PART I

# Overview of Psychiatric-Mental Health Nursing

CHAPTER 1

# Introduction to Psychiatric-Mental Health Nursing

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## LEARNING OBJECTIVES

*After reading this chapter, you will be able to:*

- Describe the evolution of psychiatric-mental health nursing care.
- List the members of the contemporary multidisciplinary treatment team and describe the distinctive abilities of each professional member.
- Explain two key concepts from each of the psychoanalytic, interpersonal, and behavioral conceptual models.
- Discuss the impact on psychiatric-mental health nursing of the works of Peplau, Orlando, King, Orem, and Riehl-Sisca.
- Describe the characteristics of individual therapy, family therapy, group therapy, milieu therapy, crisis intervention, and somatic therapies.

## KEY TERMS

**Anticipatory guidance**
**Anxiety**
**Apathy**
**Behavioral model**
**Classical conditioning**
**Cognitive model**
**Conceptual model**
**Coping mechanisms**
**Crisis**
**Developmental crises**
**Dynamisms**
**Ego defense mechanisms**
**Extinction**
**Family systems therapy**
**Genogram**
**Group therapy**
**Individual therapy**
**Levels of consciousness**
**Milieu therapy**
**Moral therapy**
**Multidisciplinary treatment team**
**Need for satisfaction**
**Need for security**
**Negative reinforcement**
**Neurobiologic model**
**Nurse-patient relationship**
**Operant conditioning**
**Personality, structure of**
**Positive reinforcement**
**Preoccupation**
**Psychoanalytic model**
**Psychodynamic nursing**
**Psychosexual theory of personality development**
**Punishment**
**Response cost**
**Security operations**
**Selective inattention**
**Self-care deficit nursing theory**
**Self-concept**
**Situational crises**
**Somatic therapies**
**Somnolent detachment**
**Structural family therapy**
**Therapeutic community**

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The use of the term *patient* in the first half of this chapter reflects historical usage.

## History

During the Middle Ages, mentally ill persons (the insane) were believed to be possessed by devils.

Society has always adopted measures designed to change the behavior of persons with mental illness. In prehistoric times, those measures were likely to have been tribal rites that, if unsuccessful, probably led to the abandonment of the ill person. During the Greek and Roman eras, the sick were treated in the temples, and treatment ranged from humane care to flogging, bleeding, and purging.

The inhumane treatment of insane persons reached its peak in the seventeenth century when almshouses, a combination of a jail and an asylum, confined both criminals and those who were mentally ill.

The plight of mentally-ill persons continued to be poor in the Middle Ages, when their care was determined by mistaken religious beliefs. The mentally ill were believed to be possessed by devils that could be exorcised by whippings and starvation. When the church stopped treating mentally ill persons during the sixteenth century, they were imprisoned in almshouses, which were a combination of a jail and an asylum. Those who were violent and delusional were placed in jails and dungeons. King Henry VIII officially dedicated Bethlehem Hospital in London as a lunatic asylum. Bethlehem Hospital soon became known as the notorious "Bedlam," whose hideous practices were immortalized by Hogarth, the famous cartoonist (**Figure 1-1**). The keepers at Bedlam were allowed to exhibit the most boisterous patients for 2 pence a look. The more harmless inmates were forced to seek charity on the streets of London; the "Bedlam beggars" of Shakespeare's King Lear were based on these prisoners (Taylor, 1994).

In 1792, Phillipe Pinel introduced moral therapy. Attendants were required to treat patients kindly and keep them busy with various activities.

Benjamin Rush (1745–1813) is considered the "father of American psychiatry." The first public psychiatric hospital in America was built in Williamsburg, Virginia, in 1773 and is still in operation today as the Eastern Psychiatric Hospital.

**Figure 1-1 Bedlam, as depicted by William Hogarth.** Note the well-dressed ladies, who made social visits to the prison to view the spectacle of the inmates as entertainment.

The inhumane treatment of mentally ill persons peaked in the seventeenth century when petty criminals and those who were mentally ill were confined together in almshouses. Treatment consisted of drastic purgings, bleedings, and whippings.

### The Eighteenth and Nineteenth Centuries

In the eighteenth century, Europe, particularly France, underwent political and social reform. In 1792, Phillipe Pinel, the medical director of the Bicêtre asylum outside Paris, introduced a new treatment regimen termed **moral therapy**. Advocates of moral therapy believed that mental illness was related to immorality or faulty upbringing, and that a therapeutic environment could correct these weaknesses. Instead of harsh confinement, patients were kept busy with work, music, or other diversions. Moral therapy required that attendants treat patients with kindness and keep them involved in the treatment program (Wasserbauer & Brodie, 1992). The Quakers, under the Brothers Tuke, established the York Retreat and brought about the same dramatic reforms in England. The development of moral therapy and its reliance on attendants were the beginnings of current psychiatric nursing care.

The first place identified as a "poorhouse, workhouse, and house of correction" in the United States opened in New York City in 1736. In 1756, under the guidance of Benjamin Franklin, the Pennsylvania Hospital was completed. One of the first two patients admitted was described as a "lunatic." Although patients with a mental illness were relegated to the cellar, they were assured clean bedding and warm rooms. Benjamin Rush (1745–1813), a humanitarian and the "father of American psychiatry," began working at Pennsylvania Hospital in 1783.

The first public psychiatric hospital in America was built in Williamsburg, Virginia, in 1773 and is known today as Eastern Psychiatric Hospital. Most states, even as late as 1830, did not have facilities for treatment of the mentally ill, although a number of excellent private hospitals existed (most notably the Hartford Retreat, founded in 1818).

