖ It is awful and terrible when things are not the way one would very much like them to be.
❖ Emotional disturbance is mainly externally caused and people have little or no ability to increase or decrease their dysfunctional feelings and behaviors.
❖ If something is or may be dangerous or fearsome, then one should be constantly and excessively concerned about it and should keep dwelling on the possibility of it occurring.
❖ One cannot and must not face life’s responsibilities and difficulties and it is easier to avoid them.
❖ One must be quite dependent on others and need them and you cannot mainly run one’s own life.
❖ One’s past history is an all-important determiner of one’s present behavior and because something once strongly affected one’s life, it should indefinitely have a similar effect.
❖ Other people’s disturbances are horrible and one must feel upset about them.
❖ There is invariably a right, precise and perfect solution to human problems and it is awful if this perfect solution is not found.

Existential theorists believe that behavioral deviations result when a person is out of touch with himself or herself or the environment. The person who is self-alienated is lonely and sad and feels helpless. Lack of self-awareness, coupled with harsh self-criticism, prevents the person from participating in satisfying relationships. The person is not free to choose from all possible alternatives because of self-imposed restrictions. Existential theorists believe that the person is avoiding personal responsibility and giving in to the wishes or demands of others.

All existential therapies have the goal of helping the person discover an authentic sense of self. They emphasize personal responsibility for one’s self, feelings, behaviors, and choices. These therapies encourage the person to live fully in the present and to look forward to the future. Carl Rogers is sometimes grouped with existential therapists. Table 3.7 summarizes existential therapies. (Videbeck 53)
It is important that the nurse

Self limiting usually resolved in

The earlier the intervention the

Resolved in one of three ways:

support programs (Videbeck 59)

community support services or community

and persistent mental illness to help them to live in

using the coping skills they have previously used.

Crisis Intervention

Defining characteristics

❖ Self limiting usually resolved in
4-6 weeks
❖ Resolved in one of three ways:
Individual returns to pre crisis
function, individual functions
better than pre crisis, individual
stabilizes at a lower level of
functioning.
❖ The earlier the intervention the
better the outcome.

Cultural considerations

❖ It is important that the nurse
avoids reaching faulty
conclusions when working with
clients and families from other
cultures.

Psychiatric Rehabilitation

Involves providing services to people with severe
and persistent mental illness to help them to live in
the community. These programs are often called
community support services or community
support programs (Videbeck 59)

Types of crisis

❖ Maturational crisis, sometimes called
developmental crises, are predictable events in the
normal course of life, such as leaving home for the
first time, getting married, having a baby, and
beginning a career.

❖ Situational crises are unanticipated or sudden
events that threaten the individual’s integrity, such as
the death of a loved one, loss of a job, and physical
or emotional illness in the individual or family member.

❖ Adventitious crises, sometimes called social crises,
include natural disasters like floods, earthquakes, or
hurricanes; war; terrorist attacks; riots; and violent
crimes such as rape or murder. (Videbeck 54)

Treatments

Community Mental Health Treatment:
❖ Current treatment reflects the belief that it is more beneficial and certainly more cost-effective for clients to remain in the community and receive outpatient treatment whenever possible.
❖ Hospital admission is indicated when the person is severely depressed and suicidal, severely psychotic, experiencing alcohol or drug withdrawal, or exhibiting behaviors that require close supervision in a safe, supportive environment. (Videbeck 55)
❖ Remember it is always best to keep the client in the least restrictive environment.

Individual psychotherapy:
❖ Brings change by allowing the patient to explore their feelings, attitudes, behavior, and thinking.
❖ Involves one to one therapy
❖ The relationship between the client and the therapist proceeds through stages similar to those of the nurse–client relationship: introduction, working, and termination. (Videbeck 55)

Group therapy
number of persons who gather in a face-to-face setting to accomplish tasks that require cooperation, collaboration, or working together.
The therapeutic results of group therapy include the following:
❖ Gaining new information, or learning
❖ Gaining inspiration or hope
❖ Interacting with others
❖ Feeling acceptance and belonging
❖ Becoming aware that one is not alone and that others share the same problems
❖ Gaining insight into one’s problems and behaviors and how they affect others
❖ Giving of oneself for the benefit of others (altruism). (Videbeck 57)

Stages of group development:
❖ Beginning phase: starts when the group meets. Members and leaders introduce themselves. The group’s purpose is discussed. Rules and expectations are discussed.
❖ Working stage: begins as members begin to focus their attention on the purpose or task the group is trying to accomplish.
❖ Termination: Begins before the group disbands. The work of the group is reviewed, with the focus on group accomplishments or growth of group members or both, depending on the purpose of the group. (Videbeck 56)

Complementary and alternative medicine
Alternative medical systems include homoeopathic medicine and naturopathic medicine in Western cultures, and traditional Chinese medicine, which includes herbal and nutritional therapy, restorative physical exercises (yoga and Tai chi), meditation, acupuncture, and remedial massage.
❖ Mind-body interventions include meditation, prayer, mental healing, and creative therapies that use art, music, or dance.
❖ Biologically based therapies use substances found in nature, such as herbs, food, and vitamins. Dietary supplements, herbal products, medicinal teas, aromatherapy, and a variety of diets are included.
❖ Manipulative and body-based therapies are based on manipulation or movement of one or more parts of the body, such as therapeutic massage and chiropractic or osteopathic manipulation.
❖ Energy therapies include two types of therapy: biofield therapies, intended to affect energy fields that are believed to surround and penetrate the body, such as therapeutic touch, qigong, and Reiki, and bioelectric-based therapies involving the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, and AC or DC fields. Qi gong is part of Chinese medicine that combines movement, meditation, and regulated breathing to enhance the flow of vital energy and promote healing. Reiki (which in Japanese means universal life energy) is based on the belief that when spiritual energy is channeled through a Reiki practitioner, the patient’s spirit and body are healed.

What am I?
A crisis can occur when one becomes stressed, overwhelmed, or experiences life-changing events such as; trauma, death, financial hardships, or illness. Individuals experience crisis when they face these experiences or events and cannot cope properly using the coping skills they have previously used.
Inpatient

Today, inpatient units must provide rapid assessment, stabilization of symptoms, and discharge planning, and they must accomplish goals quickly. A client-centered multidisciplinary approach to a brief stay is essential. Clinicians help clients recognize symptoms, identify coping skills, and choose discharge supports. When the client is safe and stable, the clinicians and the client identify long-term issues for the client to pursue in outpatient therapy. These units are usually locked and require special permissions to enter and exit. (Videbeck 65)

Transitional Care

In Canada and Scotland, the transitional discharge model (Forchuk et al., 2007) has proved successful. Patients who were discharged to the community after long hospitalizations received intensive services to facilitate their transition to successful community living and functioning. Two essential components of this model are peer support and bridging staff. Peer support is provided by a consumer now living. (Videbeck 68)

Clubhouse Model

The essence of membership in the clubhouse is based on the four guaranteed rights of members:

❖ A place to come to
❖ Meaningful work
❖ Meaningful relationships
❖ A place to return to (lifetime membership)

The clubhouse model provides members with many opportunities, including daytime work activities focused on the care, maintenance, and productivity of the clubhouse; evening, weekend, and holiday leisure activities; transitional and independent employment support and efforts; and housing options. Members are encouraged and assisted to use psychiatric services, which are usually local clinics or private practitioners. (Videbeck 69)

Special Populations

❖ Homeless people with mental illness have been the focus of recent studies. For this population, shelters, rehabilitation programs, and prisons may serve as makeshift alternatives to inpatient care or supportive housing. (Videbeck 70)

❖ The rate of mental illness in the jailed population is 13%, compared with 2% in the general population. Offenders generally have acute and chronic mental illness and poor functioning, and many are homeless. Factors cited as reasons that mentally ill people are placed in the criminal justice system include deinstitutionalization, more rigid criteria for civil commitment, lack of adequate community support, economizing on treatment for mental illness, and the attitudes of police and society. (Videbeck 70)

People with mental illness who are in the criminal justice system face several barriers to successful community reintegration:

❖ Poverty
❖ Homelessness
❖ Substance use
❖ Violence
❖ Victimization, rape, and trauma
❖ Self-harm (Videbeck 71)

Partial Hospitalization

Partial hospitalization programs (PHPs) are designed to help clients make a gradual transition from being inpatients to living independently and to prevent repeat admissions. In day treatment programs, clients return home at night; evening programs are just the reverse. The services that different PHPs offer vary, but most programs include groups for building communication and social skills, solving problems, monitoring medications, and learning coping strategies and skills for daily living. Individual sessions are available in some PHPs, as are vocational assistance and occupational and recreation therapies. (Videbeck 67)

Goals

❖ Stabilizing psychiatric symptoms
❖ Monitoring drug effectiveness
❖ Stabilizing living environment
❖ Improving activities of daily living
❖ Learning to structure time
❖ Developing social skills
❖ Obtaining meaningful work, paid employment, or a volunteer position
❖ Providing follow-up of any health concerns

Residential Settings

Persons with mental illness may live in community residential treatment settings that vary according to structure, level of supervision, and services provided (Box 4.2). Some settings are designed as transitional housing with the expectation that residents will progress to more independent living. Other residential programs serve clients for as long as the need exists, sometimes years. Board and care homes often provide a room, bathroom, laundry facilities, and one common meal each day. (Videbeck 67)

Types

❖ Group homes
❖ Supervised apartments
❖ Board and care homes
❖ Assisted living
❖ Adult foster care
❖ Respite/crisis housing (Videbeck 67)

Psychiatric Rehabilitation Programs

Psychiatric rehabilitation, sometimes called psychosocial rehabilitation, refers to services designed to promote the recovery process for clients with mental illness (Box 4.3). This recovery goes beyond symptom control and medication management to include personal growth, reintegration into the community, empowerment, increased independence, and improved quality of life. Community support programs and services provide psychiatric rehabilitation to varying degrees, often depending on the resources and funding available. (Videbeck 68)

Goals

❖ Recovery from mental illness
❖ Personal growth
❖ Quality of life
❖ Community reintegration
❖ Empowerment
❖ Increased independence
❖ Decreased hospital admissions
❖ Improved social functioning
❖ Improved vocational functioning
❖ Continuous treatment
❖ Increased involvement in treatment decisions
❖ Improved physical health
❖ Recovered sense of self (Videbeck 68)

Points to Consider When Working in Community-Based Settings

❖ The client can make mistakes, survive them, and learn from them. Mistakes are a part of normal life for everyone, and it is not the nurse’s role to protect clients from such experiences.
❖ The nurse will not always have the answer to solve a client’s problems or resolve a difficult situation.
❖ As clients move toward recovery, they need support to make decisions and follow a course of action, even if the nurse thinks the client is making decisions that are unlikely to be successful.
❖ Working with clients in community settings is a more collaborative relationship than the traditional role of caring for the client. The nurse may be more familiar and comfortable with the latter. (Videbeck 73)
Components

- **Trust:** Trust builds when the client is confident in the nurse and when the nurse’s presence conveys integrity and reliability. Trust develops when the client believes that the nurse will be consistent in his or her words and actions and can be relied on to do what he or she says. (Videbeck 79)
- **Positive regard:** When the nurse perceives him or herself, or others, aware of his or her strengths and limitations, and clearly focused, the client perceives a genuine person showing genuine interest. A client with mental illness can detect when someone is exhibiting dishonest or artificial behavior such as asking a question and then not waiting for the answer, talking over him or her, or assuring him or her everything will be alright. (Videbeck 79)
- **Empathy:** The ability of the nurse to perceive the meanings and feelings of the client and to communicate that understanding to the client. (Videbeck 80)
- **Acceptance:** The nurse who does not become upset or respond negatively to a client’s outbursts, anger, or acting out conveys acceptance to the client. Avoiding judgments of the person, no matter what the behavior, is acceptance. This does not mean acceptance of inappropriate behavior but acceptance of the person as worthy. (Videbeck 81)
- **Genuine interest:** A client with mental illness can detect when someone is genuinely interested in and involved with him or her, or senior, or from any discipline, are at risk for boundary violations, including problems with abuse of authority and power. (Videbeck 92)

Types of Relationships

- **Social relationship:** Friendships, socialization, and completion of tasks. Usually superficial communication that focuses on sharing of ideas, feelings and experience.
- **Intimate relationship:** Involves two people who are emotionally committed to each other. This may be sexual or emotional. Intimate relationships do not belong in the nurse client relationship.
- **Therapeutic relationship:** Focuses on the needs, experiences, feelings, and ideas of the client only.

