SIXTH EDITION

Essentials of Psychiatric Mental Health Nursing

Concepts of Care in Evidence-Based Practice

MARY C. TOWNSEND

DavisPlus

A guide to…

Essentials of Psychiatric Mental Health Nursing

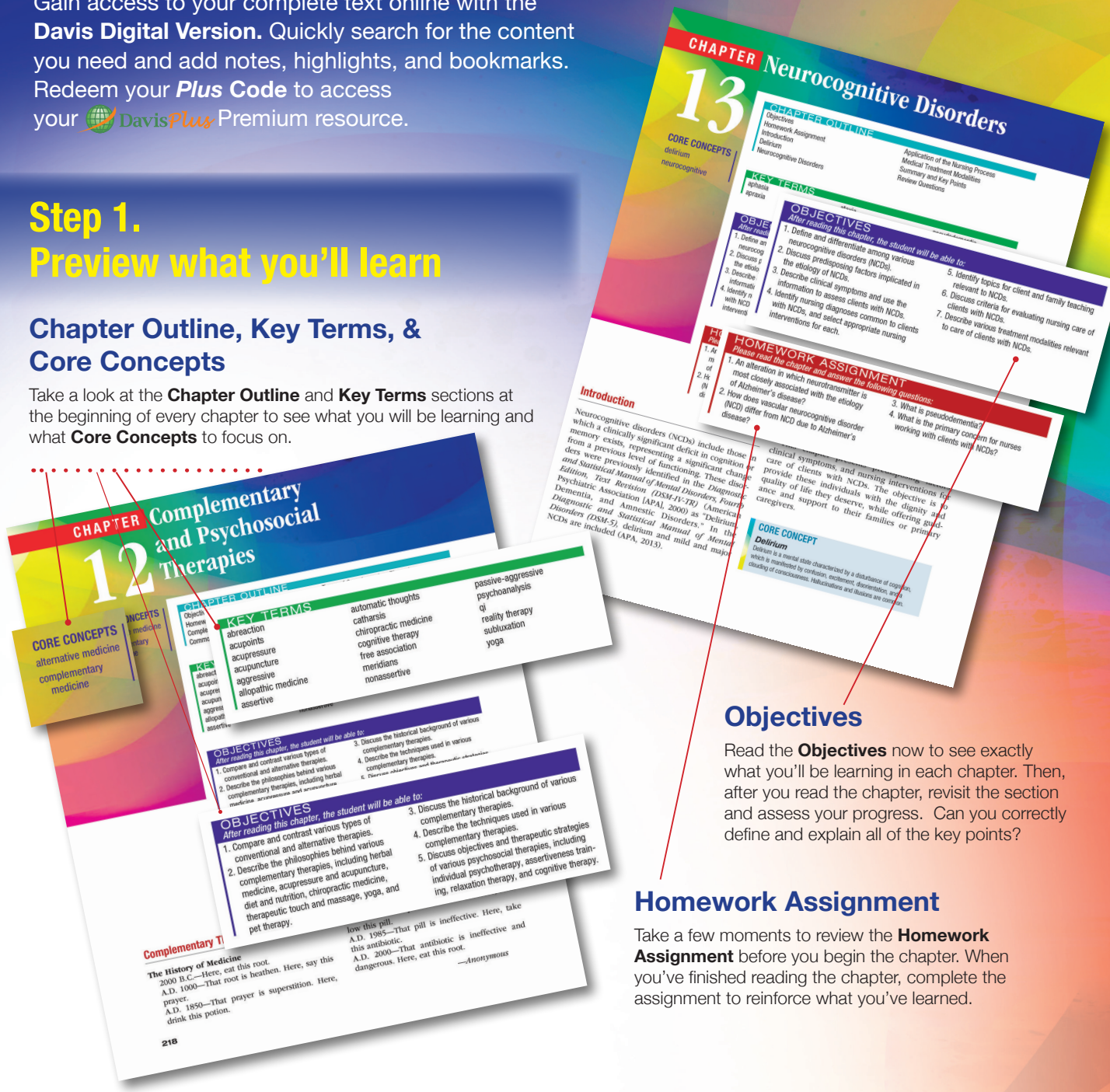
Get the most out of your textbook and resources online at DavisPlus to prepare for class, clinical, and professional success.

Gain access to your complete text online with the **Davis Digital Version.** Quickly search for the content you need and add notes, highlights, and bookmarks. Redeem your ***Plus* Code** to access your DavisPlus Premium resource.

Step 1. Preview what you'll learn

Chapter Outline, Key Terms, & Core Concepts

Take a look at the **Chapter Outline** and **Key Terms** sections at the beginning of every chapter to see what you will be learning and what **Core Concepts** to focus on.



Objectives

Read the **Objectives** now to see exactly what you'll be learning in each chapter. Then, after you read the chapter, revisit the section and assess your progress. Can you correctly define and explain all of the key points?

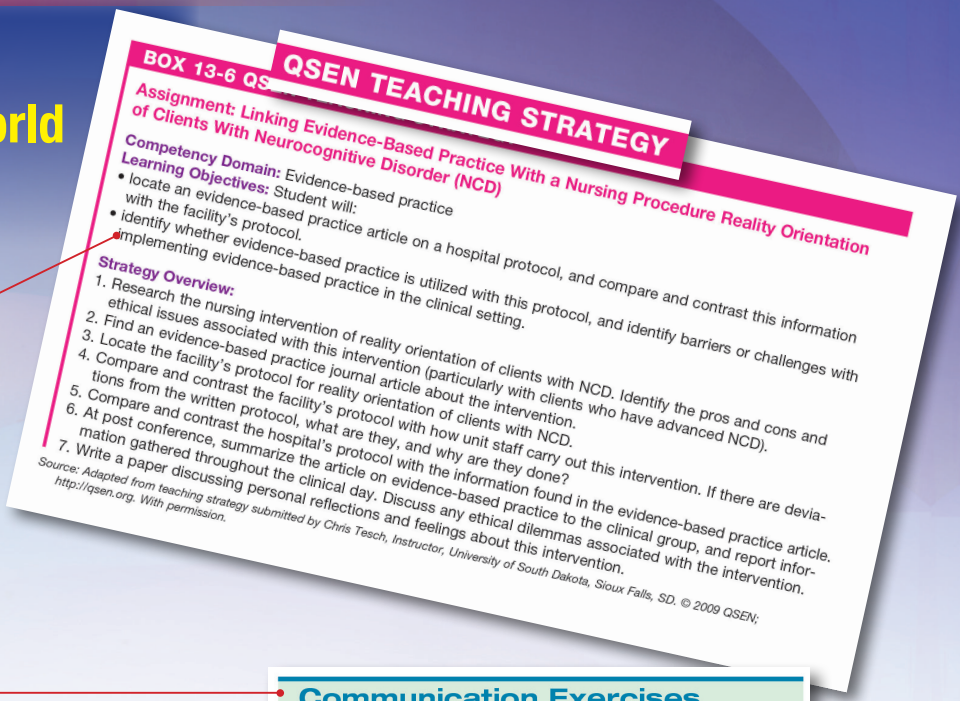
Homework Assignment

Take a few moments to review the **Homework Assignment** before you begin the chapter. When you've finished reading the chapter, complete the assignment to reinforce what you've learned.

Step 2.
Prepare for the real world of nursing practice

Quality and Safety Education for Nurses (QSEN) Activities

Stay up to date—attain the knowledge, skills, and attitudes you need to fulfill the initiative's most current quality and safety competencies.



BOX 13-6 QS

QSEN TEACHING STRATEGY

Assignment: Linking Evidence-Based Practice With a Nursing Procedure Reality Orientation of Clients With Neurocognitive Disorder (NCD)

Competency Domain: Evidence-based practice

Learning Objectives: Student will:

- locate an evidence-based practice article on a hospital protocol, and compare and contrast this information with the facility's protocol.
- identify whether evidence-based practice is utilized with this protocol, and identify barriers or challenges with implementing evidence-based practice in the clinical setting.