Dorothea Lynde Dix (1802–1887) was a schoolteacher who volunteered to tutor individuals confined to jails and poorhouses. She was horrified by the conditions in these facilities, and in 1841 began a campaign to convince state legisla-

tures that suitable hospitals, not jails, were required for those with mental illnesses. Twenty states in the United States and the Canadian government responded directly to her appeals by authorizing the construction of large institutions for the mentally ill. This was the beginning of the state hospital system in the United States.

The original intent of the state hospital system was to treat those with mental illness and then discharge them to the community or the care of their families. Because so little was known about mental illness at that time, the goals of treatment and discharge were not able to be achieved. Consequently, state hospitals rapidly became overcrowded with chronically mentally ill patients. Paradoxically, the same state hospitals that were supposed to alleviate the suffering of violent persons who were previously imprisoned contributed to the ultimate demise of moral therapy, because this treatment could not be implemented in overcrowded settings.

In 1844, the Association of Medical Superintendents was formed as psychiatry began to develop as a profession and as physicians became increasingly responsible for the administration of asylums. This organization became the American Medico-Psychological Association in 1851, and was renamed the American Psychiatric Association (APA) in 1921. It was founded by medical superintendents from 13 asylums in the United States (Wasserbauer & Brodie, 1992).

By the 1870s, asylums were considered abysmal institutions with a terrible public image. Searching for ways to improve care, psychiatrists adopted the strategies already in use at general hospitals to improve patient services. These improvements included incorporating effective therapies that had a scientific basis and using graduate nurses instead of attendants. However, asylums were unable to attract enough nurses to improve patient care, so schools of nursing in asylums were established. The first school of this type was established at the McLean Asylum in Massachusetts in 1882 (Wasserbauer & Brodie, 1992).

## The Twentieth Century

At the beginning of the twentieth century, treatment was still limited to restraints, isolation, water bath treatments, dietary regimens, and, eventually, early sedative drugs and shock treatments. Noticeable changes occurred in the state hospital system in 1908 when Clifford Beers, a psychiatric patient who was hospitalized several times, wrote a book about his experiences titled *A Mind That Found Itself*. The book's revelations led to the founding of the National Committee for Mental Hygiene. The committee, for the first time, espoused the prevention of mental illness and early intervention.

The most significant psychiatric revolution in the early twentieth century was a direct result of the work of Sigmund Freud (1856–1939). Freud made great contributions to the understanding of human behavior. Before his theories were introduced, human behavior, particularly the behavior of persons with mental illnesses, was shrouded in superstition, secrecy, and stigma. Freud brought the subject of human behavior to the public's attention. His theories served as a springboard for the scientific study of human behavior. Although much of Freudian theory is no longer embraced in scientific circles, some of his concepts have become so integrated into the mainstream that they have become part of everyday language (e.g., ego, conscience, unconscious).

The National Mental Health Act, passed in 1946, was one of the most progressive actions addressing mental illness the United States has ever taken. The legislation stemmed from the nation's concerns about the mental health of its citizens as a result of experiences during World War II. More men in the armed forces were disabled from mental disorders than from all other health problems related to military action. Immediately after the National Mental Health Act was passed, the National Institute of Mental Health (NIMH) was established in 1946. The NIMH provided funding to support research into the causes of mental illness and to provide tuition and stipends for education in the four core mental health disciplines: psychiatry, psychology, psychiatric nursing, and psychiatric social work. Major strides were made in increasing the number of mental health professionals as a result of this funding. For example, in the 1940s only five to seven graduate programs in psychiatric nursing existed; these numbers expanded greatly in the 1950s and 1960s as a result of NIMH funding.

Psychiatric nursing underwent a major change when *Interpersonal Relations in Nursing* by Hildegard Peplau was published in 1952. Reprinted in 1991 and now considered a classic, this book emphasized the significance of the relationship between the patient and nurse as a treatment modality. Dr. Peplau became the director of the graduate

Dorothea Lynde Dix (1802–1887), an early advocate for the mentally ill, convinced state legislatures that suitable hospitals, not jails, were required for those with mental illnesses.

A movement began in the 1870s to use graduate nurses instead of attendants in state hospitals. The first school of nursing at a state asylum was founded in 1882 at the McLean Asylum in Massachusetts.

*A Mind That Found Itself*, by Clifford Beers, led to the founding of the National Committee for Mental Hygiene, which espoused the prevention of mental illness and early intervention.

Sigmund Freud brought the subject of human behavior to the attention of the scientific community and public, although his theories are no longer universally acclaimed.

One of the most progressive actions ever taken by the United States in response to mental illness was the passage of the National Mental Health Act in 1946 and the subsequent establishment of NIMH.

A major turning point in psychiatric nursing was the publication of *Interpersonal Relations in Nursing* by Hildegard Peplau. This book emphasized the significance of the relationship between patient and nurse as a treatment modality.

program in psychiatric nursing at Rutgers, The State University of New Jersey, and is considered the "mother of modern psychiatric nursing."

The master's program in psychiatric nursing at Rutgers, along with many other programs, graduated hundreds of clinical nurse specialists (CNSs) in psychiatric nursing. These individuals quickly assumed leadership positions in organized nursing and lobbied for recognition as autonomous practitioners of mental health care, specifically psychotherapy. Currently, many states authorize certified psychiatric clinical nurse specialists and certified psychiatric nurse practitioners to prescribe psychopharmaceuticals, and Medicare and most insurance plans reimburse them for their services.

In 1953, the National League for Nursing required the inclusion of psychiatric nursing experience and coursework in the basic nursing curricula for all nursing students.

In 1953, the National League for Nursing, the accreditation agency for schools of nursing, required the inclusion of psychiatric nursing clinical experience and coursework in all basic curricula and required that these subjects be taught by nursing faculty. Thus, all nursing students had some exposure to the practice and theory of psychiatric nursing. However, it was not until the 1980s that the last school of nursing located in a psychiatric hospital closed.