Mental Health

**Types of the Therapeutic Relationship**

**Orientation:** Initial meeting and identification of problem

**Working:** The working phase of the nurse–client relationship is usually divided into two subphases: During problem identification, the client identifies the issues or concerns causing problems. During exploitation, the nurse guides the client to examine feelings and responses and to develop better coping skills and a more positive self-image; this encourages behavior change and develops independence. The trust established between nurse and client at this point allows them to examine the problems and to work on them within the security of the relationship.

**The specific tasks of the working phase include the following:**

- Maintaining the relationship
- Gathering more data
- Exploring perceptions of reality
- Developing positive coping mechanisms
- Promoting a positive self-concept
- Encouraging verbalization of feelings
- Facilitating behavior change
- Working through resistance
- Evaluating progress and redefining goals as appropriate
- Providing opportunities for the client to practice new behaviors
- Promoting independence

**Termination:** The termination or resolution phase is the final stage in the nurse–client relationship. It begins when the problems are resolved, and it ends when the relationship is ended. (Videbeck 89)

Role of the Nurse in a Therapeutic Relationship

- **Teacher**
- **Caregiver**
- **Advocate**
- **Parent surrogate**

Possible Warnings or Signals of Abuse of the Nurse–Client Relationship

- Secrets; reluctance to talk to others about the work being done with clients
- Sudden increase in phone calls between nurse and client or calls outside clinical hours
- Nurse making more exceptions for client than normal
- Inappropriate gift giving between client and nurse
- Loaning, trading, or selling goods or possessions
- Nurse disclosure of personal issues or information
- Inappropriate touching, comforting, or physical contact
- Overdoing, overprotecting, or overidentifying with client
- Change in nurse’s body language, dress, or appearance (with no other satisfactory explanation)
- Extended one-on-one sessions or home visits
- Spending off-duty time with the client
- Thinking about the client frequently when away from work
- Becoming defensive if another person questions the nurse’s care of the client
- Ignoring agency policies (Videbeck 91)
**Mental Health Assessment**

**History**
- Age:
- Developmental stage:
- Cultural Considerations:
- Spiritual Beliefs:
- Previous History:

**General Assessment & Motor Behavior**
- Hygiene & Grooming
- Appropriate dress
- Posture
- Eye contact
- Unusual movement
- Speech

**Mood & Affect**
- Expressed emotions
- Facial expressions

**Thought Process**
- Content: What is the patient thinking?
- Process: How the patient is thinking
- Clarity of ideas
- Self harm or suicide urges

**Abnormal Sensory Experiences**
- Concentration
- Abstract thinking abilities

**Roles & Relationships**
- Current roles
- Satisfaction with roles
- Success with roles
- Significant relationships
- Support systems

**Judgement & Insight**
- Interpretation of environment
- Ability to make decisions
- Insight: one’s own part in their current situation

**Suicide Assessment**
- Ideation: “Are you thinking of harming yourself?”
- Plan: “Do you have a plan to kill yourself?”
- Access: “How would you carry out your plan?”
- Where: “Where would you kill yourself?”
- When: “When do you plan to kill yourself?”
- Timing: “What day, or time of day do you plan on killing yourself?”

**Thought Process & Content**
- Circumstantial thinking: Eventually the patient answers, after giving unneeded information.
- Delusion: A fixed false belief that is not based on reality (If they tell you they are the king of wonderland, they will always tell you they are the king of wonderland.)
- Flight of ideas: excessive amount and rate of speech. Ideas are not complete or unrelated.
- Ideas of reference: inaccurate interpretations of general events. The patient may believe that an article in the paper is about them, a song is written about them, or believing a speech on TV was directed at them.
- Loose Association: disorganized thinking pattern that jumps from one idea to then next with no relevance. (Swimming, swimming, ocean, blue, blue shoes)
- Tangential thinking: never providing the information needed due to never being on topic
- Thought blocking: Stopping abruptly in the middle of a thought and usually unable to finish the idea.
- Thought broadcasting: delusional belief that others know or can hear what the patient is thinking.
- Word salad: flow of unconnected words that convey no meaning to the listener.

**Self Concept**
- Personal view of self
- Description of physical self
- Personal qualities

**Physiologic Self Care Considerations**
- Eating habits
- Sleep patterns
- Health problems
- Complice with current treatments
- Ability to perform ADL'S

**Acronym for Suicide Assessment**
- W: where/when
- A: Access
- I: in planning
- T: Timing
Psychiatric bill of rights

❖ To be informed about benefits, qualifications, of all providers, available treatment options, appeals, and grievance procedures.
❖ Confidentiality
❖ Choice of provider
❖ Treatment determined by professionals
❖ Parity
❖ Non discrimination
❖ All benefits within scope of benefit plan
❖ Treatment that affords the greatest protection
❖ Fair and valid treatment review process
❖ Treating professionals and payers held accountable for injury caused by gross incompetence, negligence, or clinically unjustified decisions

Involuntary Treatment

Involuntary commitment: A client must commit themselves unless they are a threatening harm to themselves or others. If this occurs they will be committed by a healthcare professional or judge for 48-72 hours depending on state regulations, until a hearing can be conducted to determine if the client needs longer treatment times. They still have the right to refuse medications.

Voluntary commitment: A client is willing to seek treatment for their mental illness. They have the right to leave. They may have to sign an "against medical advice" consent.

Duty to Warn

One exception to confidentiality is the duty to warn if there are any threats of harm made to any third party by the client. The decision to warn is based on the following criteria:
❖ Is the client dangerous to others?
❖ Is the danger a result of serious mental illness?
❖ Is the danger serious?
❖ Are means to carry out the threat available?
❖ Is the danger targeted at identifiable victims?
❖ Is the victim accessible?

Ethics

❖ Autonomy: a person’s right to self determination and independence.
❖ Beneficence: duty to benefit or promote good good for others
❖ Nonmaleficence: requirement to do harm intentionally or unintentionally
❖ Justice: fairness
❖ Veracity: duty to be honest
❖ Fidelity: obligation to honor commitments (SEMPER FIDELIS)

Rights of the Psychiatric Patient

❖ Maintain civil rights
❖ Right to refuse treatment
❖ Right to refuse visitors
❖ A suicidal client may not be permitted to have a belt, cored telephone, shoelaces, or scissors.
❖ If a certain visitor causes a client to be aggressive they may be asked to leave and unable to visit the client for a period of time.
❖ If a client makes a threatening phone call to outsiders, the client may be restricted to supervised phone calls.

Inpatient Treatment

❖ Mandatory outpatient treatment: A court ordered requirement for the client to participate in treatment involuntarily after release.
❖ Conservatorship: a.k.a. Legal guardian areas signed to those clients who are gravely disabled, debilitated, or incompetent.
❖ Confidentiality: protection and privacy of personal information.
❖ Least restrictive environment: a client does not have to be hospitalized if she or he can be treated on an outpatient basis. The client must also be free from restraint or seclusion unless necessary.
❖ Restraint: is the direct application of physical force to a person without his/her permission. Human restraint is when staff members physically control the client. Mechanical restraints are devices used on the wrists or ankles. Chemical restraints are medications such as lorazepam or haldol used to calm or sedate the client.
❖ Seclusion: involuntary confinement in a specially constructed room. The room is locked and has no windows with exception of a security window.

Things to Know

❖ Unintentional torts: Negligence or malpractice. Involves causing harm by failing to do what a reasonable or prudent practitioner would do.
❖ Intentional tort: Assault & Battery. Voluntary acts that result in harm.

Torts
Types of grief & loss

Anticipatory: one is expecting the imminent death of a loved one and has time to make arrangement and go through the grieving process.

Disenfranchised grief: grief over a loss that is not or cannot be acknowledged openly, mourned publicly, or supported socially. Circumstances that can result in disenfranchised grief include: a relationship that has no legitimacy, a child or pet, or a job.

Safety loss: Loss of a safe environment is evident in domestic violence, child abuse, or public violence. A person’s home should be a safe haven with trust that family members will provide protection, not harm or violence.

Loss of security and a sense of belonging: The loss of a loved one affects the need to love and the feeling of being loved.

Loss of self-esteem: Any change in how a person is valued at work or in relationships or by himself or herself can threaten self-esteem.

Loss related to self-actualization: An external or internal crisis that blocks or inhibits striving toward fulfillment may threaten personal goals and individual potential.

Grieving is a process through which a person may express and accommodate changes that have occurred in themselves and their relationships, and through which a person may come to terms with death. (Videbeck 162)

Cognitive Responses to Grief

In some respects, the pain that accompanies grief results from a disturbance in the person’s beliefs. The loss disrupts, if not shatters, basic assumptions about life’s meaning and purpose. Grieving often causes a person to change beliefs about self and the world, such as perceptions of the world’s benevolence, the meaning of life as related to justice, and a sense of destiny or life path. Other changes in thinking and attitude include reviewing and ranking values, becoming wiser, shedding illusions about immortality, viewing the world more realistically, and reevaluating religious or spiritual beliefs. (Videbeck 164)

Susceptibility to complicated grief

Ambivalent attachment, at least one partner is unclear about how the couple loves or does not love each other. For example, when a woman is uncertain about and feels pressure from him or her, she may then decide to stay with the body while the client notifies relatives. (Videbeck 167)

Dependent attachment, one partner relies on the other to provide for his or her needs without necessarily meeting the partner’s needs.

Insecure attachment usually forms during childhood, especially if a child has learned fear and helplessness. (Videbeck 169)
ANGER, AGGRESSION & HOSTILITY

ANGER
❖ Perceived as a negative feeling.
❖ Feeling anger at appropriate times is normal.
❖ Anger becomes a negative response when denied, suppressed, or expressed.
❖ Anger that is expressed inappropriately can become hostility and aggression.
❖ Anger can lead to physiologic issues such as coronary artery disease & hypertension.

HOSTILITY & AGGRESSION

Can be sudden & unexpected.