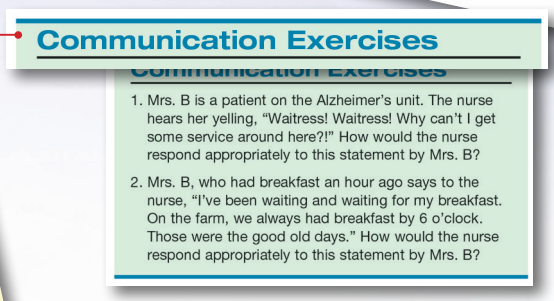
Strategy Overview:

1. Research the nursing intervention of reality orientation of clients with NCD. Identify the pros and cons and ethical issues associated with this intervention (particularly with clients who have advanced NCD).
2. Find an evidence-based practice journal article about the intervention.
3. Locate the facility's protocol for reality orientation of clients with NCD.
4. Compare and contrast the facility's protocol with how unit staff carry out this intervention. If there are deviations from the written protocol, what are they, and why are they done?
5. Compare and contrast the hospital's protocol with the information found in the evidence-based practice article.
6. At post conference, summarize the article on evidence-based practice to the clinical group, and report information gathered throughout the clinical day. Discuss any ethical dilemmas associated with the intervention.
7. Write a paper discussing personal reflections and feelings about this intervention.

Source: Adapted from teaching strategy submitted by Chris Tesch, Instructor, University of South Dakota, Sioux Falls, SD. © 2009 QSEN; http://qsen.org. With permission.

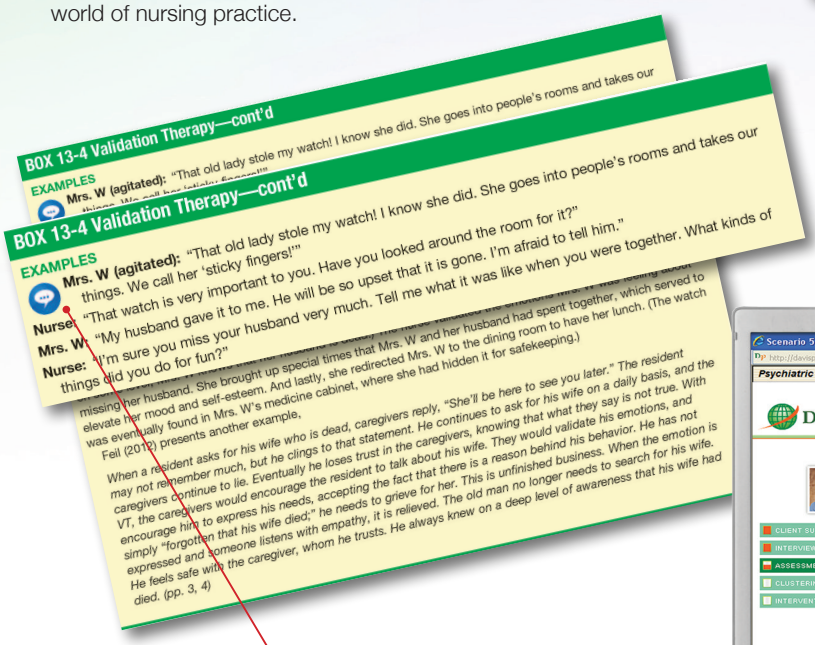
NEW! Communication Exercises Boxes

Practice your communication skills with **clinical scenarios** to prepare for the real world of nursing practice.



Communication Exercises

1. Mrs. B is a patient on the Alzheimer's unit. The nurse hears her yelling, "Waitress! Waitress! Why can't I get some service around here?!" How would the nurse respond appropriately to this statement by Mrs. B?
2. Mrs. B, who had breakfast an hour ago says to the nurse, "I've been waiting and waiting for my breakfast. On the farm, we always had breakfast by 6 o'clock. Those were the good old days." How would the nurse respond appropriately to this statement by Mrs. B?



BOX 13-4 Validation Therapy—cont'd

EXAMPLES

Mrs. W (agitated): "That old lady stole my watch! I know she did. She goes into people's rooms and takes our things. We call her 'sticky fingers!'"

Nurse: "That watch is very important to you. Have you looked around the room for it?"

Mrs. W: "My husband gave it to me. He will be so upset that it is gone. I'm afraid to tell him."

Nurse: "I'm sure you miss your husband very much. Tell me what it was like when you were together. What kinds of things did you do for fun?"

missing her husband. She brought up special times that Mrs. W and her husband had spent together, which served to elevate her mood and self-esteem. And lastly, she redirected Mrs. W to the dining room to have her lunch. (The watch was eventually found in Mrs. W's medicine cabinet, where she had hidden it for safekeeping.)

Feil (2012) presents another example,

> When a resident asks for his wife who is dead, caregivers reply, "She'll be here to see you later." The resident may not remember much, but he clings to that statement. He continues to ask for his wife on a daily basis, and the caregivers continue to lie. Eventually he loses trust in the caregivers, knowing that what they say is not true. With VT, the caregivers would encourage the resident to talk about his wife. They would validate his emotions, and encourage him to express his needs, accepting the fact that there is a reason behind his behavior. He has not simply "forgotten that his wife died;" he needs to grieve for her. This is unfinished business. When the emotion is expressed and someone listens with empathy, it is relieved. The old man no longer needs to search for his wife. He feels safe with the caregiver, whom he trusts. He always knew on a deep level of awareness that his wife had died. (pp. 3, 4)

Therapeutic Communication Icon

Find helpful interventions and guidance on how to speak to your patients—just look for this icon in the Care Plan sections.

Interactive Clinical Scenarios Online at DavisPlus *

Work through the nursing process with client summaries, multiple-choice questions with rationales, drag-and-drop activities, and much more!

*A *Plus* Code in the front of each new book unlocks Davis*Plus* Premium Content. (Access can also be purchased at Davis*Plus*.FADavis.com.)

Summary and Key Points

Summary and Key Points

- Cognitive disorders constitute a large and growing public health concern.
- Cognitive disorders include delirium, dementia, and amnestic disorders.
- A delirium is a disturbance of consciousness and a change in cognition that develop rapidly over a short period. Level of consciousness is often affected and psychomotor activity may fluctuate between agitated purposeless movements and a vegetative state resembling catatonic stupor.
- The symptoms of delirium usually begin quite abruptly and often are reversible and brief.
- Delirium may be caused by a general medical condition, substance intoxication or withdrawal, or ingestion of a medication or exposure to a toxin.
- Dementia is a syndrome of acquired, persistent intellectual impairment with compromised function in multiple spheres of mental activity, such as memory, language, visuospatial skills, emotion or personality, and cognition.
- Symptoms of dementia are insidious and develop slowly over time. In most clients, dementia runs a progressive, irreversible course.
- Dementia may be caused by genetics, cardiovascular disease, infections, neurophysiological disorders, and other general medical conditions.
- Amnestic disorders are characterized by an inability to learn new information despite normal attention and an inability to recall previously

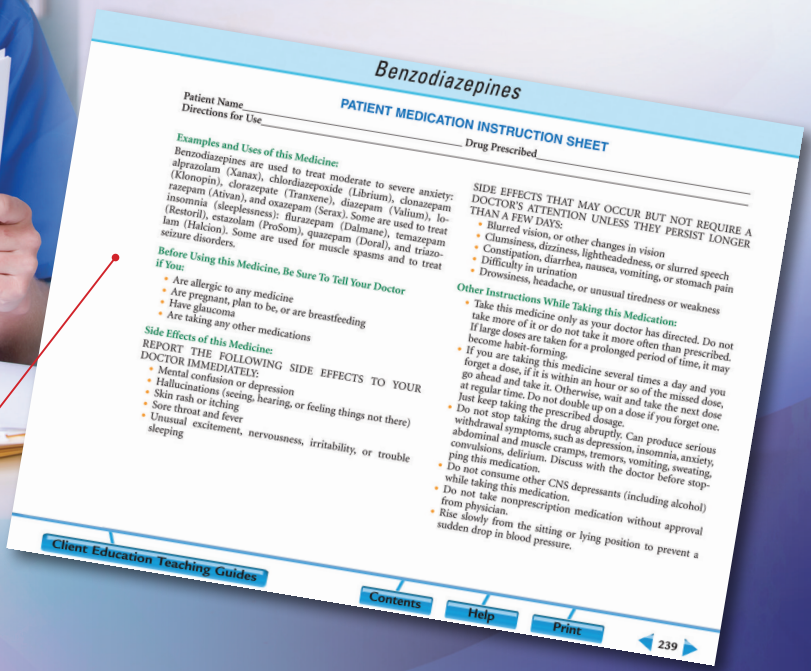
Summary and Key Points

Too busy to take notes? Refer to the **Summary and Key Points** section at the end of every chapter for a recap of the most important concepts.