The Mental Health Study Act of 1955 led to the establishment of the Joint Commission on Mental Illness; the commission's report, *Action for Mental Health*, provided a nationwide stimulus to develop more effective services for people in need of psychiatric care.

In 1955, the U.S. Congress passed the Mental Health Study Act. This act provided funds for a 5-year study of the problem of mental illness in the United States. As a result, the Joint Commission on Mental Illness was established. The commission's report, *Action for Mental Health*, provided the stimulus for developing more effective services for people in need of psychiatric care, and was the basis for additional legislation.

The care of persons with mental illness was revolutionized in the late 1950s when chlorpromazine (Thorazine) first became available for widespread use.

A revolution in care occurred in the late 1950s when the first effective antipsychotic medication, chlorpromazine (Thorazine), became widely available. Although many other, more effective, medications are currently available, none have had the impact of chlorpromazine when it was first introduced. This medication controlled many of the most distressing symptoms experienced by patients, resulting in their becoming more amenable to other forms of treatment and being able to function better both in and out of hospitals.

The 1963 Community Mental Health Centers Construction Act and its 1965 staffing amendments sought to revolutionize the provision of mental health care by emphasizing prevention and decentralized, local community treatment.

On February 5, 1963, President John F. Kennedy delivered a special message on mental illness and mental retardation to the Congress. He emphasized the goal of community care for persons with mental illnesses. In that same year, Congress authorized the Community Mental Health Centers Construction Act, which was followed in 1965 by amendments to provide for staffing in the centers (P.L. 89-105). These acts sought to revolutionize mental health care by emphasizing prevention and decentralized, local community treatment over institutional care, even for persons with the most severe psychiatric difficulties. The first federally funded centers opened in 1966, initiating the deinstitutionalization of persons with mental illness.

The first *Standards of Psychiatric and Mental Health Nursing Practice* was published in 1973 by the ANA.

In 1973, the executive committee of the division of psychiatric-mental health nursing practice of the American Nurses Association (ANA) published the first *Standards of Psychiatric and Mental Health Nursing Practice*. This document has been continually revised and reflects the current, accepted levels of practice that psychiatric nurses are expected to maintain. The most recent version is *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (2007).

In the late 1980s, NIMH shifted its focus and funding from education and service delivery to research. This legislative shift resulted, in part, from intense lobbying by the National Alliance for the Mentally Ill (NAMI), an advocacy group of families of mentally ill persons that demanded increased research into the cause and treatment of mental illness. Funding for the education of mental health practitioners was abolished, resulting in a dramatic decline in the number of nurses pursuing graduate degrees in psychiatric nursing.

Begun in the 1960s, deinstitutionalization was finally achieved in the late 1980s and early 1990s as a result of economic constraints and the availability of medications and services that enabled patients to function in the community. Currently, persons with mental illness who require hospitalization are likely to be admitted to a freestanding private hospital or a psychiatric unit in a general hospital. The nature of treatment has also changed. An individual admitted to the hospital no longer has to remain for months, with most staying for less than 2 weeks (Taylor, 1994).

**Critical Thinking Question** What are the advantages and disadvantages for clients, families, communities, and healthcare practitioners when short-term hospitalization is deemed necessary?

Finally, a major paradigm shift has occurred in understanding the causes of major mental illness, and this shift has altered the nature of psychiatric treatment. As a result of increasingly sophisticated technology, scientists have proposed that many of the most severe forms of mental illness have a neu-

**Figure 1-2 An individual psychotherapy session.**

robiologic basis. As a result, treatment relies heavily on the ever-expanding array of psychopharmaceuticals as well as the more traditional "talking" therapies (individual psychotherapy, group therapy, family therapy; see **Figure 1-2**). Furthermore, because of these findings, many graduate programs in psychiatric nursing have revised their curricula to emphasize neurobiology and psychopharmacology.

## The Twenty-First Century

The understanding of the causes and treatment of mental illness has increased dramatically over the centuries. The availability of increasingly sophisticated technology ensures even more dramatic advances in knowledge. Because of the increasing scope and complexity of this burgeoning knowledge, it is necessary for the **multidisciplinary treatment team** to work closely together to achieve the goals of preventing mental illness and effectively treating those who are ill. Therefore, the psychiatric nurse in the twenty-first century works collaboratively in the community with other healthcare practitioners, clients, and their families, each an integral part of the multidisciplinary treatment team utilizing a variety of treatments. Recognition of the patient as an integral member of the treatment team is reflected in the contemporary use of the term *client* rather than *patient* when referring to the person in need of professional mental health services.

In addition to clients and their families, the multidisciplinary treatment team includes the psychiatrist, clinical psychologist, psychiatric mental health nurse, psychiatric social worker, and activities therapists such as life skills, art, and music. All mental health professionals share a common knowledge of and skill in interpersonal relationships and a deep appreciation of the inextricable relationship between mind and body. Each professional discipline has a distinctive knowledge base and skills that enrich the treatment team.

Psychiatrists are physicians with several years of supervised residency training in the medical specialty of psychiatry. The psychiatrist prescribes

**Figure 1-3 A sample Rorschach "ink blot."**

medications and administers other somatic therapies, such as electroconvulsive therapy. Psychiatrists are particularly skilled in identifying and treating persons whose problems have highly interrelated emotional physiological components.

Many of the most severe forms of mental illness most likely have a neurobiologic basis. As a result, treatment is based on the use of psychopharmaceuticals (i.e., drug therapy).

Clinical psychologists have advanced education in the study of mental processes and the treatment of mental disorders. They have particular expertise in the use of inferential tools designed to assist in the diagnostic process and assessment of treatment effects. An example of such a tool is the Rorschach test, commonly known as the "ink blot" test (**Figure 1-3**).