PHASES
❖ Triggering phase: an incident or situation that precedes or initiates the episode of aggression.
❖ Escalation phase: response represents escalating behaviors such as; clenched fists, threatening behaviors, flushed face, yelling & sweating.
❖ Crisis phase: loss of control. The client may throw objects, hit, spit, scream or present as out of control.
❖ Recovery phase: regain of physical and emotional control. The client will become calm, voice will lower, communication may become clearer and more rational.
❖ Post crisis phase: returns to functional level and attempts reconciliation.

TREATMENTS
Treatment is aimed at treating the underlying cause of aggression.
❖ Lithium: Bipolar disorder
❖ Carbamazepine & Depakote: treat aggression related to dementia, psychosis, & personality disorders.
❖ Risperidone: treats aggression associated with mental retardation, dementia, brain injury, & personality disorders.
❖ Benzodiazepines: reduce hostility in those with dementia.
❖ Haloperidol & lorazepam: are used to treated aggression associated with psychosis.

For many clients with aggressive behavior, effective management of the comorbid psychiatric disorder is the key to controlling aggression (Videbeck 192).

NURSING ACTIONS
❖ Identify how you handle angry feelings; assess your use of assertive communication and conflict resolution. Increasing your skills in dealing with your angry feelings will help you to work more effectively with clients.
❖ Discuss situations or the care of potentially aggressive clients with experienced nurses.
❖ Do not take the client’s anger or aggressive behavior personally or as a measure of your effectiveness as a nurse. (Videbeck 193)

EITIOLOGY

Neurobiologic theory
Serotonin plays a major inhibitory role in aggressive behavior; therefore, low serotonin levels may lead to increased aggressive behavior. This finding may be related to the anger attacks seen in some clients with depression. In addition, increased activity of dopamine and norepinephrine in the brain is associated with increased impulsively violent behavior. Further, structural damage to the limbic system and the frontal and temporal lobes of the brain may alter the person’s ability to modulate aggression; this can lead to aggressive behavior (Videbeck 185).

Psychosocial
As a child matures, he or she is expected to develop impulse control (the ability to delay gratification) and socially appropriate behavior. Positive relationships with parents, teachers, and peers; success in school; and the ability to be responsible for oneself foster development of these qualities. Children in dysfunctional families with poor parenting, children who receive inconsistent responses to their behavior, and children whose families are of lower socioeconomic status are at increased risk for failing to develop socially appropriate behavior. This lack of development can result in a person who is impulsive, easily frustrated, and prone to aggressive behavior. (Videbeck 184)

CARE PLANNING

NANDA statement
❖ Risk for other-directed violence
❖ Ineffective coping

Expected outcomes
❖ Client will not harm self or others.
❖ Client will remain free of behaviors that are threatening or harmful to self or others.
❖ Client will verbalize feelings and concerns without aggression.
❖ Client will comply with treatment.

Interventions
❖ Managing the environment and allowing the client to openly express feelings in a non-threatening way.
❖ Managing aggressive behavior by approaching the client in a non threatening way during the triggering phase. Convey empathy.
❖ Assertive communication: Use I statements

RELATED DISORDERS
❖ Depression
❖ Bipolar
❖ Schizophrenia
❖ Anxiety
❖ Interimtaneous explosive disorder
❖ Acting out

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Abuse can have long term physical and emotional effects on the victim. Some victims may become agitated or withdrawn while, others may become aloof or upset. Often suffer in silence and feel guilty or shame. May have trouble relating to others. May not be able to trust others.

**Family Violence**

*Includes:* child abuse, rape, spousal abuse, emotional abuse, elder abuse.

**Characteristics**

- **Social isolation:** family members keep to themselves and usually do not invite other into the home. Children keep abuse a secret out of fear.
- **Abuse of power:** the abuser usually always holds a position of power within the family unit. They may exert physical, social, emotional, or financial power.
- **Substance abuse:** abuse can result from abuse of alcohol or drugs. Abuse of Alcohol by the abuser is also a factor in most rape cases.
- **Intergenerational transmission process:** cycle of abuse. Children are seeing the parent abuse women so the child abuses women. (Fifty Shades of Grey)

**Intimate Partner Violence:** Abuse or mistreatment of a person in the context of an emotionally intimate relationship.

**Psychological abuse:** (emotional abuse) includes name-calling, belittling, screaming, yelling, destroying property, and making threats as well as subtler forms, such as refusing to speak to or ignoring the victim.

**Child abuse** or maltreatment generally is defined as the intentional injury of a child. It can include physical abuse or injuries, neglect or failure to prevent harm, failure to provide adequate physical or emotional care or supervision, abandonment, sexual assault or intrusion, and overt torture or maiming.

**Elder abuse:** is the maltreatment of older adults by family members or others in a caregiver role. It may include physical and sexual abuse, psychological abuse, neglect, self-neglect, financial exploitation, and denial of adequate medical treatment. (Videbeck 204)

**Rape** is a crime of violence and humiliation of the victim expressed through sexual means. Rape is the perpetration of an act of sexual intercourse with a female against her will and without her consent, whether her will is overcome by force, fear of force, drugs, or intoxicants.

**Warning Signs of Child Abuse**

- Serious injuries such as fractures, burns, or lacerations with no reported history of trauma
- Delay in seeking treatment for a significant injury
- Child or parent giving a history inconsistent with severity of injury, such as a baby with contrecoup injuries to the brain (shaken baby syndrome) that the parents claim happened when the infant rolled off the sofa
- Inconsistencies or changes in the child’s history during the evaluation by either the child or the adult
- Unusual injuries for the child’s age and level of development, such as a fractured femur in a 2-month-old or a dislocated shoulder in a 2-year-old
- High incidence of urinary tract infections; bruised, red, or swollen genitalia; tears or bruising of rectum or vagina
- Evidence of old injuries not reported, such as scars, fractures not treated, and multiple bruises that parent/caregiver cannot explain adequately (Videbeck 203)

*The priority is to get the child safe and away from the abuse.*

Nurses should be sensitive to the safety and belonging needs of abuse victims

**Do not**

- Don’t tell the victim what to do.
- Don’t express disgust, disbelief, or anger.
- Don’t disclose client communications without the client’s consent.
- Don’t preach, moralize, or imply that you doubt the client. Don’t minimize the impact of violence.
- Don’t express outrage with the perpetrator.
- Don’t imply that the client is responsible for the abuse.
- Don’t recommend couples’ counseling.
- Don’t direct the client to leave the relationship.
- Don’t take charge and do everything for the client. (Videbeck 201)

**Do**

- Do believe the victim.
- Do ensure and maintain the client’s confidentiality.
- Do listen, affirm, and say, “I am sorry you have been hurt.”
- Do tell the victim, “You have a right to be safe and respected.”
- Do express, “I’m concerned for your safety.”
- Do say, “The abuse is not your fault.”
- Do recommend a support group or an individual counseling.
- Do identify community resources and encourage the client to develop a safety plan.
- Do offer to help the client contact a shelter, the police, or other resources.
- Do accept and respect the victim’s decision.

**Safety Assessment Questions**

- **Stress/Safety:** What stress do you experience in your relationships? Do you feel safe in your relationships? Should I be concerned for your safety?
- **Afraid/Abused:** Have there been situations in your relationships where you have felt afraid? Has your partner ever threatened or abused you or your children? Have you ever been physically hurt or threatened by your partner? Are you in a relationship like that now? Has your partner ever forced you to engage in sexual intercourse that you did not want? People in relationships/marriages often fight; what happens when you and your partner disagree?
- **Friends/Family:** Are your friends aware that you have been hurt? Do your parents or siblings know about this abuse? Do you think you could tell them, and would they be able to give you support?
- **Emergency Plan:** Do you have a safe place to go and the resources you (and your children) need in an emergency? If you are in danger now, would you like help in locating a shelter? Would you like to talk to a social worker/a counselor/me to develop an emergency plan? (Videbeck 201)

**Cultural Considerations**

Although domestic violence affects families of all ethnicities, races, ages, national origins, sexual orientations, religions, and socioeconomic backgrounds, a specific population is particularly at risk: immigrant women.

- The battered woman may come from a culture that accepts domestic violence.
- She may believe she has less access to legal and social services than do U.S. citizens.
- She is isolated by cultural norms that do not permit her to leave her husband or seek legal assistance.
- She is isolated by cultural dynamics that do not permit her to leave her husband, economically, she may be unable to gather the resources to leave, work, or go to school.
- Language barriers may interfere with her ability to call 911, learn about her rights or legal options, and obtain shelter, financial assistance, or food. (Videbeck 198)
**What is PTSD?**

PTSD (posttraumatic stress disorder) is chronic in nature mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault.

**Elements**
- Re Experiencing the trauma through dreams or intrusive thoughts
- Feeling detached
- Being on guard or hypervigilant
- Irritability
- Hyper Arousability
- Flashbacks
- Avoidance of triggers associated with stimuli
- Insomnia

**Complications**
- Avoidance behaviors
- Isolation

**Criteria**
- Must have symptoms for longer than 3 months
- Must have direct “witnessed a trauma”
- Event must be persistently experienced
- Trauma related thoughts
- Negative thoughts or feelings
- Trauma related arousal: irritability, risky behavior
- Trauma created social or functional distress
- Symptoms must not be related to medications or illness

In addition to meeting the above criteria the client may experience :
1. Depersonalization: experience of being an outside observer or detachment from self.
2. Derealization: experiences unreality, distance or distortion.

**Assessment**
- History of abuse or trauma
- Memory gaps
- Wide range of moods possible
- Nightmares
- Flashbacks
- Low self esteem
- Difficulty with roles and relationships
- Anxiety
- Nightmares
- Sleep issues
- Handles life poorly
- Experience the trauma again
- Low self esteem
- Low inhibition
- Serious abuse
- Hypervigilance
- Out of it (dissociation)
- Can not focus
- Keeps away from crowds

**Treatment**
- Cognitive behavioral treatment
- Exposure therapy: exposing the client to triggers to desensitize them to the specific stimuli
- Adaptive disclosure: specialized CBT approach developed by the military. Offers intense short term therapy to combat PTSD.
- Cognitive processing: structured sessions that involve examining erroneous beliefs such as guilt or self blame.
- SSRI/SNRI

**Elder Considerations**
- Most elders suffering from PTSD are underdiagnosed. Must have been misdiagnosed with combat fatigue.
- Most of the elder population with PTSD are WWII veterans.
- Vietnam veterans are among the first to be diagnosed with PTSD

**Client & Family Education**
- Ask for support
- Avoid isolation
- Join a support group
- Share emotions and experiences
- Follow a daily routine
- Set small, specific goals
- Accept feelings
- Eat balanced meals
- Avoid drugs and alcohol
- Practice stress reducing techniques and positive coping

**Cultural Considerations**
- Ptsd is universal and not specific to any culture

**Who is at risk**
- Military personnel
- Those who have witnessed traumatic events
- Those in war torn countries
- Victims of abuse or violence
- Adolescents who have a traumatic experience are more likely to develop PTSD than adults or children who suffer the same trauma.