Step 3. Build your confidence

NCLEX-Style Test Bank Online at DavisPlus *

Practice makes perfect! Quiz yourself and assess your progress with a wealth of questions, including alternate-item-format questions.



Client Teaching Guide Online at DavisPlus

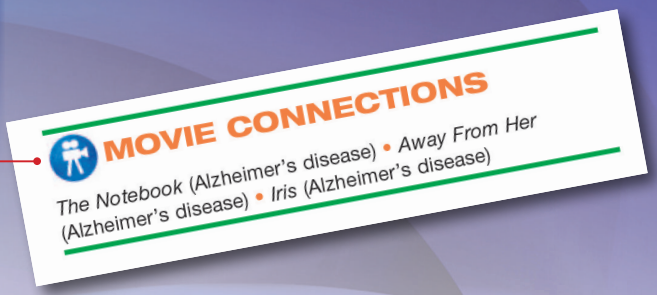
Review the crucial information your patients need to know, including possible side effects and what to do before, during, and after taking medication.

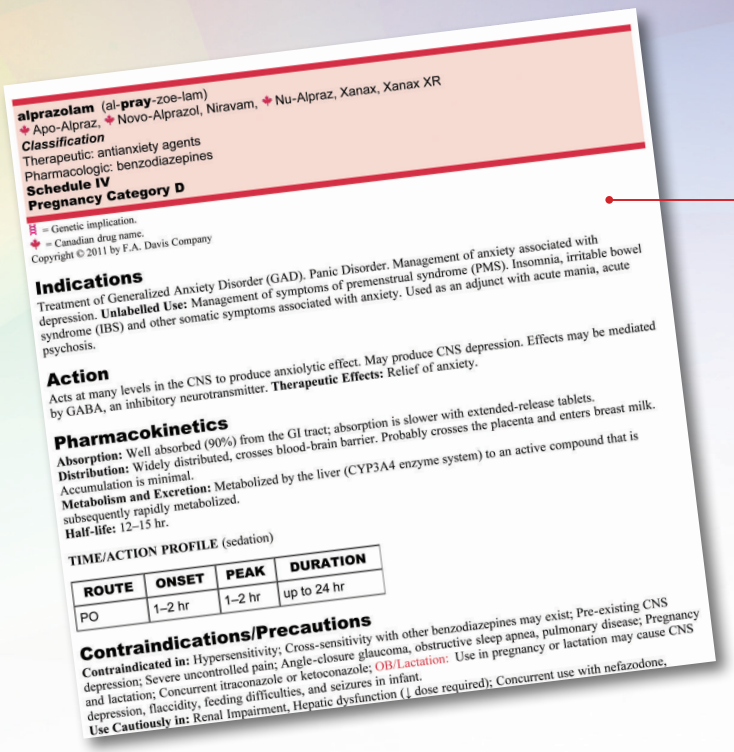
*A *Plus* Code in the front of each new book unlocks Davis*Plus* Premium Content. (Access can also be purchased at Davis*Plus*.FADavis.com.)

Step 4.
Expand your knowledge

NEW! Lists of Movies

Take a visual approach—watch the movies listed in every chapter to better understand the conditions and behaviors you may not encounter in clinical.





alprazolam (al-**pray**-zoe-lam)
Apo-Alpraz, Novo-Alprazol, Niravam, Nu-Alpraz, Xanax, Xanax XR
Classification
Therapeutic: antianxiety agents
Pharmacologic: benzodiazepines
Schedule IV
Pregnancy Category D

= Genetic implication.
= Canadian drug name.

Indications
Treatment of Generalized Anxiety Disorder (GAD). Panic Disorder. Management of anxiety associated with depression. **Unlabelled Use:** Management of symptoms of premenstrual syndrome (PMS). Insomnia, irritable bowel syndrome (IBS) and other somatic symptoms associated with anxiety. Used as an adjunct with acute mania, acute psychosis.

Action
Acts at many levels in the CNS to produce anxiolytic effect. May produce CNS depression. Effects may be mediated by GABA, an inhibitory neurotransmitter. **Therapeutic Effects:** Relief of anxiety.

Pharmacokinetics
Absorption: Well absorbed (90%) from the GI tract; absorption is slower with extended-release tablets.
Distribution: Widely distributed, crosses blood-brain barrier. Probably crosses the placenta and enters breast milk. Accumulation is minimal.
Metabolism and Excretion: Metabolized by the liver (CYP3A4 enzyme system) to an active compound that is subsequently rapidly metabolized.
Half-life: 12–15 hr.

TIME/ACTION PROFILE (sedation)

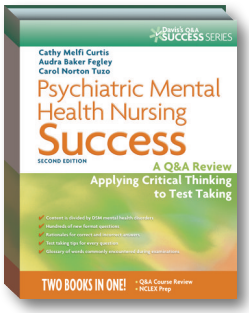
ROUTE	ONSET	PEAK	DURATION
PO	1–2 hr	1–2 hr	up to 24 hr

Contraindications/Precautions
Contraindicated in: Hypersensitivity; Cross-sensitivity with other benzodiazepines may exist; Pre-existing CNS depression; Severe uncontrolled pain; Angle-closure glaucoma, obstructive sleep apnea, pulmonary disease; Pregnancy and lactation; Concurrent itraconazole or ketoconazole; OB/Lactation: Use in pregnancy or lactation may cause CNS depression, flaccidity, feeding difficulties, and seizures in infant.
Use Cautiously in: Renal Impairment, Hepatic dysfunction (↓ dose required); Concurrent use with nefazodone,

Psychotropic Drug Monographs Online at DavisPlus

Attach these handy, printable monographs to your care plans or take them into clinical rotations. Patient safety information, classifications, indications, actions, and nursing implications are easy to find on each psychotropic drug monograph from the trusted Davis's Drug Guide for Nurses® database.

More resources for SUCCESS!



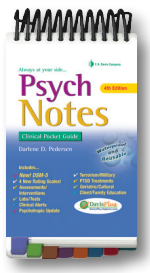
Curtis, Fegley, & Tuzo

Psychiatric Mental Health Nursing Success

A Q&A Review Applying Critical Thinking to Test Taking

2 books in 1—Course Review & NCLEX Prep! Looking for more Q&A review to prepare for classroom exams? Multiple-choice and alternate-item-format questions help assure your mastery of psychiatric mental health nursing knowledge while honing your critical-thinking and test-taking skills. Perfect for classroom exams and the NCLEX, too.

Visit www.FADavis.com for details.



Pedersen

Psych Notes

Clinical Pocket Guide

Includes DSM-5 Content! Quickly find crucial, yet succinct information on all aspects of psychiatric mental health nursing—from basic behavioral theories to psychiatric and crisis interventions—in a waterproof, spiral-bound pocket guide.