Psychiatric-mental health nurse generalists and advanced practice psychiatric nurses work collaboratively in out-patient and in-patient treatment settings. According to the Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN), psychiatric-mental health nurses are registered nurses who are educationally prepared in nursing, licensed to practice in their individual states, and qualified to practice in the psychiatric-mental health nursing specialty at one of two levels: basic or advanced. All nurses bring expertise in assessing the client's ability to engage in activities of daily living and to assist the client to cope as necessary. The nurse in an in-patient setting is responsible for establishing and maintaining an environment that is therapeutic for the client population as a whole. It is believed that the therapeutic nurse-client relationship is the hallmark of psychiatric nursing. For a more complete discussion of these roles, see Chapter 2.

Psychiatric social workers are prepared at the master's degree level and have particular skill in assessing familial, environmental, and social factors that contribute to the problems of clients and

**Figure 1-4 A client engaged in painting.**
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their families. They are also major contributors to discharge planning and the follow-up care of the client.

Activity therapists have at least a bachelor's degree, and increasingly a master's degree is required in their specialty field. The basis of activity therapy is the belief that persons can benefit from engaging in activities that focus outside of the self, such as exercise, crafts, writing, music, or painting (see **Figure 1-4**). These activities can be done either alone or in conjunction with other clients. Therefore, the activity therapist is skilled in the development, implementation, and evaluation of a highly individualized activity regimen designed to meet the needs of the person for whom it is designed.

A conceptual model is a framework of related concepts. Most mental health practitioners use a variety of approaches to assist clients in achieving mental health.

## Conceptual Models

A **conceptual model** is a framework of related concepts. Conceptual models used by mental health practitioners address the bases for behavior in order to direct interventions. Although some mental health practitioners adhere strictly to one conceptual model, most practitioners in the United States use an eclectic approach in which they employ one or more approaches from several models. The most important conceptual models are the psychoanalytic, interpersonal, behavioral, cognitive, developmental, and neurobiologic models. We will discuss all the models in this chapter, but the last three models are discussed in more detail in other chapters of this book.

The founder of the psychoanalytic model is Sigmund Freud. Key Freudian concepts include levels of consciousness, structure of the personality, and psychosexual development.

**Critical Thinking Question** Why would most mental health practitioners choose to use an eclectic approach to treatment? What are the advantages of this practice? Are there any disadvantages to this approach?

The three levels of consciousness are the conscious, the preconscious, and the unconscious; the three aspects of the personality are the id, the ego, and the superego.

## Psychoanalytic Model

Sigmund Freud is the founder of the **psychoanalytic model**. Freud was an Austrian physician who began his career as a neurologist. He developed an elaborate theory of human behavior based primarily on his work with persons suffering from disabling anxiety. The treatment approach derived from his theories is termed *psychoanalysis*. Key Freudian concepts include levels of consciousness, structure of the personality, and psychosexual development.

### Three Levels of Consciousness

Freud believed in three **levels of consciousness**. The first level of consciousness is the conscious mind, that part of the mind that is aware of the present and functions only when the person is awake. It represents the smallest part of the mind and directs an individual's rational, thoughtful behavior.

The second level of consciousness is the preconscious. The preconscious (or subconscious) is the part of the mind in which thoughts, feelings, and sensations are stored. Although materials stored in the preconscious mind are outside of awareness, they can be brought to the conscious mind with the proper stimulus, such as a direct question.

The third level of consciousness is the unconscious. The unconscious represents the largest part of the mind and is the storehouse for all of the thoughts, feelings, and sensations experienced during the individual's lifetime. The individual is rarely aware of the unconscious mind, except when it demonstrates its presence through dreams, slips of the tongue, unexplained behavior, jokes, and lapses of memory (Taylor, 1994). These thoughts, feelings, and sensations cannot be recalled at will, but nevertheless exert a powerful influence on the person's behavior. Belief in the existence of the unconscious is the basis for the saying "All behavior has meaning."

### Structure of the Personality

The second major concept developed by Freud is the **structure of the personality**. Freud believed that the personality consists of three aspects, the id, the ego, and the superego. The id is part of and derived from the unconscious. It is unlearned, primitive, and selfish. The id does not have a sense of right and wrong, and ruthlessly insists on immediate satisfaction of its impulses and desires, which are

geared toward avoiding pain and experiencing pleasure. The personality of newborns consists solely of the id, a belief that is not difficult to accept when one observes the behavior of infants. They may, for example, cry lustily when hungry, regardless of the social appropriateness of such behavior. Even mature adults experience unceasing pressure from the id to satisfy its demands. The other parts of the personality are responsible for keeping the id under control.

The ego develops as a result of the infant's interaction with its environment. It establishes an acceptable compromise between the crude, pleasure-seeking strivings of the id and the inhibitions of the superego through reality testing. Reality testing is a process the ego employs to ascertain the likely consequences of behavior. The ego is the practical part of the personality. As an individual matures, the ego becomes the rational, reasonable, conscious part of the personality and strives to integrate the total personality into a smoothly functioning, coherent whole. In the mature adult, the ego represents the self to others and individualizes the person from other human beings (Taylor, 1994).

Chronologically, the superego develops last. The superego acts as the moral judge of the individual based on what the person has learned from significant others, such as parents and teachers. It operates mostly at the unconscious level and controls the id. The two aspects of the superego are the conscience, which punishes individuals through guilt and anxiety when their behavior deviates from the strict standards of the superego, and the ego ideal, which rewards individuals with feelings of well-being when their behavior achieves those standards believed desirable by the superego. Neither the punishing nor the rewarding functions of the superego are based on the reality of the situation. Rather, they are based on the individual's internalized standards of right and wrong and good and bad that were learned at an early age and are stored primarily in the unconscious (Taylor, 1994).