**ASSESSMENT**
- **S**: Sleep issues
- **H**: Handles life poorly
- **E**: Experience the trauma again
- **L**: Low self esteem
- **L**: Low inhibition
- **S**: Serious abuse
- **H**: Hypervigilance
- **O**: Out of it (dissociation)
- **C**: Can not focus
- **K**: Keeps away from crowds

**PTSD can result in dissociation**
- **Dissociation**: A subconscious defense mechanism to protect oneself from trauma.
  - They can occur both during and after the traumatic event.
  - Treated with group therapy or individual therapy.
    - Dissociative amnesia: the client can’t remember details of their life. Usually include a fugue state where the client may make a sudden move to a new state with no memory of past events (Prince Charming in once upon a time)
    - Dissociative identity disorder: when the client displays two or more personalities as a protective mechanism (The movie Split)
    - Depersonalization/ derealization: persistent feelings of detachment (Hudson Milbank in NUMB)

Simple Nursing would like to thank all of our veterans for the many sacrifices they have made both on and off the battlefield. Because of you we have the freedom to pursue the fantastic profession of nursing!
**What is it?**

Dissociative disorders (DD) are conditions that involve disruptions or breakdowns of memory, awareness, identity, or perception. People with dissociative disorders use dissociation, as a defence mechanism, pathologically and involuntarily.

**Assessment**

- Memory loss (amnesia) of certain time periods, events, people and personal information
- A sense of being detached from yourself and your emotions
- A perception of the people and things around you as distorted and unreal
- A blurred sense of identity
- Significant stress or problems in your relationships, work or other important areas of your life
- Inability to cope well with emotional or professional stress
- Mental health problems, such as depression, anxiety, and suicidal thoughts and behaviors

**Causes**

Dissociative disorders usually develop as a way to cope with trauma. The disorders most often form in children subjected to long-term physical, sexual or emotional abuse or, less often, a home environment that's frightening or highly unpredictable. The stress of war or natural disasters also can bring on dissociative disorders. Personal identity is still forming during childhood. So a child is more able than an adult to step outside of himself or herself and observe trauma as though it's happening to a different person. A child who learns to dissociate in order to endure a traumatic experience may use this coping mechanism in response to stressful situations throughout life. (Mayo Clinic, 2018)

**Three Types**

- **Dissociative amnesia:** the client can’t remember details of their life. Usually include a fugue state where the client may make a sudden move to a new state with no memory of past events (Prince Charming in Once Upon a Time).
- **Dissociative identity disorder:** when the client displays two or more personalities as a protective mechanism (The movie Split).
- **Depersonalization/ Derealization:** persistent feelings of detachment (Hudson Milbank in Numb).

**Complications**

- Self-harm or mutilation
- Suicidal thoughts and behavior
- Sexual dysfunction
- Alcoholism and drug use disorders
- Depression and anxiety disorders
- Post-traumatic stress disorder
- Personality disorders
- Sleep disorders, including nightmares, insomnia and sleepwalking
- Eating disorders
- Physical symptoms such as lightheadedness or non-epileptic seizures
- Major difficulties in personal relationships and at work

**Famous Faces Case Study**

Jim Carrey’s character Charlie Baileygates morphs into alter ego Hank Evans as a self-defense mechanism. Extremely assertive, and inappropriately so, his confrontational alternate provides an outlet for what Charlie is too feeble to express himself.

Dissociation is often a coping mechanism. Charlie went through a trauma “his divorce” which is causing him to dissociate to protect himself. Hank is a release of Charlie’s cooped up anger.

During switching, Hank surfaces. Characteristics of switching can include; violence substance abuse, mood swings, depression, anxiety, panic attacks, phobias, compulsions, hallucinations, eating disorders, time loo, amnesia, and self violence.

**Treatments**

- Psychotherapy
- Hypnosis
- Mood stabilizers
Stress occurs in everyday life. It can come from relationships, work, school, and so on. The body can also perceive stress from other factors such as illness, toxins, pain, and heat.

G.A.S
General Adaptation syndrome is the body’s physiological response to stress based on the response of the sympathetic nervous system.

**Phases**
- **Alarm stage:** stimulation of sympathetic nervous system alarms the body to send messages from the hypothalamus to hormone receptors in the adrenals to release epinephrine and norepinephrine. The liver is signaled to convert glycogen into glucose.
- **Resistance phase:** the digestive system shuts down function and the body shunts blood to vital organs. Lungs take in more air, the heart beats faster and harder to circulate more oxygen rich blood to the body.
- **Exhaustion phase:** occurs when a negative response to anxiety occurs. Body stores are depleted.

**Levels of Anxiety**
- **Mild:** heightened sensation, increased focus, able to solve problems. Mild anxiety is good for motivation to finish a project or do well on an exam.
- **Moderate:** the person becomes nervous or agitated. One can still take in and understand information and instruction. Moderate anxiety may cause difficulty with concentrating but one can still be redirected to the topic.
- **Severe anxiety:** survival skills begin to take over. Cognition decreases. The person will have a hard time thinking, concentrating, muscles become tense, vital signs begin to elevate. The person may pace, become restless, irritable, or angry.
- **Panic:** the flight or flight mechanism has taken over. The person may present with tachycardia, tachypnea, elevated bp, pupils enlarge. The main focus becomes survival.

**Nursing Interventions**
- **Mild anxiety:** is good for the client. The may not need to intervene.
- **Moderate:** the nurse must assess if the client is focusing on what the nurse is saying. Speak in short simple terms and stop to evaluate if the client understands.
- **Severe:** goal is to lower the persons anxiety to moderate or mild before they can effectively communicate. Stay with the client. Walking while talking can be effective if the person is too restless. Guiding the person to take deep breaths can also be effective.
- **Panic:** safety is the priority concern when the person/client is in a state of panic. They may not be rational or be able to perceive harm. The nurse must be comforting and therapeutic. Decrease environmental stimuli, offer reassurance that the panic is temporary and will pass.

**Assessment**
- Decreased attention span
- Restlessness
- Irritability
- Impulsiveness
- Feeling apprehension, discomfort, helpless
- Hyperactivity
- Pacing
- Wringing hands
- Perception deficits
- Inability to communicate

**Medications**
- Benzodiazepines for short term use. 4-6 weeks
- SSRI
- Propranolol

**Famous Face Case Study**

Piglet often cowers in fear even when moments are unthreatening. Though his best friend, Pooh, and the others don’t seem to mind Piglet’s constant fears and happily brings him along and protects him through every adventure, Piglet is noticeably ashamed of his cowardliness, and many storylines have revolved around him making attempts to overcome his fears. It is quite clear that Piglet’s timid, jittery, and hesitant qualities are grounds to diagnose him with Generalized Anxiety Disorder (GAD). Piglet’s irrational anxiety causes him to suffer from a distinct stuttering speech impediment, stress, and general nervousness. Those with GAD worry endlessly and cannot be relaxed immediately, like Piglet. Symptoms of GAD that Piglet experiences are excessive and ongoing worry and tension, an unrealistic view of problems, and being easily startled. Piglet often thinks of how any situation can go wrong and endures internal conflicts regarding what he should do in case a situation does go wrong. For example, while trying to find a heffalump (a creature that resembles an elephant) Piglet thinks to himself how he can fake a headache so he will not have to face one of these creatures, lest it is fierce. Then he worries if he fakes a headache, he will be stuck in bed all morning; which he wants to avoid. Scenarios like these usually make Piglet extremely anxious. Piglet’s anxiety causes him to shake, blush, twitch, and get flustered. Piglet also has phobias of the dark, wind, heffalumps, being abandoned, etc. As defined by Mayo Clinic, “a phobia is an overwhelming and unreasonable fear of an object or situation that poses little real danger but provokes anxiety and avoidance.” Piglet’s fears are undeniably “overwhelming and unreasonable” because heffalumps, the dark, and the wind pose “little real danger” to Piglet. But does not seize to evoke anxiety in him. In a conversation with Owl, Piglet says “Oh Owl, I don’t mean to c-c-complain, but I’m afraid, I’m scared.” As portrayed, Piglet’s anxiety causes him to stutter. Despite Piglet’s worries, Owl confidently and faithfully replies, “Piglet, Chin up... A rescue’s being thought of. Be brave, little Piglet!” Piglet attributes his cowardliness to his little frame by responding. “It’s awfully hard to be b-b-b-b-b-brave when you’re such a small animal.” Here, he begins to stutter more immensely and seems to be unable to overcome his fears despite Owl’s assurance. Piglet undoubtedly suffers from Generalized Anxiety Disorder and his character is developed through his anxious demeanor.
**Stress Disorders: Panic**

**What is it?**
A psychiatric disorder in which debilitating anxiety and fear arise frequently and without reasonable cause. Discreet episodes of panic frequently occur and last 15-20 minutes.

**Assessment**
- Intense anxiety
- Automatisms: fidgeting, jerking, tapping.
- Sweating
- Tremors
- Shortness of breath
- Sense of suffocation
- Impending doom
- Chest pain
- Nausea
- Abdominal distress
- Dizziness
- Paraesthesias
- Hot flashes

**Diagnoses**
- Recurrent persistent panic attacks followed by 1 month of worry of future attacks.
- Most common in those without higher education and those who are not married.
- Peaks in late adolescence
- Panic attacks can lead to avoidant behavior or agoraphobia

**Thought Process**
- The client may feel as though they have lost control.
- They may contemplate suicide.
- Their thoughts will be disorganized, they will be irrational.
- They may be confused or disoriented
- Unable to assess safety
- They make self-blaming statements: “I am so weak, how did I let myself get to this point.”
- Typically will avoid people and places associated with triggers.
- They will report trouble sleeping or insomnia.

**Gains**
- **Primary:** the feeling of relief that they are home after performing the specific anxiety driven behavior.
- **Secondary gain:** the attention the client receives as a result of their dysfunction.

**Treatments**
- Cognitive behavioral therapy
- Relaxation
- Deep breathing
- SSRI
- Benzodiazepines
- Tricyclic antidepressants
- Clonidine & propranolol: antihypertensives

**Nursing Interventions**
- During a panic attack it is the nurse’s priority to provide a safe environment.
- Remain with the client
- In a soothing calm voice, give brief directions and reassure the client that they are safe.
- Help them focus on deep breathing
- Teach relaxation techniques
- Aid the client in using cognitive restructuring
- Help the client explore ways to decrease scissors

**Education**
- Breathing techniques
- Coping strategies
- Encourage regular exercise
- Educate on medication regimen
- Encourage management techniques such as creating lists
- Encourage them to go to support groups and maintain a social circle.

**Famous Faces Case Study**
Captain Hook, not only suffers from anxiety, he suffers from panic disorder. Captain Hook lost his hand to a crocodile in a previous battle with Peter Pan. Since then he lives in a state of worry of when Pan will return. He frequently paces and extremely irritable. Captain Hook shakes and quivers when he hears the name Peter Pan. Additionally, he also panics when he hear the clock. He lives isolated on his ship with only Mr. Smea.
**What is it?**

A phobia is a type of anxiety disorder that causes an individual to experience extreme, irrational fear about a situation, living creature, place, or object.

**Types and subtypes**

**Social phobia, or social anxiety:** This is a profound fear of public humiliation and being singled out or judged by others in a social situation. The idea of large social gatherings is terrifying for someone with social anxiety. It is not the same as shyness.

**Agoraphobia:** This is a fear of situations from which it would be difficult to escape if a person were to experience extreme panic, such as being in a lift or being outside of the home. It is commonly misunderstood as a fear of open spaces but could also apply to being confined in a small space, such as an elevator, or being on public transport. People with agoraphobia have an increased risk of panic disorder.