SIXTH EDITION

Essentials of Psychiatric Mental Health Nursing

Concepts of Care in Evidence-Based Practice

MARY C. TOWNSEND, DSN, PMHCNS-BC
Clinical Specialist/Nurse Consultant
Adult Psychiatric Mental Health Nursing

Former Assistant Professor and
Coordinator, Mental Health Nursing
Kramer School of Nursing
Oklahoma City University
Oklahoma City, Oklahoma

F.A. Davis Company • Philadelphia

F. A. Davis Company
1915 Arch Street
Philadelphia, PA 19103
www.fadavis.com

Printed in the United States of America

Last digit indicates print number: 10 9 8 7 6 5 4 3 2 1

Publisher, Nursing: Robert G. Martone
Director of Content Development: Darlene D. Pedersen
Project Editor: Jacalyn C. Clay
Electronic Project Editor: Katherine E. Crowley
Cover Design: Carolyn O'Brien

Library of Congress Cataloging-in-Publication Data

Townsend, Mary C., 1941-
Essentials of psychiatric mental health nursing : concepts of care in evidence-based practice/Mary C. Townsend. — 6th ed.
p. ; cm.
Includes bibliographical references and index.
ISBN-13: 978-0-8036-3876-1
ISBN-10: 0-8036-3876-0
I. Title.
[DNLM: 1. Psychiatric Nursing—methods. 2. Evidence-Based Nursing. 3. Mental Disorders—nursing. WY 160]
RC440
616.89'0231—dc23

2013005234

To my best friend, Jimmy

CONTRIBUTORS

Lois Angelo, MSN, APRN, BC
Assistant Professor
Massachusetts College of Pharmacy and Health Sciences
Boston, Massachusetts

Cathy Melfi Curtis, MSN, RN-BC
Nursing Educator Consultant
Charleston, South Carolina

Tona Leiker, PhD, APRN-CNS, CNE
Clinical Nurse Specialist
Wesley Medical Center
Wichita, Kansas

Karyn I. Morgan, RN, MSN, CNS
Senior Instructor, Mental Health Nursing
The University of Akron
Akron, Ohio and CNS, Intensive Outpatient Psychiatry
Summa Health System
Akron, Ohio

Carol Norton Tuzo, MSN, RN-BC
Nursing Educator Consultant
Charleston, South Carolina

REVIEWERS

Lois Angelo, MSN, APRN, BC
Assistant Professor
MA College of Pharmacy and Health Sciences
Boston, Massachusetts

Linda Blair, BSN, RN
Nursing Instructor
Central Carolina Community College
Sanford, North Carolina

Debra DeVoe, RN, MSN, NE-BC
Nursing Instructor
Our Lady of Lourdes
Camden, New Jersey

Donna A. Enrico, MBS, BSN, RN
Clinical Instructor
College of Southern Nevada
Las Vegas, Nevada

Elizabeth Fife, MSN, RN, CNS, CPN
Associate Professor
Louisiana Tech University
Ruston, Louisiana

Wanda Golden, RN, MSN, CCRN, PhD(c)
Dean and Associate Professor of Nursing
Abraham Baldwin Agricultural College
Tifton, Georgia

Patricia J. Hefner, MSN, RN-BC
Faculty; Course Coordinator of Psychiatric Mental Health Nursing
Heritage Valley Sewickley
Moon, Pennsylvania

Sharon A. Henle, Ed.D, ANP, RHIA, CNE
Assistant Professor of Nursing
Farmingdale State College
Farmingdale, New York

Jennifer E. Herrold, RN, MSN, CRNP
Instuctor
Thomas Jefferson University
Danville, Pennsylvania

Beverly J. Howard, MSN, RN, FNP
Instructor
Alvin Community College
Alvin, Texas

Katherine M. Howard, MS, RN-BC
Nursing Instructor
Middlesex County College Nursing Program, Raritan Bay Medical Center
Edison, New Jersey

Janet K. Johnson, MBA, MSN, RN
Nursing Coordinator
Fort Berthold Community College
New Town, North Dakota

Rebecca King, RN, MSN, PMHCNS-BC
Division Chair for Nursing and Allied Health
University of Arkansas, Community College of Batesville
Batesville, Arkansas

Brenda Kucirka, PhD(c), RN, PMHCNS-BC, CNE
Clinical Instructor
Widener University
Chester, Pennsylvania

Jan E. Lawrenz Blasi, MSN, RN
Nursing Instructor
Chandler School of Nursing and Allied Health, Pratt Community College
Pratt, Kansas

Anne Marie Leveille, RN, MSN, MPH
Assistant Professor
Medgar Evers College
Brooklyn, New York

Tamar Lucas, BSN, MSN, RN, BC
Nursing Instructor
Itawamba Community College
Fulton, Mississippi

Jana S. Martin, MS, RN, CNE
Division Chair, Allied Health Services
OSU Institute of Technology
Okmulgee, Oklahoma

Renee Menkens, RN, MS
Assistant Professor
Southwestern Oregon Community College
Coos Bay, Oregon

Norma Perez, MSN/Ed, RN
Assistant Professor
Ivy Tech Community College Northwest
Valparaiso, Indiana

Susan M. Reading-Martin, MS, RN, CS, FNP, ARNP-BC
Nursing Faculty
Western Nebraska Community College
Scottsbluff, Nebraska

Donna F. Rye, MSN, RN
Assistant Professor
Cox College
Springfield, Missouri

Karen B. Silva, RN, MSN, MFN, BC
Nursing Faculty
Keiser University
Sarasota, Florida

Alexandra Winter, RN, MSN
Assistant Director of Nursing
Metropolitan Community College
Omaha, Nebraska

ACKNOWLEDGMENTS

Sincere thanks go to

Robert G. Martone, **Publisher, Nursing, F. A. Davis Company,** for your sense of humor and continuous optimistic outlook about the outcome of this project.

Jacalyn Clay, **Project Editor, Nursing, F. A. Davis Company,** for all your help and support in preparing the manuscript for publication.

Sam Rondinelli, **Assistant Director of Production, F.A. Davis Company, and *Christine Becker,* Production Manager, Progressive Publishing Alternatives,** for your support and competence in the final editing and production of the manuscript.

The nursing educators, students, and clinicians, who provide critical information about the usability of the textbook, and offer suggestions for improvements. Many changes have been made based on your input.

The individuals who critiqued the manuscript for this edition and shared your ideas, opinions, and suggestions for enhancement. I sincerely appreciate your contributions to the final product.

Mary C. Townsend

TO THE INSTRUCTOR

Currently in progress, implementation of the recommendations set forth by the New Freedom Commission on Mental Health has given enhanced priority to mental health care in the United States. Moreover, at the 65th meeting of the World Health Assembly (WHA) in May 2012, India, Switzerland, and the United States cosponsored a resolution requesting that the World Health Organization, in collaboration with member countries, develop a global mental health action plan. By their support of this resolution, member countries have expressed their commitment to "promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment, and recovery of persons with mental disorders." Should this resolution pass, mental health services would be afforded to millions who currently receive no treatment.

Many nurse leaders see this period of mental health-care reform as an opportunity for nurses to expand their roles and assume key positions in education, prevention, assessment, and referral. Nurses are, and will continue to be, in key positions to assist individuals to attain, maintain, or regain optimal emotional wellness.

As it has been with each new edition of *Essentials of Psychiatric Mental Health Nursing: Concepts of Care in Evidence-Based Nursing*, the goal of this sixth edition is to bring to practicing nurses and nursing students the most up-to-date information related to neurobiology, psychopharmacology, and evidence-based nursing interventions. Notable in this edition are changes associated with the recently published fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*).