Freud believed that when id impulses unacceptable to the superego threaten to emerge, the individual experiences anxiety. **Anxiety** is a diffuse, vague sense of impending doom, and is always perceived as a negative emotion. Therefore, the person experiencing anxiety works to get rid of this feeling, often through the use of **ego defense mechanisms**, mental mechanisms derived from the ego that are designed to effect a compromise between the demands of the id and the superego to relieve anxiety. Ego defense mechanisms operate on the unconscious level, although an objective observer may be able to discern when others are using them. For example, a student who perceives herself as very intelligent but who fails a test may rationalize this otherwise anxiety-producing outcome by telling herself and others that the test was not important. Persons with whom she shares this belief may be very aware that she is using the ego defense mechanism of rationalization. **Table 1-1** details commonly used defense mechanisms.

In contrast to the unconscious nature of defense mechanisms, **coping mechanisms** are conscious mental strategies or behaviors the individual employs to lower anxiety. The various coping mechanisms cannot be listed because their number is as great as the creativity and resourcefulness of human beings. Coping mechanisms are categorized as short-term or long-term.

Short-term coping mechanisms are designed to address the immediate problem. For example, a person experiencing a great deal of work-related stress may drink alcohol as a means of coping. Although this action may relieve the immediate anxiety, it does not address the source of the stress or prevent the anxiety from reemerging. In contrast, long-term coping mechanisms address the cause of the anxiety and are likely to benefit the individual more than short-term coping mechanisms. Some examples are relaxation techniques, biofeedback, exercise, assertiveness training, setting goals, clarifying communications, visualization and guided imagery, meditation, yoga, seeking out peer support, and self-hypnosis.

### Psychosexual Theory of Personality Development

Freud also defined the developmental stages of personality. His theory of personality development is termed the **psychosexual theory of personality development**. Prior to this theory, children were seen as miniature adults. Freud claimed that personality is a dynamic, evolving process that develops from birth through young adulthood. Freud's stages of psychosexual development are oral (birth to 18 months), anal (18 months to 3 years), phallic (3 to 6 years), and genital (13 years to adulthood).

Although specific portions of Freud's theory are now viewed as an outgrowth of the Victorian era in which he lived, his theories provided the foundation for the work of subsequent theorists. Erik Erikson expanded Freud's theory of personality development to include the entire life span, and emphasized the importance of culture as a

Anxiety is a diffuse, vague sense of impending doom and is perceived by the individual as a negative emotion.

One way in which people control their anxiety is through ego defense mechanisms, which operate on an unconscious level. Coping mechanisms (short-term or long-term) are conscious mental strategies or behaviors used to lower anxiety and adjust to demands in a purposeful manner.

Freud developed the psychosexual theory of personality development. He claimed that personality develops in stages (oral, anal, phallic, latency, genital) from birth through young adulthood.

Erik Erikson expanded Freud's theory of personality development to include the entire life span from a psychosocial framework. Erikson's theory is known as the Eight Ages of Man—trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation, and ego integrity versus despair.

**Table 1-1 Ego Defense Mechanisms**

| Defense Mechanism | Definition | Example |
|---|---|---|
| Compensation | Exaggerating one trait to make up for feelings of inadequacy or inferiority in another dimension. | A physically small man verbally bullies his employees. |
| Displacement | Attributing feelings to a person or object that are really directed at another person or object. | A young woman kicks her cat after a telephone argument with her boss. |
| Denial | Failing to perceive some threatening object or event in the external world. | A woman sets a place for dinner for her husband, who has just been killed. |
| Fixation | Remaining "stuck" in a developmental stage. | A husband depends totally on his wife for most of his activities of daily living. |
| Sublimation | Redirecting socially unacceptable urges into socially acceptable behavior. | An angry, hostile young man becomes a boxer. |
| Reaction formation | Substituting directly opposite wishes for one's true wishes. | An adult who grew up in a very messy home is compulsively neat in his or her own home. |
| Identification | Integrating desired attributes of an admired person to compensate for perceived inadequacy. | A shy adolescent girl styles her hair identically to that of a popular rock star. |
| Introjection | Incorporating another person to avoid the threat posed by the person or by one's own urges. | A psychotically depressed woman attempts suicide to kill her mother, who she states is in her stomach. |
| Undoing | Engaging in certain thoughts and actions so as to cancel out or atone for threatening thoughts or actions that have previously occurred. | A business executive studies to become a nursery school teacher after having an abortion. |
| Isolation | Severing the connection between the thoughts and feelings associated with an event so the event can remain conscious without undue anxiety. | A single parent talks unemotionally about her only child's recent diagnosis of a malignant brain tumor. |
| Rationalization | Substituting a fictitious, socially acceptable reason for the genuine, unacceptable reason for one's wishes or actions. | "I would have helped you if I could, but I had to take my dog to the vet." |
| Repression | Forcibly dismissing anxiety-producing thoughts, feelings, or events from consciousness. | A woman is unable to remember being raped by her brother when she was 10 years old. |
| Regression | Returning to patterns of behavior characteristic of a less anxiety-producing stage of development. | A 6-year-old girl begins to wet the bed at night after her mother's remarriage. |
| Projection | Attributing to others an objectionable trait or feeling that really emanates from oneself. | "My husband is cheating on me." |
| Symbolization and condensation | Using a neutral idea or object to represent an unacceptable idea or object. | A 40-year-old man has unconscious feelings of inadequacy as a male and spends all his money on guns and all his time polishing and cleaning them. |
| Conversion | Expressing unconscious emotional conflicts through a physical symptom with no demonstrable organic basis. | A young woman wakes up paralyzed from the waist down on the morning of her wedding day. |

From Taylor, C. M. (1994). *Essentials of Psychiatric Nursing* (p. 211). St. Louis: Mosby Yearbook. Reprinted with permission.

major determinant of personality development. Erikson's theory of psychosocial development is called the Eight Ages of Man and encompasses trust versus mistrust (infancy, 0 to 1 year), autonomy versus shame and doubt (early childhood, 1 to 3 years), initiative versus guilt (preschool, 3 to 6 years), industry versus inferiority (school age, 6 to 12 years), identity versus role confusion (adolescence, 12 to 18 years), intimacy versus isolation (young adulthood, 18 to 25 years), generativity versus stagnation (adulthood, 25 to 45 years), and ego integrity versus despair (older adulthood, 45 years to death).