**Specific phobias** are known as simple phobias as they can be linked to an identifiable cause that may not frequently occur in the everyday life of an individual, such as snakes. These are therefore not likely to affect day-to-day living in a significant way.

- **Natural environmental phobia:** fear of storms or natural disasters
- **Blood /injections:** fear of blood
- **Situational:** fear of being put into a situation such as being stuck on a bridge or train tracks
- **Animal phobia:** fear of animals or insects

**Assessment**

A person with a phobia will experience the following symptoms. They are common across the majority of phobias:

- a sensation of uncontrollable anxiety when exposed to the source of fear
- a feeling that the source of that fear must be avoided at all costs
- not being able to function properly when exposed to the trigger
- acknowledgment that the fear is irrational, unreasonable, and exaggerated, combined with an inability to control the feelings

A person is likely to experience feelings of panic and intense anxiety when exposed to the object of their phobia. The physical effects of these sensations can include:

- sweating
- abnormal breathing
- accelerated heartbeat
- trembling
- hot flashes or chills
- a choking sensation
- chest pains or tightness
- butterflies in the stomach
- pins and needles
- dry mouth
- confusion and disorientation
- nausea
- dizziness
- headache

**Facts**

- Phobias are more serious than simple fear sensations and are not limited to fears of specific triggers.
- Despite individuals being aware that their phobia is irrational, they cannot control the fear reaction.
- Symptoms may include sweating, chest pains, and pins and needles.
- Treatment can include medication and behavioral therapy.
- 19 million people in the United States have a phobia.

**Onset**

- Usually occur in childhood or adolescence
- Lifelong if they persist into adulthood

**Treatment**

- Systematic desensitization: recurrent exposure to object that the client fears
- Flooding: rapid desensitization. The therapist shows a picture or the object until anxiety ceases

**Famous faces case study**

Agoraphobia: Elsa’s powers can cause a very real threat to the people around her, so much so that you could argue that her paranoia early in the film is fully justified. That being said, the two powerful events in her childhood: almost killing her sister Anna and the death of her parents at sea, are the triggers for a very clear disorder, her agoraphobia. The young princess shuts herself away, refusing even to see her sister in the years leading up to her coronation. That event itself is an obvious sign of distress for Elsa; she spends the ceremony and the celebration afterwards in a state of half-panic. Shutting herself away seems the only solution available to protect Anna and her subjects and as a result, her powers almost destroy her. When Elsa plunges the kingdom of Arendelle into deepest winter, she flees, but as soon as she is isolated from everyone she returns to her old habits, creating the ice palace and shutting herself inside. It is only when Anna shows her that their sibling love is greater than any threat does she finally break the cycle, realising that in gaining acceptance from her people that she doesn’t need to hide away any longer.
**WHAT IS IT?**

__Obsessions are__ recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses that cause marked anxiety and interfere with interpersonal, social, or occupational function. The person knows these thoughts are excessive or unreasonable but believes he or she has no control over them.

__Compulsions are__ ritualistic or repetitive behaviors or mental acts that a person carries out continuously in an attempt to neutralize anxiety. Usually, the theme of the ritual is associated with that of the obsession.

Common compulsions include the following:
- Checking rituals (repeatedly making sure the door is locked or the coffee pot is turned off)
- Counting rituals (each step taken, ceiling tiles, concrete blocks, or desks in a classroom)
- Washing and scrubbing until the skin is raw
- Praying or chanting
- Touching, rubbing, or tapping (feeling the texture of each material in a clothing store; touching people, doors, walls, or oneself)
- Hoarding items (for fear of throwing away something important)
- Ordering (arranging and rearranging furniture or items on a desk or shelf into perfect order; vacuuming the rug pile in one direction)
- Exhibiting rigid performance (getting dressed in an unvarying pattern)
- Having aggressive urges (for instance, to throw one’s child against a wall) (Videbeck, 2018)

**Onset**

OCD can start in childhood, especially in males. In females, it more commonly begins in the 20s. Overall, distribution between the sexes is equal. Onset is usually gradual.

Exacerbation of symptoms may be related to stress.

**Assessment**

- Tense, anxious, worried, and fretful. They may have difficulty relating symptoms because of embarrassment.
- Appearance is unremarkable nothing may seem out of place
- Mood and affect, clients report ongoing, overwhelming feelings of anxiety in response to the obsessive thoughts, images, or urges. They may look sad and anxious.
- Intact intellectual functioning. The client may describe difficulty concentrating or paying attention when obsessions are strong. There is no impairment of memory or sensory functioning
- Client recognizes that the obsessions are irrational, but he or she cannot stop them. He or she can make sound judgments.
- Client voices concern that he or she is “going crazy.” Feelings of powerlessness to control the obsessions or compulsions contribute to low self-esteem.
- Trouble sleeping
- Loss of appetite

**NURSING INTERVENTIONS**

- Offer encouragement, support, and compassion.
- Be clear with the client that you believe he or she can change.
- Encourage the client to talk about feelings, obsessions, and rituals in detail.
- Gradually decrease time for the client to carry out ritualistic behaviors.
- Assist client to use exposure and response prevention behavioral techniques.
- Encourage client to use techniques to manage and tolerate anxiety responses.
- Assist client to complete daily routine and activities within agreed-on time limits.
- Encourage the client to develop and follow a written schedule with specified times and activities.

**TREATMENT**

Behavior therapy specifically includes exposure and response prevention:
- Exposure involves assisting the client to deliberately confront the situations and stimuli that he or she usually avoids.
- Response prevention focuses on delaying or avoiding performance of rituals. The person learns to tolerate the anxiety and to recognize that it will recede without the disastrous imagined consequences. Other techniques discussed previously, such as deep breathing and relaxation, also can assist the person to tolerate and eventually manage the anxiety (Bandelow, 2008).

**EDUCATION**

- Teach about OCD.
- Review the importance of talking openly about obsessions, compulsions, and anxiety.
- Emphasize medication compliance as an important part of treatment.
- Discuss necessary behavioral techniques for managing anxiety and decreasing prominence of obsessions.

**FAMOUS FACES CASE STUDY**

**ARIEL**

Would you classify Ariel as having obsessive compulsive disorder (OCD), as the little mermaid has many obsessions? Ariel is a hoarder and suffers from disposophobia. This rebellious teenager does not know what it is to clean up her room and just can’t throw anything away. Her cavern is overflowing with things that she has no clue how to use, and she can’t part with them. “I’ve got gadgets and gizmos a-plenty. I’ve got whozits and whatzits galore. You want thingamabobs? I’ve got twenty! But who cares? No big deal. I want more!”

Aside from hoarding, another obsession is a serious case of species dysphoria, wherein she cannot reconcile her mermaid existence to accurately reflect her identity. The 16-year-old mermaid princess (fish) meets up with a sea witch and makes a deal that turns her into a human mute, giving up her voice so she can hook up with a good-looking human prince of another species. This little fish will give up her whole identity to gain a human figure and be with her human prince.
SCHIZOPHRENIA

WHAT IS IT?
Casts distorted and bizarre thoughts, perceptions, emotions, movements, and behavior. It cannot be
defined as a single illness; rather, schizophrenia is
tought of as a syndrome or as disease process with
many different varieties and symptoms

ONSET
Early adulthood. Rarely does it manifest in childhood.
The peak incidence of onset is 15 to 25 years of age for men
and 25 to 35 years of age for women (American
Psychiatric Association [APA], 2000). Onset may be
abrupt or insidious, but most clients slowly and gradually
develop signs and symptoms such as social withdrawal,
unusual behavior, loss of interest in school or work, and
neglected hygiene.

TYPES
The following are the types of schizophrenia according to the
DSM-IV-TR (APA, 2000). The diagnosis is made according to
the client’s predominant symptoms:

- Schizophrenia, paranoid type: characterized by persecutory
  (feeling victimized or spied on) or grandiose delusions,
  hallucinations, and, occasionally, excessive religiosity
  (delusional religious focus) or hostile and aggressive behavior

- Schizophrenia, disorganized type: characterized by
grotesque inappropriate or flat affect, incoherence,
  loose associations, and extremely disorganized behavior

- Schizophrenia, catatonic type: characterized by marked
  psychomotor disturbance, either motionless or
  excessive motor activity. Motor immobility may be
  manifested by catalepsy (waxy flexibility) or stupor.
  Excessive motor activity is apparently purposesless and
  is not influenced by external stimuli. Other features
  include extreme negativism, mutism, peculiarities of
  voluntary movement, echolalia, and echopraxia.

- Schizophrenia, undifferentiated type: characterized by
  mixed schizophrenic symptoms (of other types) along with disturbances of thought,
  affect, and behavior

- Schizophrenia, residual type: characterized by at
  least one previous, though not a current, episode;
  social withdrawal; flat affect; and looseness of
  associations

- Schizoaffective disorder: is diagnosed when the
  client has the psychotic symptoms of schizophrenia
  and meets the criteria for a major affective or mood
  disorder. The mood disorder can be mania,
  depression, or mixed moods

UNUSUAL SPEECH PATTERNS
Clang associations are ideas that are related to one another based
on sound or rhyming rather than meaning. Example: “I will take a
pill I’ll go up the hill but not if my name is Jill, I don’t want to kill.”

Neologism are words invented by the client. Example: “I’m afraid
to go up the hill but not if my name is Jill, I don’t want to kill.”

Verberation is the stereotyped repetition of words or phrases that
may or may not have meaning to the listener. Example: “I want to go
home, go home, go home, go home.”

Echolalia is the client’s imitation or repetition of what the nurse
says. Example: Nurse: “Can you tell me how you’re feeling?” Client:
“Can you tell me how you’re feeling, how you’re feeling?”

Perseveration is the persistent adherence to a single idea or topic
and verbal repetition of a sentence, phrase, or word, even when
another person attempts to change the topic. Example: Nurse: “How
have you been sleeping lately?” Client: “I think people have
been following me.”

Word salad is a combination of jumbled words and phrases that are
disconnected or incoherent and make no sense to the listener.
Example: “Corn, potatoes, jump up, play games, grass, cupboard.”