Content and Features New to the Sixth Edition

- **All content has been updated** to reflect the current state of the discipline of nursing.
- **All psychiatric diagnostic content is reflective** of the newly published American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (2013).
- **All nursing diagnoses are current** with the NANDA-I *Nursing Diagnoses: Definitions and Classification 2012–2014.*
- **"Communication Exercises" boxes** are presented in chapters 13, "Neurocognitive Disorders," 14, "Substance-Use and Addictive Disorders," 15, "Schizophrenia Spectrum and Other Psychotic Disorders," 23, "Personality Disorders," and 25, "Survivors of Abuse or Neglect." These exercises portray clinical scenarios that allow the student to practice communication skills with clients. Answers appear in an appendix at the back of the book.
- **A list of movies** at the end of most diagnostic chapters may be used to visually reinforce material discussed in the textbook. These movies may be used as learning tools to allow students to see on screen the behaviors that they may only read about.
- **Several new assessment scales** are included: the Abnormal Involuntary Movement Scale (AIMS), which aids in the early detection of tardive dyskinesia; the Hamilton Depression Rating Scale; and the Hamilton Anxiety Rating Scale.
- **New content on gambling disorder** appears in Chapter 14, "Substance-Use and Addictive Disorders."
- **New content on gender dysphoria** appears in Chapter 21, "Issues Related to Human Sexuality and Gender Dysphoria."
- **Chapter 11, "The Recovery Model,"** is new to Unit 2, "Psychiatric/Mental Health Nursing Interventions." Additional content on the Recovery Model appears in Chapter 15, "Schizophrenia Spectrum and Other Psychotic Disorders," and Chapter 17, "Bipolar and Related Disorders."

- **Updated information about new psychotropic drugs** approved since the publication of the fifth edition is added to the specific diagnostic chapters to which they apply.
- **New clinical scenarios** are added to each of the concept care maps to make them more client specific rather than standardized.
- **New content on trichotillomania (hair-pulling disorder)** appears in Chapter 18, "Anxiety, Obsessive-Compulsive, and Related Disorders."
- **New content on adjustment disorder** appears in Chapter 19, "Trauma- and Stressor-Related Disorders."
- **New content on body dysmorphic disorder** appears in Chapter 20, "Somatic Symptom and Dissociative Disorders."
- **New content on factitious disorder** is also included in Chapter 20.

Features That Have Been Retained in the Sixth Edition

The concept of **holistic nursing** is retained in the sixth edition of *Essentials of Psychiatric Mental Health Nursing*. An attempt has been made to ensure that the physical aspects of psychiatric/mental health nursing are not overlooked. In all relevant situations, the mind/body connection is addressed.

Nursing process is retained in the sixth edition as the tool for delivery of care to the individual with a psychiatric disorder or to assist in the primary prevention or exacerbation of mental illness symptoms. The six steps of the nursing process, as described in the American Nurses Association *Standards of Clinical Nursing Practice,* are used to provide guidelines for the nurse. These standards of care are included for the *DSM-5* diagnoses as well as for the aging individual, the bereaved individual, victims of abuse and neglect, and as examples in several of the therapeutic approaches. The six steps are:

- **Assessment:** Background assessment data, including a description of symptomatology, provides an extensive knowledge base from which the nurse may draw when performing an assessment. Several assessment tools are also included.
- **Diagnosis:** Analysis of the data is included, from which nursing diagnoses common to specific psychiatric disorders are derived.
- **Outcome identification:** Outcomes are derived from the nursing diagnoses and stated as measurable goals.
- **Planning:** A plan of care is presented with selected nursing diagnoses for the *DSM-5* diagnoses as well as for the elderly client, the bereaved individual, survivors of abuse and neglect, the elderly homebound client, and the primary caregiver of the client with a chronic mental illness. The planning standard also includes tables that list topics for educating clients and families about mental illness. Concept map care plans are included for all major psychiatric diagnoses.
- **Implementation:** The interventions that have been identified in the plan of care are included along with rationale for each. Case studies at the end of each *DSM-5* chapter assist the student in the practical application of theoretical material. Also included as a part of this particular standard is Unit Two of the textbook: "Psychiatric/Mental Health Nursing Interventions". This section of the textbook addresses psychiatric nursing intervention in depth and frequently speaks to the differentiation in scope of practice between the basic psychiatric nurse and advanced-practice psychiatric nurse.
- **Evaluation:** The evaluation standard includes a set of questions that the nurse may use to assess whether the nursing actions have been successful in achieving the objectives of care.

Other Features

Internet references for each *DSM-5* diagnosis, with website listings for information related to the disorder

Tables that list topics for client/family education (clinical chapters)

Boxes that include current research studies with implications for evidence-based nursing practice (clinical chapters)

Assigning nursing diagnoses to client behaviors (diagnostic chapters and Appendix B)

Taxonomy and diagnostic criteria from the *DSM-5* (2013), used throughout the text

Updated references throughout the text with classical references distinguished from general references

Boxes with definitions of core concepts throughout the text

Comprehensive glossary (Appendix D)

Answers to end-of-chapter review questions (Appendix E)

Answers to communication exercises (Appendix F)

Website. An F.A. Davis/Townsend website that contains additional nursing care plans that do not appear in the text, links to psychotropic medications, concept map care plans, and neurobiological content and illustrations

Premium Content on DavisPlus that includes practice test questions, learning activities, concept map care plans, and client teaching guides

Additional Educational Resources

Faculty may also find the following teaching aids that accompany this textbook helpful. Instructor materials on DavisPlus include:

- Hundreds of multiple choice questions **(including new format questions reflecting the latest NCLEX blueprint)**
- Lecture outlines **for all chapters**
- Learning activities **for all chapters (including answer key)**
- Answers to the Critical Thinking Exercises **from the textbook**
- PowerPoint Presentation **to accompany all chapters in the textbook**
- Answers to the Homework Assignment Questions **from the textbook**

It is hoped that the revisions and additions to this sixth edition of *Essentials of Psychiatric Mental Health Nursing* continue to satisfy a need in psychiatric/mental health nursing practice. The mission of this textbook has been, and continues to be, to provide both students and clinicians with up-to-date information about psychiatric/mental health nursing. The user-friendly format and easy-to-understand language, for which we have received many positive comments, have been retained in this edition. I hope that this sixth edition continues to promote and advance the commitment to psychiatric/mental health nursing.

Mary C. Townsend

CONTENTS IN BRIEF

CONTENTS

UNIT 1

Introduction to Psychiatric/Mental Health Concepts

CHAPTER 1 Mental Health and Mental Illness

CORE CONCEPTS

anxiety

grief

CHAPTER OUTLINE

KEY TERMS

anticipatory grief
bereavement overload
ego defense mechanisms
fight-or-flight syndrome
neurosis
psychosis

OBJECTIVES

After reading this chapter, the student will be able to:

1. Define *mental health* and *mental illness.*
2. Discuss cultural elements that influence attitudes toward mental health and mental illness.
3. Identify physiological responses to stress.
4. Discuss the concepts of *anxiety* and *grief* as psychological responses to stress.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. Explain the concepts of *incomprehensibility* and *cultural relativity.*
2. Describe some symptoms of panic anxiety.
3. Jane was involved in an automobile accident in which both her parents were killed. When you ask her about it, she says she has no memory of the accident. What ego defense mechanism is she using?
4. In what stage of the grieving process is the individual with delayed or inhibited grief fixed?

Introduction

The concepts of mental health and mental illness are culturally defined. Some cultures are quite liberal in the range of behaviors that are considered acceptable, whereas others have very little tolerance for behaviors that deviate from the cultural norms. A study of the history of psychiatric care reveals some shocking truths about past treatment of mentally ill individuals. Many were kept in control by means that were cruel and inhumane.

Primitive beliefs regarding mental disturbances took several views. Some thought that an individual with mental illness had been dispossessed of his or her soul and that the only way wellness could be achieved was if the soul returned. Others believed that evil spirits or supernatural or magical powers had entered the body. The "cure" for these individuals involved a ritualistic exorcism to purge the body of these unwanted forces that often consisted of brutal beatings, starvation, or other torturous means. Still others considered that the mentally ill individual may have broken a taboo or sinned against another individual or God, for which ritualistic purification was required or various types of retribution were demanded. The correlation of mental illness to demonology or witchcraft led to some mentally ill individuals being burned at the stake.