## Interpersonal Model

The interpersonal model was first developed by an American-born psychiatrist, Harry Stack Sullivan (1892–1949). Sullivan believed the most critical factor in the development of the individual's personality, and thus his or her behavior, is the person's relationship with significant others.

Sullivan believed that all human behavior is goal-directed toward the fulfillment of two needs, the need for satisfaction and the need for security. The **need for satisfaction** derives from the person's biologic needs for air, food, sex, shelter, and so on. The **need for security** derives from the person's emotional needs for feeling states such as interpersonal intimacy, status, and self-esteem. When these needs are perceived, internal tension results and the individual employs a variety of methods to meet them and thereby reduce the tension. Sullivan termed these methods **dynamisms**. He emphasized that dynamisms are age-specific, which helps to explain the characteristics of each stage of personality development, from infancy (birth to 18 months), childhood (18 months to 6 years), juvenile (6 to 9 years), preadolescence (9 to 12 years), early adolescence (12 to 14 years), and late adolescence (14 to 21 years). During infancy, the oral cavity is used almost exclusively to meet the needs for satisfaction (by crying to be fed) and the needs for security (by crying to be held). Therefore, the stage of infancy is characterized by the oral dynamism, because it is the means through which the individual establishes interpersonal contact to meet needs and reduce tension (Taylor, 1994).

The concept of anxiety is central to Sullivan's theory. He postulated that anxiety is a response to feelings of disapproval from a significant adult. These feelings of disapproval may not be based on reality, and the adult whose disapproval is feared may be real or a symbolic representation. Sullivan believed that people defend against such anxiety by using **security operations**, including apathy, somnolent detachment, selective inattention, and preoccupation. Individuals use **apathy** by not allowing themselves to feel the emotion associated with an anxiety-producing event. Thus, an individual appears indifferent in a situation expected to elicit a great deal of anxiety in most persons. **Somnolent detachment** is a primitive defense in which the individual falls asleep when confronted by a highly threatening, anxiety-producing experience. More common is **selective inattention**, in which anxiety-producing aspects of a situation are not allowed into awareness, enabling the individual to maintain a sense of stability. Finally, the security operation of **preoccupation** manifests as a consuming interest in a person, thought, or event to the exclusion of the anxiety-producing reality.

Sullivan defined the **self-concept** as the result of reflected appraisals of significant others. He believed that the development of the self-concept begins in the stage of infancy and is closely related to the quality of the infant's feeding experiences. If infants frequently experience satisfaction and security from the mothering they receive during the feeding process, they begin to see themselves as worthwhile individuals; they start to develop what Sullivan refers to as "good me" self-concepts. However, if their needs for satisfaction and security often are not met, anxiety results and infants believe they are not worthwhile; this lays the foundation for the development of "bad me" self-concepts. In extreme cases where infants are severely deprived or when the majority of interpersonal relationships are fraught with great threats to their existence, infants defend themselves by dissociating the anxiety-generating experiences. As a result, because they cannot develop a sense of self from reflected appraisals, infants develop a "not me" self-concept, which may lead to severe emotional problems.

Once developed, the self-concept tends to self-perpetuate because people behave in a manner consistent with their self-concept and elicit interpersonal responses from others that reinforce their self-concept. Persons with good me self-concepts tend to relate to others in a positive way, eliciting positive responses that reinforce the self-concept. People with bad me self-concepts tend to relate to others in a manner that reflects their poor view of themselves and, predictably, elicits responses that reinforce this view. Anxiety occurs when others' responses are incongruent with the person's self-concept. People deal with this anxiety by utilizing security operations that enable them to ignore

The interpersonal model is based on relationships. Harry Stack Sullivan believed that all human behavior is goal-directed toward the fulfillment of two needs, the need for satisfaction and the need for security. When these needs are perceived, internal tension results, and the individual uses dynamisms to relieve the tension.

People defend against anxiety by using the security operations of apathy, somnolent detachment, selective inattention, and preoccupation.

The self-concept is the result of reflected appraisals of significant others and may include "good me," "bad me," and "not me."

differing input. This theory helps to explain why some persons succeed against all odds and others fail despite all advantages.

## Behavioral Model

Ivan Pavlov developed the theory of classical conditioning in which events and reactions become associated. B. F. Skinner developed the theory of operant conditioning, which addresses the relationship between voluntary behavior and the environment.

Unlike the psychoanalytic and interpersonal models, **behavioral models** are concerned with the here and now, not with how or why people developed the behavior they currently exhibit. Ivan Pavlov (1849–1936) was the first behavioral researcher. His work on classical conditioning is well known to all students of psychology. **Classical conditioning** focuses on involuntary behaviors, such as blinking and salivation. In classical conditioning, a person has a reaction to a neutral event because the reaction and the event have become associated. For example, a person who exhibits the involuntary symptoms of anxiety (pounding heart, rapid respirations) when he or she sees a picture of a tall building somehow has learned to associate tall buildings or heights with danger.