POSITIVE OR HARD SYMPTOMS

- Ambivalence: Holding seemingly contradictory
  beliefs or feelings about the same person, event, or
  situation

- Associative looseness: Fragmented or poorly related
  thoughts and ideas

- Delusions: Fixed false beliefs that have no basis in reality

- Echopraxia: Imitation of the movements and
  gestures of another person whom the client is
  observing

- Flight of ideas: Continuous flow of verbalization in
  which the person jumps rapidly from one topic to
  another

- Hallucinations: False sensory perceptions or
  perceptual experiences that do not exist in reality; can
  be visual, auditory, tactile, or olfactory

- Ideas of reference: False impressions that external
  events have special meaning for the person

Perseveration: Persistent adherence to a single idea or topic;
verbal repetition of a sentence, word, or phrase; resisting attempts to change the topic

CAUSES
- Genetic factors: Twins have an increased risk
- Neurochemical: Increased dopamine levels
- Viral illness

INTERVENTIONS
- Promoting safety of client and others and right to privacy
  and dignity
- Establishing therapeutic relationship by establishing trust
- Using therapeutic communication (clarifying feelings and
  statements when speech and thoughts are disorganized or
  confused)
- Interventions for delusions: Do not openly confront the
  delusion or argue with the client. Establish and maintain reality
  for the client. Use distracting techniques. Teach the
  client positive self-talk, positive thinking, and to
  ignore delusional beliefs.
- Interventions for hallucinations: Help present and
  maintain reality by frequent contact and communication with
  client. Elicit description of hallucination to protect
  client and others. The nurse’s understanding of the
  hallucination helps him or her know how to calm or
  reassure the client. Engage the client in reality-based activities
  such as card playing, occupational therapy, or listening to
  music.
- Coping with socially inappropriate behaviors: Redirect
  client away from problem situations. Deal with
  inappropriate behaviors in a nonjudgmental and
  matter-of-fact manner; give factual statements; do not
  scold. Reassure others that the client’s inappropriate
  behaviors or comments are not his or her fault (without
  violating client confidentiality). Try to reimage the
  client into the treatment milieu as soon as possible. Do
  not make the client feel punished or shunned for
  inappropriate behaviors. Teach social skills through
  education, role modeling, and practice.
- Client and family teaching
- Establishing community support systems and care

NEGATIVE OR SOFT SYMPTOMS

- Alogia: Tendency to speak very little or to convey
  little substance of meaning (poverty of content)
- Anhedonia: Feeling no joy or pleasure from life or
  any activities or relationships
- Apathy: Feelings of indifference toward people,
  activities, and events
- Blunted affect: Restricted range of emotional feeling,
  tone, or mood
- Catatonia: Psychologically induced immobility
  occasionally marked by periods of agitation or
  excitement; the client seems motionless, as if in a
  trance
- Flat affect: Absence of any facial expression that
  would indicate emotions or mood
- Lack of volition: Absence of will, ambition, or drive
to take action or accomplish tasks

TREATMENT
- Antipsychotics: Haloperidol, haldol
- Neuroleptics

SIDE EFFECTS
- Extrapyramidal Side Effects. EPS are reversible movement disorders induced by
  neuroleptic medication. They include dystonic reactions, parkinsonism, and akathisia.
- Dystonic reactions: spasms in discrete muscle groups such as the neck muscles (torticollis) or
  eye muscles (oculogyric crisis). These spasms also may be accompanied by protrusion of the
  tongue, dysphagia, and laryngeal and pharyngeal spasms that can compromise the
  client’s airway, causing a medical emergency.
- Dystonic reactions are extremely frightening and painful for the client. Acute treatment
  consists of diphenhydramine (Benadryl) given either intramuscularly or intravenously, or
  benzotropin (Cogentin) given intramuscularly.
- Pseudoparkinsonism, or neuroleptic-induced parkinsonism, includes a
  shuffling gait, mask-like facies, muscle stiffness (continuous) or cogwheeling rigidity
  (ratchet-like movements of joints), drooling, and akinesia (slowness and difficulty initiating
  movement).
- Akathisia is characterized by restlessness, pacing, inability to remain still, and the
  client’s report of inner restlessness. A
- Tardive dyskinesia, a late-appearing irreversible side effect of antipsychotic medications, is characterized by abnormal, involuntary movements such as lip smacking, tongue protrusion, chewing, blinking, grimacing, and choreiform movements of the limbs and feet.

FAMOUS CASES CASE STUDY

While we’re all supposed to believe that Alice finds a portal to a magical fantastic world (specifically all the little children who would rather hallucinate than learn their history lessons), it’s also possible that she’s suffering from schizophrenia. This disorder normally develops around late adolescence, but childhood schizophrenia is a thing, though rare. That being said, if anyone’s got it, it’s Alice. She hangs out with floating cats and has full-blown conversations with caterpillars, she’s freaking out about the Queen of Hearts cutting off her head all the time, her whole body seemed grows and shrinks to different sizes, and she’s pretty damn convinced that this world is real, despite all the illogical stuff happening around her.
**Mood Disorders: Bipolar Disorder**

**WHAT IS IT?**

Mood disorders, also called affective disorders, are pervasive alterations in emotions that are manifested by depression, mania, or both. They interfere with a person’s life, plaguing him or her with drastic and long-term sadness, agitation, or elation. Accompanying self-doubt, guilt, and anger alter life activities, especially those involving work and management.

**Types**

- **Bipolar I disorder**: one or more manic or mixed episodes usually accompanied by major depressive episodes.
- **Bipolar II disorder**: one or more major depressive episodes accompanied by at least one hypomanic episode.

**TREATMENTS**

- **Mood stabilizers**: Lithium
- **Anticonvulsant**: Prevents or controls seizures, relieves pain, and treats symptoms of certain psychiatric disorders.
- **Antipsychotic**: Reduces or improves the symptoms of certain psychiatric conditions.
- **Selective Serotonin Reuptake Inhibitor (SSRI)**: Eases symptoms of depressed mood and anxiety.
- **Therapies**
  - Support group, Cognitive behavioral therapy, Psychoeducation, Family therapy, and Psychotherapy

**LITHIUM**

Having too much salt in the diet because of unusually salty foods or the ingestion of salts containing antacids can reduce receptor availability for lithium and increase lithium excretion, so the lithium level will be too low. If there is too much water, lithium is diluted and the lithium level will be too low to be therapeutic. Drinking too little water or losing fluid through excessive sweating, vomiting, or diarrhea increases the lithium level, which may result in toxicity.

**FAMOUS FACES CASE STUDY**

The Mad Hatter is depicted in Alice in Wonderland with bipolar disorder tendencies. The Hatter is often gloomy and depressed over the way “Underland” is due to the Red Queen’s reign. In some occasions, however, the Hatter seems to be going through manic episodes, both happy and blabbering, jumping from topic to topic talking a mile a minute. This is where the Hatter displays symptoms of bipolar disorder, also defined as a manic depressive disorder. Mixed episodes often occur for someone diagnosed with bipolar disorder resulting in mood swings and difficulties with impulse control, which can explain the Hatter’s bursts of anger and confusion.

**CAUSES**

Hormonal problems: Hormonal imbalances might trigger or cause bipolar disorder. Environmental factors: Abuse, mental stress, a “significant loss,” or some other traumatic event may contribute to or trigger bipolar disorder.

**INTERVENTIONS FOR MANIA FOR MANIA**

- Provide for client’s physical safety and those around.
- Set limits on client’s behavior when needed.
- Remind the client to respect distances between self and others.
- Use short, simple sentences to communicate.
- Clarify the meaning of client’s communication.
- Frequently provide finger foods that are high in calories and protein.
- Promote rest and sleep.
- Protect the client’s dignity when inappropriate behavior occurs.
- channel client’s need for movement into socially acceptable motor activities

**EDUCATION FOR MANIA**

- Teach about bipolar illness and ways to manage the disorder.
- Teach about medication management, including the need for periodic blood work and management of side effects.
- For clients taking lithium, teach about the need for adequate salt and fluid intake. The physician should be contacted if the client has diarrhea, fever, flu, or any condition that leads to dehydration.
- Teach the client and family about signs of toxicity and the need to seek medical attention immediately.
- Educate the client and family about risk-taking behavior and how to avoid it.
- Teach about behavioral signs of relapse and how to seek treatment in early stages.

**CLIENT FAMILY EDUCATION FOR DEPRESSION**

- Teach about the illness of depression.
- Identify early signs of relapse.
- Discuss the importance of support groups and assist in locating resources.
- Teach the client and family about the benefits of therapy and follow-up appointments.
- Encourage participation in support groups.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.

**ASSESSMENT**

**MAJOR DEPRESSIVE EPISODE**: changes in appetite or weight, sleep, or psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. These symptoms must be present every day for 2 weeks and result in significant distress or impair social, occupational, or other important areas of functioning (American Psychiatric Association [APA], 2000).

**MANIA**: inflated self-esteem or grandiosity; decreased need for sleep; pressured speech (unrelenting, rapid, often loud talking without pause); flight of ideas (racing, often unconnected, thoughts); distractibility; increased involvement in goal-directed activity or psychomotor agitation; and excessive involvement in pleasure-seeking activities with a high potential for painful consequences (APA, 2000). Some people also exhibit delusions and hallucinations during a manic episode.

**THERAPY**

- Support group, Cognitive behavioral therapy, Psychoeducation, Family therapy, and Psychotherapy

**NURSING INTERVENTIONS FOR DEPRESSION**

- Provide for the safety of the client and others.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending non demanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects

**HYPOMANIA**

A period of abnormally and persistently elevated, expansive, or irritable mood lasting 4 days and including three or four of the additional symptoms described earlier. Hypomania does not interfere with the person’s daily functioning.

**ANXIETY**

- Relaxation techniques
- Deep breathing
- Guided imagery
- Biofeedback
- Cognitive restructuring
- ERP

**INTERVENTIONS FOR MANIA**

- Begin a therapeutic relationship by spending non demanding time with the client.
- Promote completion of activities of daily living.
- Establish adequate nutrition and hydration.
- Encourage participation in support groups.
- Teach about the illness of depression.
- Identify early signs of relapse.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.

**HOW DOES IT WORK?**

Bipolar disorder is diagnosed when a person’s mood cycles between extremes of mania and depression.

- **Mania** is a distinct period during which mood is abnormally and persistently elevated, expansive, or irritable. Typically, this period lasts about 1 week.
- **A major depressive episode** lasts at least 2 weeks, during which the person experiences a depressed mood or loss of pleasure in nearly all activities. In addition, four of the following symptoms are present:
  - Hypomania is a period of abnormally and persistently elevated, expansive, or irritable mood lasting 4 days and including three or four of the additional symptoms described earlier. Hypomania does not interfere with the person’s daily functioning.
  - **Hypomania** does not interfere with the person’s daily functioning.

- **Depression**
  - **Major depressive episode**
  - **Major depressive episode** lasts at least 2 weeks, during which the person experiences a depressed mood or loss of pleasure in nearly all activities. In addition, four of the following symptoms are present:
  - **Major depressive episode** lasts at least 2 weeks, during which the person experiences a depressed mood or loss of pleasure in nearly all activities. In addition, four of the following symptoms are present:
  - **At least 2 weeks of depressed mood**
  - **Daytime insomnia**
  - **At least 2 weeks of depressed mood**
  - **Daytime insomnia**
  - **At least 2 weeks of depressed mood**
  - **Daytime insomnia**
  - **At least 2 weeks of depressed mood**

**INTERRUPTIONS FOR MAJIC DEPRESSIVE EPISODE**

- Education for mania
- Identify early signs of relapse.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.

**Types**

- **Bipolar I disorder**: one or more manic or mixed episodes usually accompanied by major depressive episodes.
- **Bipolar II disorder**: one or more major depressive episodes accompanied by at least one hypomanic episode.