This chapter defines *mental health* and *mental illness* and describes physical and psychological responses to stress. Symptoms associated with

anxiety and grief are presented as major psychological responses in the adaptation to stress.

Mental Health

A number of theorists have attempted to define the concept of mental health. Many of these theories deal with various aspects of individual functioning. Maslow (1970) emphasized an individual's motivation in the continuous quest for self-actualization. He identified a "hierarchy of needs," the lower needs requiring fulfillment before those at higher levels can be achieved, with self-actualization being fulfillment of one's highest potential. An individual's position within the hierarchy may fluctuate based on life circumstances. For example, an individual facing major surgery who has been working on tasks to achieve self-actualization may become preoccupied, if only temporarily, with the need for physiological safety. A representation of this needs hierarchy is presented in Figure 1-1.

Maslow described self-actualization as the state of being "psychologically healthy, fully human, highly evolved, and fully mature." He believed that healthy, or *self-actualized*, individuals possessed the following characteristics:

- An appropriate perception of reality
- The ability to accept oneself, others, and human nature
- The ability to manifest spontaneity
- The capacity for focusing concentration on problem-solving
- A need for detachment and desire for privacy
- Independence, autonomy, and a resistance to enculturation
- An intensity of emotional reaction
- A frequency of "peak" experiences that validate the worthwhileness, richness, and beauty of life
- An identification with humankind
- The ability to achieve satisfactory interpersonal relationships
- A democratic character structure and strong sense of ethics
- Creativeness
- A degree of nonconformance

Black and Andreasen (2011) define mental health as "a state of being that is relative rather than absolute. The successful performance of mental functions shown by productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (p. 608).

Townsend (2012) defines mental health as "the successful adaptation to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviors that are age-appropriate and congruent with local and cultural norms" (p. 16).

This definition of mental health will be used for purposes of this text.

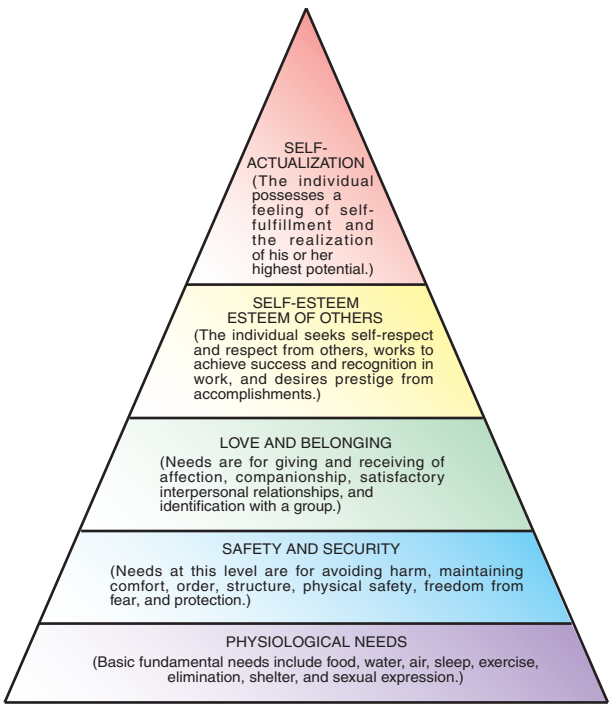


FIGURE 1-1 Maslow's hierarchy of needs.

Mental Illness

A universal concept of mental illness is difficult to define because of the cultural factors that influence such a concept. However, certain elements are associated with individuals' perceptions of mental illness, regardless of cultural origin. Horwitz (2002) identifies two of these elements as *incomprehensibility* and *cultural relativity*.

Incomprehensibility relates to the inability of the general population to understand the motivation

behind the behavior. When observers are unable to find meaning or comprehensibility in behavior, they are likely to label that behavior as mental illness. Horwitz states, "Observers attribute labels of mental illness when the rules, conventions, and understandings they use to interpret behavior fail to find any intelligible motivation behind an action" (p. 17).

The element of *cultural relativity* considers that these rules, conventions, and understandings are conceived within an individual's own particular culture. Behavior is categorized as "normal" or "abnormal" according to one's cultural or societal norms. Therefore, a behavior that is recognized as evidence of mental illness in one society may be viewed as normal in another society, and vice versa. Horwitz identified a number of cultural aspects of mental illness, which are presented in Box 1-1.

The American Psychiatric Association (APA, 2012), defines mental disorder as "a health condition characterized by significant dysfunction in an individual's cognitions, emotions, or behaviors that reflects a disturbance in the psychological, biological or developmental processes underlying mental functioning."

Townsend (2012) defines mental illness as "maladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviors that are incongruent with the local and cultural norms, and interfere with the individual's social, occupational, and/or physical functioning" (p. 17).

This definition of mental illness will be used for purposes of this text.

Physical and Psychological Responses to Stress

Physical Responses

In 1956, Hans Selye published the results of his research concerning the physiological response of a biological system to a change imposed on it. After the initial publication of his findings, he

BOX 1-1 Cultural Aspects of Mental Illness

1. It is usually members of the lay community rather than a psychiatric professional who initially recognize that an individual's behavior deviates from the social norms.
2. People who are related to an individual or who are of the same cultural or social group are less likely to label that individual's behavior as mental illness than is someone who is relationally or culturally distant. Family members (or people of the same cultural or social group) try to "normalize" the behavior and try to find an explanation for the behavior.
3. Psychiatrists see a person with mental illness most often when the family members can no longer deny the illness and often when the behavior is at its worst. The local or cultural norms define pathological behavior.
4. Individuals in the lowest socioeconomic class usually display the highest amount of mental illness symptoms. However, they tend to tolerate a wider range of behaviors that deviate from societal norms and are less likely to consider these behaviors as indicative of mental illness. Mental illness labels are most often applied by psychiatric professionals.
5. The higher the social class, the greater the recognition of mental illness behaviors (as defined by societal norms). Members of the higher social classes are likely to be self-labeled or labeled by family members or friends. Psychiatric assistance is sought soon after the first signs of emotional disturbance.
6. The more highly educated the person, the greater the recognition of mental illness behaviors. However, even more relevant than *amount* of education is *type* of education. Individuals in the more humanistic types of professions (e.g., lawyers, social workers, artists, teachers, nurses) are more likely to seek psychiatric assistance than are other professionals such as business executives, computer specialists, accountants, and engineers.
7. In terms of religion, Jewish people are more likely to seek psychiatric assistance than are people who are Catholic or Protestant.
8. Women are more likely than men to recognize the symptoms of mental illness and seek assistance.
9. The greater the cultural distance from the mainstream of society (i.e., the fewer the ties with conventional society), the greater the likelihood of a negative response by society to mental illness. For example, immigrants have a greater distance from the mainstream than the native born, ethnic minorities greater than the dominant culture, and "bohemians" more than bourgeoisie. They are more likely to be subjected to coercive treatment, and involuntary psychiatric commitments are more common.

Source: Adapted from Horwitz (2002).

revised his definition of stress to "the state manifested by a specific syndrome which consists of all the nonspecifically-induced changes within a biologic system" (Selye, 1976, p. 64). This syndrome of symptoms has come to be known as the **fight-or-flight syndrome.** Selye called this general reaction of the body to stress the *general adaptation syndrome*. He described the reaction in three distinct stages:

1. **Alarm reaction stage:** During this stage, the responses of the fight-or-flight syndrome are initiated.
2. **Stage of resistance:** The individual uses the physiological responses of the first stage as a defense in the attempt to adapt to the stressor. If adaptation occurs, the third stage is prevented or delayed. Physiological symptoms may disappear.
3. **Stage of exhaustion:** This stage occurs when there is a prolonged exposure to the stressor to which the body has become adjusted. The adaptive energy is depleted, and the individual can no longer draw from the resources for adaptation described in the first two stages. Diseases of adaptation (e.g., headaches, mental disorders, coronary artery disease, ulcers, colitis) may occur. Without intervention for reversal, exhaustion and even death ensues (Selye, 1956, 1974).