The theory of **operant conditioning** has been credited to B. F. Skinner (1904–1990) and his associates. Operant conditioning is concerned with the relationship between voluntary behavior and the environment. Skinner demonstrated that behaviors are influenced by their consequences; those behaviors that have a positive consequence increase in strength and are likely to be repeated, whereas behaviors that result in negative consequences are weakened and are less likely to be repeated (Stuart, Laraia, & Sundeen, 1998).

A desired behavior can be increased through positive and negative reinforcement. Behavior is decreased through punishment, response cost, and extinction.

Increasing a desired behavior is achieved through positive and negative reinforcement. **Positive reinforcement** rewards the desired behavior. For example, a person who receives a pay raise because he or she produced more widgets is likely to continue trying to produce even more widgets, assuming that he or she values an increase in pay. **Negative reinforcement** increases the frequency of a behavior by reinforcing the behavior's power to control a negative stimulus. For example, children quickly learn which behaviors are likely to prevent their parents from yelling at them.

Jean Piaget was the first theorist to describe cognitive development (sensorimotor, preoperational, concrete operations, formal operations).

Decreasing behavior is a more difficult task. It is achieved through punishment, response cost, and extinction. **Punishment** is an aversive stimulus that occurs after the behavior and serves to decrease its future occurrence. For example, a child whose parents make him take a "time out" by standing in the corner every time he uses a swear word is likely to decrease his use of swear words after several time outs. In **response cost**, a person experiences a loss or penalty as a consequence of engaging in a certain behavior. The teenager who is "grounded" 1 day for every 5 minutes she is late coming home from a date is likely to arrive home on time after several experiences of being grounded. **Extinction** is the process of eliminating a behavior by ignoring or not rewarding it. Repeatedly ignoring a child's temper tantrums is an example of extinction. Efforts to increase or decrease behavior require a plan of treatment that is consistently implemented and avoids unintended secondary gains, such as getting much-desired attention.

## Cognitive Models

**Cognitive models** of development examine the perceptual and intellectual growth of the individual. Although individuals appear to follow a pattern in cognitive development, such timetables can be very individual. Children often appear to develop in one area while falling behind in others (e.g., learning to talk before or after walking, but not simultaneously).

An early cognitive theorist of the 1930s named Jean Piaget (1896–1980) focused on the process involved in a child's ability to know and understand. Like Freud, Piaget's theories are less accepted by today's therapists. However, he was the first theorist to postulate the different maturation cycles involved in how children gain an awareness of self through cognitive abilities. His stages of cognitive development include: sensorimotor (birth to 18 months), preoperational (2 to 7 years), concrete operations (6 to 12 years), and formal operations (12 years to adulthood). For more on this topic, see Chapter 24.

## Developmental Models

There are a variety of developmental models offered by theorists that assist one in understanding how growth and development impact upon an individual's mental health. These include:

- An attachment model (John Bowlby, 1907–1990) based on the establishment of trust, bonding, and attachment as essential to the survival of the human species.
- A behavior modification model in which children are taught how to establish controls from within and that there are consequences (natural, logical, and unrelated) to one's behavior.

- A psychosocial model (Erik Erikson, 1902–1994) based on the importance of trust as a basic building block for normal psychological development, that includes eight stages of developmental growth (see Chapter 24).

## Neurobiologic Model

In the last several decades, it has become apparent that an understanding of the brain and the nervous system is basic to understanding the symptoms, processes, and treatment of mental illnesses and disorders. Molecular biology is the foundation for molecular psychiatry.

Psychiatric-mental health nurses and other clinicians are increasingly challenged to understand neurons, neuronal transmitter brain receptors, ion channel variants, and intercellular neuronal molecules and their effect on neural circuits, and ultimately, the behavior of individuals. The **neurobiologic model** and its associated psychopharmcologic treatments will be driving forces in the next era of psychiatric interventions. For most clients, pharmacologic treatment controls the main symptoms of the mental illness or disorder and is used in conjunction with supportive therapies such as individual psychotherapy, group therapy, family therapy, and self-help groups (see Chapter 4).

The neurobiologic model and its associated psychopharmacologic treatments are the driving forces in the next era of psychiatric-mental health care.

## Selected Nurse Theorists and Their Conceptual Models

Several nurse theorists stress the interpersonal dimension of nursing in their conceptual models and believe that some form of personal interaction with clients is the basis of the profession. A brief description of some of these theorists and their models follows.

Nurse theorists such as Peplau, Orlando, King, Orem, and Riehl-Sisca emphasize the interpersonal dimension of nursing in their respective conceptual models.

## Hildegard Peplau

Hildegard Peplau has had the greatest impact on the development and practice of psychiatric nursing. Although Peplau has held a number of significant positions, she is best known for initiating and developing the graduate program in psychiatric nursing at Rutgers, where she was the director from 1954 until her retirement in 1974. Her textbook, *Interpersonal Relations in Nursing*, first published in 1952, significantly changed psychiatric nursing from a medical model to an interpersonal model in which the nurse has a major role in therapeutic interventions. It was empowering to nurses and the nursing profession at a critical time when their contributions to the care of patients were not recognized. Furthermore, her theories were widely applicable to the practice of nursing in all settings and with all types of patients. The major concepts of Peplau's theories are **psychodynamic nursing**, the **nurse-patient relationship**, and nursing roles.

As described by Marriner-Tomey, "Psychodynamic nursing is being able to understand one's own behavior to help others identify felt difficulties, and to apply principles of human relations to the problems that arise at all levels of experience" (1998, p. 327). The therapeutic nurse-patient relationship is the concept for which Peplau is best known. She describes an interaction between the nurse and patient as having four distinct yet overlapping phases: orientation, identification, exploitation, and resolution. In the orientation phase there is a "felt need," and professional assistance is sought by the patient. Identification occurs after the patient has clarified the situation and begins to respond selectively to the various healthcare practitioners. In the exploitation phase, the patient has identified with a specific nurse and makes full use of all offered services. The resolution phase occurs as the patient gradually relinquishes identification with the caregivers (nurses and others) and is once again independent (Peplau, 1952).