**Interventions for Mania**

- Provide for client’s physical safety and those around.
- Set limits on client’s behavior when needed.
- Remind the client to respect distances between self and others.
- Use short, simple sentences to communicate.
- Clarify the meaning of client’s communication.
- Frequently provide finger foods that are high in calories and protein.
- Promote rest and sleep.
- Protect the client’s dignity when inappropriate behavior occurs.
- Channel client’s need for movement into socially acceptable motor activities

**Education for Mania**

- Teach about bipolar illness and ways to manage the disorder.
- Teach about medication management, including the need for periodic blood work and management of side effects.
- For clients taking lithium, teach about the need for adequate salt and fluid intake. The physician should be contacted if the client has diarrhea, fever, flu, or any condition that leads to dehydration.
- Teach the client and family about signs of toxicity and the need to seek medical attention immediately.
- Educate the client and family about risk-taking behavior and how to avoid it.
- Teach about behavioral signs of relapse and how to seek treatment in early stages.

**Nursing Interventions for Depression**

- Provide for the safety of the client and others.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending non demanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects

**Lithium**

Having too much salt in the diet because of unusually salty foods or the ingestion of salts containing antacids can reduce receptor availability for lithium and increase lithium excretion, so the lithium level will be too low. If there is too much water, lithium is diluted and the lithium level will be too low to be therapeutic. Drinking too little water or losing fluid through excessive sweating, vomiting, or diarrhea increases the lithium level, which may result in toxicity.

**Causes**

Hormonal problems: Hormonal imbalances might trigger or cause bipolar disorder. Environmental factors: Abuse, mental stress, a “significant loss,” or some other traumatic event may contribute to or trigger bipolar disorder.

**Types**

- **Bipolar I disorder**: one or more manic or mixed episodes usually accompanied by major depressive episodes.
- **Bipolar II disorder**: one or more major depressive episodes accompanied by at least one hypomanic episode.
What is it?

A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. With at least four other symptoms of depression such as anhedonia and changes in weight, sleep, energy, concentration, decision making, self-esteem, and goals.

Assessment

- Depressed mood
- Anhedonism (decreased attention to and enjoyment from previously pleasurable activities)
- Unintentional weight change of 5% or more in a month
- Change in sleep pattern
- Agitation or psychomotor retardation
- Tiredness
- Worthlessness or guilt inappropriate to the situation (possibly delusional)
- Difficulty thinking, focusing, or making decisions
- Hopelessness, helplessness, and/or suicidal ideation

CLINICAL PICTURE

An untreated episode of depression can last 6 to 24 months before remitting.

NURSING INTERVENTIONS FOR DEPRESSION

- Provide for the safety of the client and others.
- The first priority is to determine whether a client with depression is suicidal.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending non-demanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects.

TREATMENTS

- MAOI
- SSRI
- Tricyclic antidepressants
- Atypical antidepressants

SEROTONIN SYNDROME

Serotonin syndrome occurs when there is an inadequate washout period between taking MAOIs and SSRIs or when MAOIs are combined with meperidine. Symptoms of serotonin syndrome include:

- Change in mental state: confusion and agitation
- Neuromuscular excitement: muscle rigidity, weakness, sluggish pupils, shivering, tremors, myoclonic jerks, collapse, and muscle paralysis
- Autonomic abnormalities: hyperthermia, tachycardia, tachypnea, hypersalivation, and diaphoresis.

NCLEX ALERT!

- If you have a client on antidepressants and they are reporting feeling more energy after about 2-4 weeks monitor closely for suicide. This is when they have the energy to complete the act, or follow through with a plan.

CLIENT FAMILY EDUCATION FOR DEPRESSION

- Teach about the illness of depression.
- Identify early signs of relapse.
- Discuss the importance of support groups and assist in locating resources.
- Teach the client and family about the benefits of therapy and follow-up appointments.
- Encourage participation in support groups.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.

FAMOUS FACES CASE STUDY

Eeyore

Eeyore is a character that displays a relatively accurate example of major depressive disorder. One major issue with the character portrayed is his consistent involvement with a support group. A lack of interest in activities is common with this disorder, causing most persons with depression to not frequently spend time with others. Eeyore exhibits five symptoms of a major depressive episode, and has also experienced these for several years, therefore meeting full criteria. Criteria met include depressed mood most of the day, markedly diminished interest or pleasure in activities, and a lack of interest in activities, fatigue, loss of energy nearly every day, feelings of worthlessness, and diminished ability to think or concentrate were indicated.

Overall, Eeyore exhibits severe clinical major depression without psychotic features. Further diagnosis will be needed to determine catatonic, melancholic, or atypical features as details are limited at this point. Postpartum onset is not a factor.
What is it?
Suicide is the intentional act of killing oneself. Suicidal thoughts are common in people with mood disorders, especially depression.

Risk Factors

Psychiatric disorders
❖ Depression
❖ Bipolar disorder, schizophrenia
❖ Substance abuse, posttraumatic stress disorder,
❖ Borderline personality disorder (Rihmer, 2007).

Chronic medical illnesses
❖ Cancer
❖ HIV or AIDS
❖ Diabetes
❖ Cerebrovascular accidents
❖ Head and spinal cord injury.

Environmental factors
❖ Isolation
❖ Recent loss
❖ Lack of social support
❖ Unemployment
❖ Critical life events, family history of depression or suicide.

Behavioral factors
❖ Impulsivity, erratic or unexplained changes from usual behavior, and unstable lifestyle (Smith et al., 2008).

Assessment

When a client admits to suicidal thoughts, the next step is to determine potential lethality. This assessment involves asking the following questions:
❖ Does the client have a plan? If so, what is it? Is the plan specific?
❖ Are the means available to carry out this plan? (For example, if the person plans to hang himself, does he have access to a secluded place and a rope?)
❖ If the client carries out the plan, is it likely to be lethal? (For example, a plan to take 3 benadryl is not lethal, while a plan to take a 2-week supply of Clonidine is.)
❖ Has the client made preparations for death, such as giving away prized possessions, writing a suicide note, or talking to friends one last time?
❖ Where and when does the client intend to carry out the plan?
❖ Is the intended time a special date or anniversary that has meaning for the client?

Specific and positive answers to these questions all increase the client’s likelihood of committing suicide.

Antidepressants and Suicide

Depressed clients who begin taking an antidepressant may have a continued or increased risk for suicide in the first few weeks of therapy. They may experience an increase in energy from the antidepressant but remain depressed. This increase in energy may make clients more likely to act on suicidal ideas and able to carry them out. Also, because antidepressants take several weeks to reach their peak effect, clients may become discouraged and act on suicidal ideas because they believe the medication is not helping them. For these reasons, it is extremely important to monitor the suicidal ideation of depressed clients until the risk has subsided (videbeck, 2018).

Examples of Outcomes for a Suicidal Person

❖ The client will be safe from harming self or others.
❖ The client will engage in a therapeutic relationship.
❖ The client will establish a no-suicide contract.
❖ The client will create a list of positive attributes.
❖ The client will generate, test, and evaluate realistic plans to address underlying issues.

Providing a Safe Environment

Clients may not have access to materials on cleaning carts, their own medications, sharp scissors, and penknives. For suicidal clients, staff members remove any item they can use to commit suicide, such as sharp objects, shoelaces, belts, lighters, matches, pencils, pens, and even clothing with drawstrings. This depends on hospital policy.

Robin Williams
1951-2014

I think the saddest people always try their hardest to make people happy because they know what it’s like to feel absolutely worthless and they don’t want anyone else to feel like that.

Interventions

❖ Intervention for suicide or suicidal ideation becomes the first priority of nursing care.
❖ Help clients stay safe.
❖ When dealing with a client who has suicidal ideation or attempts, the nurse’s attitude must indicate unconditional positive regard not for the act but for the person and his or her desperation.
❖ The nurse uses a nonjudgmental tone of voice and monitors his or her body language and facial expressions to make sure not to convey disgust or blame.
❖ Nurses also must realize that no matter how competent and caring interventions are, a few clients will still commit suicide.
Paranoid personality disorder is characterized by pervasive mistrust and suspiciousness of others. Clients with this disorder interpret others’ actions as potentially harmful. During periods of stress, they may develop transient psychotic symptoms.

Clinical picture
- These clients use the defense mechanism of projection, which is blaming other people, institutions, or events for their own difficulties.
- Conflict with authority figures on the job is common; clients may even resent being given directions from a supervisor.
- Paranoia may extend to feelings of being singled out for menial tasks, treated as stupid, or more closely monitored than other employees.
- Paranoid Personality should not be confused with Paranoid Delusions in disorders like Schizophrenia. The complaints for somebody with Paranoid Personality Disorder are at least plausible. For example, my wife is cheating on me or I was abducted by aliens. Paranoid Personality is like a distortion of reality while paranoid delusions are almost entirely disconnected from reality.

Interventions
- The nurse must approach these clients in a formal, business-like manner and refrain from social chitchat or jokes. Being on time, keeping commitments, and being particularly straightforward are essential to the success of the nurse–client relationship.
- Clients are more likely to engage in the therapeutic process if they believe they have something to gain. One of the most effective interventions is helping clients to learn to validate ideas before taking action; however, this requires the ability to trust and to listen to one person.

Presenting symptoms
- Social isolation
- Detachment
- Concern that others have hidden motives
- Suspicious
- Fear of exploitation

Famous faces Case Study
Mel gibson plays a taxi driver in Conspiracy theory who is afraid that the soviet union is out to get him. He lives in an apartment in which he has four locks on his doors to keep out intruders. He also keeps a lock on his refrigerator to avoid anyone poisoning his food. He is extremely suspicious of those around him. His apartment is set up so that if someone was to enter it would set fire to itself without harming surrounding apartments. He spends most of his time researching world events and looking for clues to support his theories which play into his paranoia.

“If the intelligence community is a family, think of us as the uncle no one talks about.”

Treatments
- Difficult to treat because they are usually suspicious of doctors.
- Anti Anxiety
- Antipsychotics
**WHAT IS IT?**

Schizoid personality disorder is characterized by a pervasive pattern of detachment from social relationships and a limited range of emotional expression in conversation. They may succeed in vocational areas, provided they value their jobs and have little contact with others in work, which typically involves computers or electronics.

These people are super introverted. They have no desire to have friends and voluntarily choose to be socially isolated. They often daydream a lot, have a limited range of emotions and are largely apathetic. These individuals may also be uninterested in sexual contact with others. Examples include Squidward from Spongebob Squarepants and Dexter Morgan from Dexter (just his personality not the serial killing).

**INTERVENTIONS**

Focus on improved functioning in the community.

**TREATMENT**

Treatment likely will focus on increasing general coping skills, as well as on improving social interaction, communication, and self-esteem. Because trust is an important component of therapy, treatment can be challenging for the therapist, because people with schizoid personality disorder have difficulty forming relationships with others. Social skills training also can be an important component of treatment.

**ASSESSMENT**

- They do not desire or enjoy close relationships, even with family members.
- They choose solitary jobs and activities.
- They take pleasure in few activities, including sex.
- They have no close friends, except first-degree relatives.
- They have difficulty relating to others.
- They are indifferent to praise or criticism.
- They are aloof and show little emotion.
- They might daydream and/or create vivid fantasies of complex inner lives.