Biological responses associated with the fight-or-flight syndrome include the following:

- **The immediate response:** The hypothalamus stimulates the sympathetic nervous system, which results in the following physical effects:
  - The adrenal medulla releases norepinephrine and epinephrine into the bloodstream.
  - The pupils of the eye dilate.
  - Secretion from the lacrimal (tear) glands is increased.
  - In the lungs, the bronchioles dilate and the respiration rate is increased.
  - The force of cardiac contraction increases, as does cardiac output, heart rate, and blood pressure.
  - Gastrointestinal motility and secretions decrease, and sphincters contract.
  - In the liver, there is increased glycogenolysis and gluconeogenesis and decreased glycogen synthesis.
  - The bladder muscle contracts, and the sphincter relaxes; there is increased ureter motility.
  - Secretion from the sweat glands is increased.
  - Lipolysis occurs in the fat cells.
- **The sustained response:** When the stress response is not relieved immediately and the individual remains under stress for a long period of time, the hypothalamus stimulates the pituitary gland to release hormones that produce the following effects:
  - Adrenocorticotropic hormone (ACTH) stimulates the adrenal cortex to release glucocorticoids and mineralocorticoids, resulting in increased gluconeogenesis and retention of sodium and water and decreased immune and inflammatory responses.
  - Vasopressin (antidiuretic hormone) increases fluid retention and also increases blood pressure through constriction of blood vessels.
  - Growth hormone has a direct effect on protein, carbohydrate, and lipid metabolism, resulting in increased serum glucose and free fatty acids.
  - Thyrotropic hormone stimulates the thyroid gland to increase the basal metabolic rate.
  - Gonadotropins cause a decrease in secretion of sex hormones, resulting in decreased libido and impotence.

This fight-or-flight response undoubtedly served our ancestors well. Those *Homo sapiens* who had to face the giant grizzly bear or the saber-toothed tiger as a facet of their struggle for survival must have used these adaptive resources to their advantage. The response was elicited in emergencies, used in the preservation of life, and followed by restoration of the compensatory mechanisms to the pre-emergent condition (homeostasis).

Selye performed his extensive research in a controlled setting with laboratory animals as subjects. He elicited physiological responses with physical stimuli, such as exposure to heat or extreme cold, electric shock, injection of toxic agents, restraint, and surgical injury. Since the publication of Selye's original research, it has become apparent that the fight-or-flight syndrome occurs in response to psychological or emotional stimuli, just as it does to physical stimuli. The psychological or emotional stressors are often not resolved as rapidly as some physical stressors; therefore the body may be depleted of its adaptive energy more readily than

it is from physical stressors. The fight-or-flight response may be inappropriate or even dangerous to the lifestyle of today, wherein *stress* has been described as a psychosocial state that is pervasive, chronic, and relentless. It is this chronic response that maintains the body in the aroused condition for extended periods that promotes susceptibility to diseases of adaptation.

Psychological Responses

Anxiety and **grief** have been described as two major, primary psychological response patterns to stress. A variety of thoughts, feelings, and behaviors are associated with each of these response patterns. Adaptation is determined by the degree to which the thoughts, feelings, and behaviors interfere with an individual's functioning.

CORE CONCEPT

Anxiety

A diffuse apprehension that is vague in nature and is associated with feelings of uncertainty and helplessness.

Anxiety

Feelings of anxiety are so common in our society that they are almost considered universal. Anxiety arises from the chaos and confusion that exists in the world today. Fears of the unknown and conditions of ambiguity offer a perfect breeding ground for anxiety to take root and grow. Low levels of anxiety are adaptive and can provide the motivation required for survival. Anxiety becomes problematic when the individual is unable to prevent the anxiety from escalating to a level that interferes with the ability to meet basic needs.

Peplau (1963) described four levels of anxiety: mild, moderate, severe, and panic. Nurses must be able to recognize the symptoms associated with each level to plan for appropriate intervention with anxious individuals.

- **Mild anxiety:** This level of anxiety is seldom a problem for the individual. It is associated with the tension experienced in response to the events of day-to-day living. Mild anxiety prepares people for action. It sharpens the senses, increases motivation for productivity, increases the perceptual field, and results in a heightened awareness of the environment. Learning is enhanced, and the individual is able to function at his or her optimal level.
- **Moderate anxiety:** As the level of anxiety increases, the extent of the perceptual field diminishes. The moderately anxious individual is less alert to events occurring within the environment. The individual's attention span and ability to concentrate decrease, although he or she may still attend to needs with direction. Assistance with problem-solving may be required. Increased muscular tension and restlessness are evident.
- **Severe anxiety:** The perceptual field of the severely anxious individual is so greatly diminished that concentration centers on one particular detail only or on many extraneous details. Attention span is extremely limited, and the individual has much difficulty completing even the simplest task. Physical symptoms (e.g., headaches, palpitations, insomnia) and emotional symptoms (e.g., confusion, dread, horror) may be evident. Discomfort is experienced to the degree that virtually all overt behavior is aimed at relieving the anxiety.
- **Panic anxiety:** In this most intense state of anxiety, the individual is unable to focus on even one detail within the environment. Misperceptions are common, and a loss of contact with reality may occur. The individual may experience hallucinations or delusions. Behavior may be characterized by wild and desperate actions or extreme withdrawal. Human functioning and communication with others are ineffective. Panic anxiety is associated with a feeling of terror, and individuals may be convinced that they have a life-threatening illness or fear that they are "going crazy," are losing control, or are emotionally weak. Prolonged panic anxiety can lead to physical and emotional exhaustion and can be life threatening.

A variety of behavioral adaptation responses occur at each level of anxiety. Figure 1-2 depicts these behavioral responses on a continuum of anxiety ranging from mild to panic.

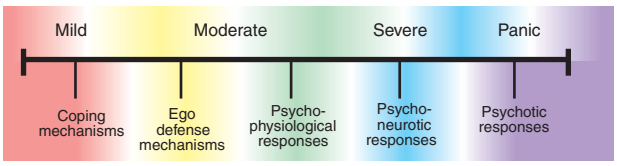


FIGURE 1-2 Adaptation responses on a continuum of anxiety.

Mild Anxiety

At the mild level, individuals use any of a number of coping behaviors that satisfy their needs for comfort. Menninger (1963) described the following types of coping mechanisms that individuals use to relieve anxiety in stressful situations:

- Sleeping
- Eating
- Physical exercise
- Smoking
- Crying
- Yawning
- Drinking
- Daydreaming
- Laughing
- Cursing
- Pacing
- Foot swinging
- Fidgeting
- Nail biting
- Finger tapping
- Talking to someone with whom one feels comfortable

Undoubtedly there are many more coping mechanisms, too numerous to mention here, considering that each individual develops his or her own unique ways to relieve anxiety at the mild level. Some of these behaviors are much more adaptive than others.

Mild to Moderate Anxiety

Sigmund Freud (1961) identified the ego as the reality component of the personality that governs problem-solving and rational thinking. As the level of anxiety increases, the strength of the ego is tested, and energy is mobilized to confront the threat. Anna Freud (1953) identified a number of defense mechanisms employed by the ego in the face of threat to biological or psychological integrity (Table 1-1). Some of these **ego defense mechanisms** are more adaptive than others, but all are used either consciously or unconsciously as protective devices for the ego in an effort to relieve mild to moderate anxiety. They become maladaptive when an individual uses them to such a degree that there is interference with the ability to deal with reality, with interpersonal relations, or with occupational performance.

Moderate to Severe Anxiety

Anxiety at the moderate to severe level that remains unresolved over an extended period can contribute to a number of physiological disorders. The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition *(DSM-5)* (APA, 2013) describes these disorders under the category

TABLE 1-1 Ego Defense Mechanisms

DEFENSE MECHANISM	EXAMPLE	DEFENSE MECHANISM	EXAMPLE
Compensation Covering up a real or perceived weakness by emphasizing a trait one considers more desirable	A physically handicapped boy is unable to participate in football, so he compensates by becoming a great scholar.	**Rationalization** Attempting to make excuses or formulate logical reasons to justify unacceptable feelings or behaviors	John tells the rehab nurse, "I drink because it's the only way I can deal with my bad marriage and my worse job."
Denial Refusing to acknowledge the existence of a real situation or the feelings associated with it	A woman drinks alcohol every day and cannot stop, failing to acknowledge that she has a problem.	**Reaction Formation** Preventing unacceptable or undesirable thoughts or behaviors from being expressed by exaggerating opposite thoughts or types of behaviors	Jane hates nursing. She attended nursing school to please her parents. During career day, she speaks to prospective students about the excellence of nursing as a career.
Displacement The transfer of feelings from one target to another that is considered less threatening or that is neutral	A client is angry at his doctor, does not express it, but becomes verbally abusive with the nurse.	**Regression** Responding to stress by retreating to an earlier level of development and the comfort measures associated with that level of functioning	When 2-year-old Jay is hospitalized for tonsillitis he will drink only from a bottle, although his mother states he has been drinking from a cup for 6 months.

Continued

TABLE 1-1 Ego Defense Mechanisms—cont'd

DEFENSE MECHANISM	EXAMPLE	DEFENSE MECHANISM	EXAMPLE
Identification An attempt to increase self-worth by acquiring certain attributes and characteristics of an individual one admires	A teenaged boy who required lengthy rehabilitation after an accident decides to become a physical therapist as a result of his experiences.	**Repression** Involuntarily blocking unpleasant feelings and experiences from one's awareness	An accident victim can remember nothing about the accident.
Intellectualization An attempt to avoid expressing actual emotions associated with a stressful situation by using the intellectual processes of logic, reasoning, and analysis	Susan's husband is being transferred with his job to a city far away from her parents. She hides anxiety by explaining to her parents the advantages associated with the move.	**Sublimation** Rechanneling of drives or impulses that are personally or socially unacceptable into activities that are constructive	A mother whose son was killed by a drunk driver channels her anger and energy into being the president of the local chapter of Mothers Against Drunk Drivers.
Introjection Integrating the beliefs and values of another individual into one's own ego structure	Children integrate their parents' value system into the process of conscience formation. A child says to friend, "Don't cheat. It's wrong."	**Suppression** The voluntary blocking of unpleasant feelings and experiences from one's awareness	Scarlett O'Hara says, "I don't want to think about that now. I'll think about that tomorrow."
Isolation Separating a thought or memory from the feeling tone or emotion associated with it	Without showing any emotion, a young woman describes being attacked and raped.	**Undoing** Symbolically negating or canceling out an experience that one finds intolerable	Joe is nervous about his new job and yells at his wife. On his way home he stops and buys her some flowers.
Projection Attributing feelings or impulses unacceptable to one's self to another person	Sue feels a strong sexual attraction to her track coach and tells her friend, "He's coming on to me!"		

"Psychological Factors Affecting other Medical Conditions." The psychological factors may exacerbate symptoms of, delay recovery from, or interfere with treatment of the medical condition. The condition may be initiated or exacerbated by an environmental situation that the individual perceives as stressful. Measurable pathophysiology can be demonstrated. It is thought that psychological and behavioral factors may affect the course of almost every major category of disease, including, but not limited to, cardiovascular, gastrointestinal, neoplastic, neurological, and pulmonary conditions.

Severe Anxiety

Extended periods of repressed severe anxiety can result in psychoneurotic patterns of behaving. **Neurosis** is no longer considered a separate category of mental disorder. However, the term sometimes is still used in the literature to further describe the symptomatology of certain disorders and to differentiate from behaviors that occur at the more serious level of *psychosis*. Neuroses are psychiatric disturbances characterized by excessive anxiety that is expressed directly or altered through defense mechanisms. It appears as a symptom, such as an obsession, a compulsion, a phobia, or a sexual dysfunction (Sadock & Sadock, 2007). The following are common characteristics of people with neuroses:

- They are aware that they are experiencing distress.
- They are aware that their behaviors are maladaptive.
- They are unaware of any possible psychological causes of the distress.
- They feel helpless to change their situation.
- They experience no loss of contact with reality.

The following disorders are examples of psychoneurotic responses to severe anxiety as they appear in the *DSM-5:*

- **Anxiety disorders:** Disorders in which the characteristic features are symptoms of anxiety and avoidance behavior (e.g., phobias, panic disorder, generalized anxiety disorder, and separation anxiety disorder).
- **Somatic symptom disorders:** Disorders in which the characteristic features are physical symptoms for which there is no demonstrable organic pathology. Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the symptoms (e.g., somatic symptom disorder, illness anxiety disorder, conversion disorder, and factitious disorder).
- **Dissociative disorders:** Disorders in which the characteristic feature is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment (e.g., dissociative amnesia, dissociative identity disorder, and depersonalization-derealization disorder).

Panic Anxiety

At this extreme level of anxiety, an individual is not capable of processing what is happening in the environment and may lose contact with reality. **Psychosis** is defined as "a severe mental disorder characterized by gross impairment in reality testing, typically manifested by delusions, hallucinations, disorganized speech, or disorganized or catatonic behavior" (Black & Andreasen, 2011, p. 618). The following are common characteristics of people with psychoses:

- They exhibit minimal distress (emotional tone is flat, bland, or inappropriate).
- They are unaware that their behavior is maladaptive.
- They are unaware of any psychological problems.
- They are exhibiting a flight from reality into a less stressful world or into one in which they are attempting to adapt.

Examples of psychotic responses to anxiety include the schizophrenic, schizoaffective, and delusional disorders.

CORE CONCEPT

Grief

Grief is a subjective state of emotional, physical, and social responses to the loss of a valued entity.

Grief

Most individuals experience intense emotional anguish in response to a significant personal loss. A loss is anything that is perceived as such by the individual. Losses may be real, in which case they can be substantiated by others (e.g., death of a loved one, loss of personal possessions), or they may be perceived by the individual alone and unable to be shared or identified by others (e.g., loss of the feeling of femininity following a mastectomy). Any situation that creates change for an individual can be identified as a loss. Failure (either real or perceived) can be viewed as a loss.

The loss, or anticipated loss, of anything of value to an individual can trigger the grief response. This period of characteristic emotions and behaviors is called *mourning*. The "normal" mourning process is adaptive and is characterized by feelings of sadness, guilt, anger, helplessness, hopelessness, and despair. Indeed, an absence of mourning after a loss may be considered maladaptive.

Stages of Grief

Kübler-Ross (1969), in extensive research with terminally ill patients, identified five stages of feelings and behaviors that individuals experience in response to a real, perceived, or anticipated loss:

- **Stage 1—Denial:** This is a stage of shock and disbelief. The response may be one of "No, it can't be true!" The reality of the loss is not acknowledged. Denial is a protective mechanism that allows the individual to cope within an immediate time frame while organizing more effective defense strategies.
- **Stage 2—Anger:** "Why me?" and "It's not fair!" are comments often expressed during the anger stage. Envy and resentment toward individuals not affected by the loss are common. Anger may be directed at the self or displaced on loved ones, caregivers, and even God. There may be a preoccupation with an idealized image of the lost entity.
- **Stage 3—Bargaining:** "If God will help me through this, I promise I will go to church every Sunday and volunteer my time to help others." During this stage, which is usually not visible or evident to others, a "bargain" is made with God in an attempt to reverse or postpone the loss. Sometimes the promise is associated with feelings of guilt for not having performed satisfactorily, appropriately, or sufficiently.