**FAMOUS FACES CASE STUDY**

**Batman** (Must meet 4 criteria)

- *Neither desires nor enjoys close relationships, including being part of a family:* His only relationship is with his butler. He has no friends or family. Not even parents. (Okay, the latter is not his fault)
- *Almost always chooses solitary activities:* Living in a bat cave will do that to you
- *Has little, if any, interest in having sexual experiences with another person:* His resistance of Catwoman is beyond comprehension
- *Takes pleasure in few, if any, activities:* His known activities are fighting crime and killing. It is unclear if this qualifies as a career or activities though. Regardless, it’s unclear if he could be enjoying these activities…
- *Lacks close friends or confidants other than first-degree relatives:* To be fair, they all get killed by his nemeses
- *Appears indifferent to the praise or criticism of others:* The police criticize him all the time and he couldn’t care less. Batman only cares about what Batman thinks
- *Shows emotional coldness, detachment, or flattened affectivity:* His voice literally has no inflection in it. I guess if growly was an emotion, he would have that. But otherwise, his demeanor definitely comes off as unemotional
WHAT IS IT?
Clients often have an odd appearance that causes others to notice them. They may be unkempt and disheveled, and their clothes are often ill-fitting, do not match, and may be stained or dirty. They may wander aimlessly and, at times, become preoccupied with some environmental detail. Speech is coherent but may be loose, digressive, or vague. Clients often provide unsatisfactory answers to questions and may be unable to specify or to describe information clearly. These people are extremely nerdy & awkward. Magical thinking, such as paranormal or superstitious beliefs, is common. They often have odd speech, dress, and mannerisms. They usually have voluntary social withdrawal similar to people who are Schizoid. So you can think of Schizotypal and Schizoid plus magical thinking and odd behavior. Examples include Kramer from Seinfeld, Doc Brown from Back to the Future and the characters on the Big Bang Theory.

RISK FACTORS
- schizophrenia
- schizotypal personality disorder
- another personality disorder
- abuse
- neglect
- trauma
- stress
- having a parent who is emotionally detached

TREATMENTS
- Psychotherapy
- Talk therapy
- Cognitive behavioral therapy

ASSessment
- strange thinking or behavior.
- unusual beliefs.
- discomfort in social situations.
- a lack of emotion or inappropriate emotional responses.
- odd speech that may be vague or rambling.
- a lack of close friends.
- extreme social anxiety.
- paranoia.

U: unusual perceptions
F: friendliness except for family
O: odd beliefs, thoughts & speech
A: affect inappropriate, constricted
I: ideas of reference
D: doubts of others
E: eccentric
R: reluctant to social situations

NurSING INterventions
The focus of nursing care for clients with schizotypal personality disorder is development of self-care and social skills and improved functioning in the community. The nurse encourages clients to establish a daily routine for hygiene and grooming.

RIsk FACTORS
- schizophrenia
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- having a parent who is emotionally detached

TREATMENTS
- Psychotherapy
- Talk therapy
- Cognitive behavioral therapy

FAMOUS FACE CASE STUDY
Willy Wonka
(Must meet 5 criteria)
Ideas of reference (excluding delusions of reference)
Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms: “I am the maker of music, the dreamer of dreams!” He believes that all dreams can be followed, even dreams that are impossible. Unusual perceptual experiences, including bodily illusions
Odd thinking and speech (e.g., vague, circumstantial, metaphorical, over elaborate, or stereotyped): Half the words he uses are made-up and he uses phrases like “Oh, my sainted aunt!”
Suspiciousness or paranoid ideation
Inappropriate or constricted affect: Children are turning into candy bits in his factory, and he has absolutely no problem with this. No concern, no fear, no awareness.
Behavior or appearance that is odd, eccentric, or peculiar: This goes without saying. The purple suit and hat are just the tip of the iceberg. He lives in a chocolate factory...
Lack of close friends or confidants other than first-degree relatives: His social life is limited to Oompa Loompas
Excessive social anxiety: He avoids social interactions with people his own age at all costs. He has an easier time interacting with children
**WHAT IS IT?**

Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of others—and with the central characteristics of deceit and manipulation. This pattern also has been referred to as psychopathy, sociopathy, or dysocial personality disorder. It occurs in about 3% of the general population and is three to four times more common in men than in women. They are basically psychopaths and predators that exploit others without feeling guilt. These patients are exploitive, deceitful, good at reading social cues and appear charming to others. They have a disregard for others wellbeing and frequently violate the rights of others. These individuals often have a history of committing crimes. Examples include Serial Killers, The Joker and The Grinch.

**ASSESSMENT**

- Violation of the rights of others
- Lack of remorse for behavior
- Shallow emotions
- Lying
- Rationalization of own behavior
- Poor judgment
- Impulsivity Irritability and aggressiveness
- Lack of insight
- Thrill-seeking behaviors Exploitation of people in relationships
- Poor work history
- Consistent irresponsibility

**EDUCATION**

- Avoiding use of alcohol and other drugs
- Appropriate social skills
- Effective problem-solving skills
- Managing emotions such as anger and frustration
- Taking a time-out to avoid stressful situations

**INTERVENTIONS**

- Promoting responsible behavior
- Limit setting: State the limit. Identify consequences of exceeding the limit. Identify expected or acceptable behavior.
- Consistent adherence to rules and treatment plan
- Confrontation: Point out problem behavior. Keep client focused on self. Helping clients solve problems and control emotions
- Effective problem-solving skills
- Decreased impulsivity
- Expressing negative emotions such as anger or frustration
- Taking a time-out from stressful situations
- Enhancing role performance
- Identifying barriers to role fulfillment
- Decreasing or eliminating use of drugs and alcohol

**FAMOUS FACES CASE STUDY**

The problems The Joker displays are tremendous. To begin, he absolutely hates Batman and everything to do with justice and peace. He seems to hate everything about himself as well, considering he has to hurt others around him to feel better. His only purpose in life is to destroy Gotham for no apparent reason and to destroy Batman considering he is constantly in The Joker’s way to destruction. The Joker wanted humans to understand that they were “bad” and destroyers when all the while he was the one committing crimes. The Joker expressed absolutely no empathy for his ruthless actions along with being extremely sadistic. He blatantly disregarded laws and social norms of society as a whole, all of which are related to antisocial personality disorder.

We’re not in Wonderland anymore Alice
-Charles Manson

Madness, as you know, is a lot like gravity; all it takes is a little push.
**What Is It**
A very temperamental person with drastic mood swings. They have poor impulse control which often leads to substance abuse. They may consider suicide or self-mutilation during emotional outbursts and then seem totally fine just a few minutes later. Some people think of Borderline Personality as a less extreme version of Bipolar Disorder. These patients often display the splitting defense mechanism where they think people are all good or all bad. They will say you are the best doctor in the whole world while your nurse is completely incompetent or vice versa.

**Assessment**
- Fear of abandonment, real or perceived
- Unstable and intense relationships
- Unstable self-image
- Impulsivity or recklessness
- Recurrent self-mutilating behavior or suicidal threats or gestures
- Chronic feelings of emptiness and boredom
- Labile mood
- Irritability
- Polarized thinking about self and others (“splitting”)
- Impaired judgment
- Lack of insight
- Transient psychotic symptoms such as hallucinations demanding self-harm

**Interventions**
- Promoting client’s safety
- No-self-harm contract
- Safe expression of feelings and emotions Helping client to cope and control emotions
- Identifying feelings • Journal entries
- Moderating emotional responses
- Decreasing impulsivity
- Delving gratification Cognitive restructuring techniques
- Thought stopping
- Decatastrophizing: Structuring time Teaching social skills Teaching effective communication skills Entering therapeutic relationship
- Limit setting
- Confrontation

**Education**
- Teaching social skills
- Maintaining personal boundaries
- Realistic expectations of relationships Teaching time structuring
- Making a written schedule of activities
- Making a list of solitary activities to combat boredom Teaching self-management through cognitive restructuring
- Decatastrophizing situation
- Thought stopping
- Positive self-talk Using assertiveness techniques such as “I” statements Using distraction, such as walking or listening to music

**Treatments**
- Cognitive restructuring is a technique useful in changing patterns of thinking by helping clients to recognize negative thoughts
- Minimizing unstructured time by planning activities can help clients to manage time alone.
- Decatastrophizing is a technique that involves learning to assess situations realistically rather than always assuming a catastrophe will happen.
- Positive self-talk, the client reframes negative thoughts into positive ones: “I made a mistake, but it’s not the end of the world. Next time, I’ll know what to do”
- Thought stopping is a technique to alter the process of negative or self-critical thought patterns such as “I’m dumb, I’m stupid, I can’t do anything right.” When the thoughts begin

**Famous Faces Case Study**
Megara, otherwise known as Meg, is a servant of the diabolic Hades. Pretty much as soon as she meets Hercules, she falls in love with him. You can see a lot of proof in the movie that shows of her Borderline Personality Disorder. Persons suffering with this mental illness have to deal with self-image issues, mood swings and most of the time self-harming. In the movie it gets really clear, that she has quite some issues to clarify to herself where she belongs. Should she try something new and try to be good by the side of Hercules, or should she stick to the only thing she knew her whole life, the bad side lead by Hades. She is also constantly scared that Hercules might leave her, but she gets easily annoyed by him on the other hand. So she clearly has some issues situating herself in this world.
Histrionic Personality Disorder

What is it?

Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking. A childish Prima Donna that is overly theatrical or dramatic. These patients are usually very colorful, extroverted and flirtatious. They always need to be the center of attention and are willing to act impulsively or in an extremely sexual manner to get that attention. They are very concerned with how they look and often display the defense mechanism of regression.

Assessment

preoccupation with physical appearance, seeks to be the center of attention, or talks dramatically considers relationships closer than they are, easily influenced by others, or depression inappropriately sexual or provocative behavior or rapid shifts in emotion

❖ Be uncomfortable unless he or she is the center of attention
❖ Dress provocatively and/or exhibit inappropriately seductive or flirtatious behavior
❖ Shift emotions rapidly
❖ Act very dramatically, as though performing before an audience, with exaggerated emotions and expressions, yet appears to lack sincerity
❖ Be overly concerned with physical appearance
❖ Constantly seek reassurance or approval
❖ Be gullible and easily influenced by others
❖ Be excessively sensitive to criticism or disapproval
❖ Have a low tolerance for frustration and be easily bored by routine, often beginning projects without finishing them or skipping from one event to another
❖ Not think before acting
❖ Make rash decisions
❖ Be self-centered and rarely show concern for others
❖ Have difficulty maintaining relationships, often seeming fake or shallow in their dealings with others
❖ Threaten or attempt suicide to get attention

Interventions

❖ Teach social skills
❖ Provide honest feedback about undesirable behavior
❖ set limits on undesirable behavior
❖ Set limits on attention seeking behavior
❖ “When you embrace and kiss other people on first meeting them, they may interpret your behavior in a sexual manner. It would be more acceptable to stand at least 2 feet away from them and to shake hands.”

(Videbeck,2018)

Treatment

❖ Psychotherapy

Famous faces Case Study

Pocahontas is considered to be one of the best princesses to look up to because of how she deals with the conflict between her tribe and the English. But, as awesome as she is, she also suffers from a personality disorder. Pocahontas best identifies with histrionic personality disorder because of her constant need for attention. She has a constant need to be noticed and will oftentimes try to gain people’s attention by acting in a dramatic or inappropriate way. People with this disorder also happen to be able to make others do what they want. Pocahontas exhibits this disorder throughout most of the movie as she not only throws herself onto Englishman, John Smith, every chance she gets, but she also causes love triangles and convinces her entire tribe to do whatever it is she wants.