Finally, Peplau describes six different nursing roles that emerge in the various phases of the nurse-patient relationship: stranger, resource person, teacher, leader, surrogate, and counselor. The roles change with the patients and the circumstances. Peplau emphasized that skill in these roles is developed only through practice and with ongoing, competent supervision.

No other nurse has had a greater impact on the development and practice of psychiatric nursing than Hildegard Peplau. The major concepts of Peplau's theories are psychodynamic nursing, the nurse-patient relationship, and nursing roles.

## Ida Jean Orlando (Pelletier)

Orlando's first book, *The Dynamic Nurse-Patient Relationship: Function, Process and Principles of Professional Nursing Practice*, was published in 1961. Of all Orlando's work, this book's theories, emphasizing the reciprocal relationship between patient and nurse, have had the greatest impact on psychiatric nursing.

Orlando was one of the first leaders of nursing to emphasize the elements of the nursing process and the critical importance of the patient's participation during the nursing process (Marriner-Tomey, 1998). As with Peplau's theories, Orlando's theories apply to all nurse-patient interactions.

*The Dynamic Nurse-Patient Relationship: Function, Process and Principles of Professional Nursing Practice*, written by Ida Jean Orlando and published in 1961, emphasizes the reciprocal relationship between patient and nurse.

The conceptual framework Imogene King formulated represents personal, interpersonal, and social systems as the domain of nursing.

## Imogene King

Imogene King's first book, *Toward a Theory for Nursing: General Concepts of Human Behavior*, was published in 1971. King's theory of goal attainment is heavily based on systems theory. The conceptual framework she formulated represents personal, interpersonal, and social systems as the domain of nursing (Marriner-Tomey, 1998).

The self-care deficit nursing theory was developed by Dorothea E. Orem and is based on an interactive process between the nurse and the patient.

## Dorothea E. Orem

Dorothea E. Orem's first book, *Nursing: Concepts of Practice*, was published initially in 1971. Orem's theory, termed **self-care deficit nursing theory**, describes how the actions of nurse and patient are determined by the patient's self-care agency, "the complex acquired ability to meet one's continuing requirements for care that regulates life processes, maintains or promotes integrity of human structure and functioning and human development, and promotes well being" (Marriner-Tomey, 1998, p. 190). Nursing is an interactive process based on the amount and kind of nursing agency needed.

Joan Riehl-Sisca applies the sociologic theory of symbolic interactionism to nursing.

## Joan Riehl-Sisca

Joan Riehl-Sisca applies the sociologic theory of symbolic interactionism to nursing. Riehl-Sisca believes that

> . . . the nurse must view the actions of the individual as he perceives them. By role playing, explicitly or implicitly the nurse is able to understand why the patient does what he does and is thus better able to identify the source of difficulty, or nursing diagnosis. Then, having interpreted the patient's action and studied the process recordings, the nurse is able to intervene with a plan of care. The plan of care involves helping the patient and/or family assume roles they have used in the past, or are currently using, to cope with the present illness. The evaluation process is then used to determine the success of this "role taking." (Marriner-Tomey, 1998, p. 373)

Individual therapy focuses on the person. Almost all conceptual models are now implemented as types of individual therapy.

## Individual Therapy

**Individual therapy** focuses on the person and includes other aspects of the person's life only as they relate to the individual. Psychoanalysis was the original form of individual therapy, although almost all conceptual models are now implemented as types of individual therapy. Individual therapy continues to be the most commonly used form of mental health therapy, although most therapists agree that treating individuals in the absence of their social support groups is the least desirable form of treatment.

Family therapy is based on the belief that the person who is identified as ill exhibits symptoms that emanate from problems within the family system.

## Family Therapy

Although all nurses are concerned with the family's impact on the client, only those educated as advanced practice psychiatric nurses function as family therapists. Family therapy is based on the belief that the person identified as ill, the identified client, exhibits symptoms that emanate from problems within the family system. Therefore, treatment of the identified client in isolation from his or her family is doomed to failure. Two of the theoretical bases of family therapy are family systems therapy and **structural family therapy**.

Family systems therapy is based on the belief that families are systems in which change in one aspect of the system affects the entire system.

**Family systems therapy** was developed by Murray Bowen in the 1950s, and is based on the belief that families are systems in which change in one aspect of the system affects the entire system. Therefore, when there is a change in the functioning of one family member, the entire family is affected. Family systems theory consists of seven interlocking concepts. Three concepts apply to overall characteristics of family systems: differentiation of self, triangles, and the nuclear family emotional system. The other four concepts are related to the central family characteristics: multigenerational transmission process, family projection process, sibling position, and emotional cutoff (Stuart et al., 1998).

Bowen believes that a member's movement toward either increased emotional closeness or distance is reflexive and predictable. The higher the level of differentiation, the higher the level of functioning. Differentiating the self from "weness" is the ultimate goal of treatment (Stuart et al., 1998). Family genograms are commonly used to depict the familial emotional system through generations (**Figure 1-5**). A **genogram** is a diagram or map of multiple generations of a family indicating family relationships, life events, family functioning, and significant developmental events. Men are represented by boxes, women by circles. Other symbols and lines represent births,

**Critical Thinking Question** Which of the above nursing models do you think would be most useful in the practice of psychiatric-mental health nursing, and why?

## Treatment Modalities

Based on the conceptual models used by the therapist and an assessment of the needs of the client, a treatment modality is selected, implemented, and evaluated. The following briefly describes the most commonly used treatments.

A genogram is a map of a family for several generations. It is a very useful picture that reveals multigenerational patterns. An example of a genogram is shown here.

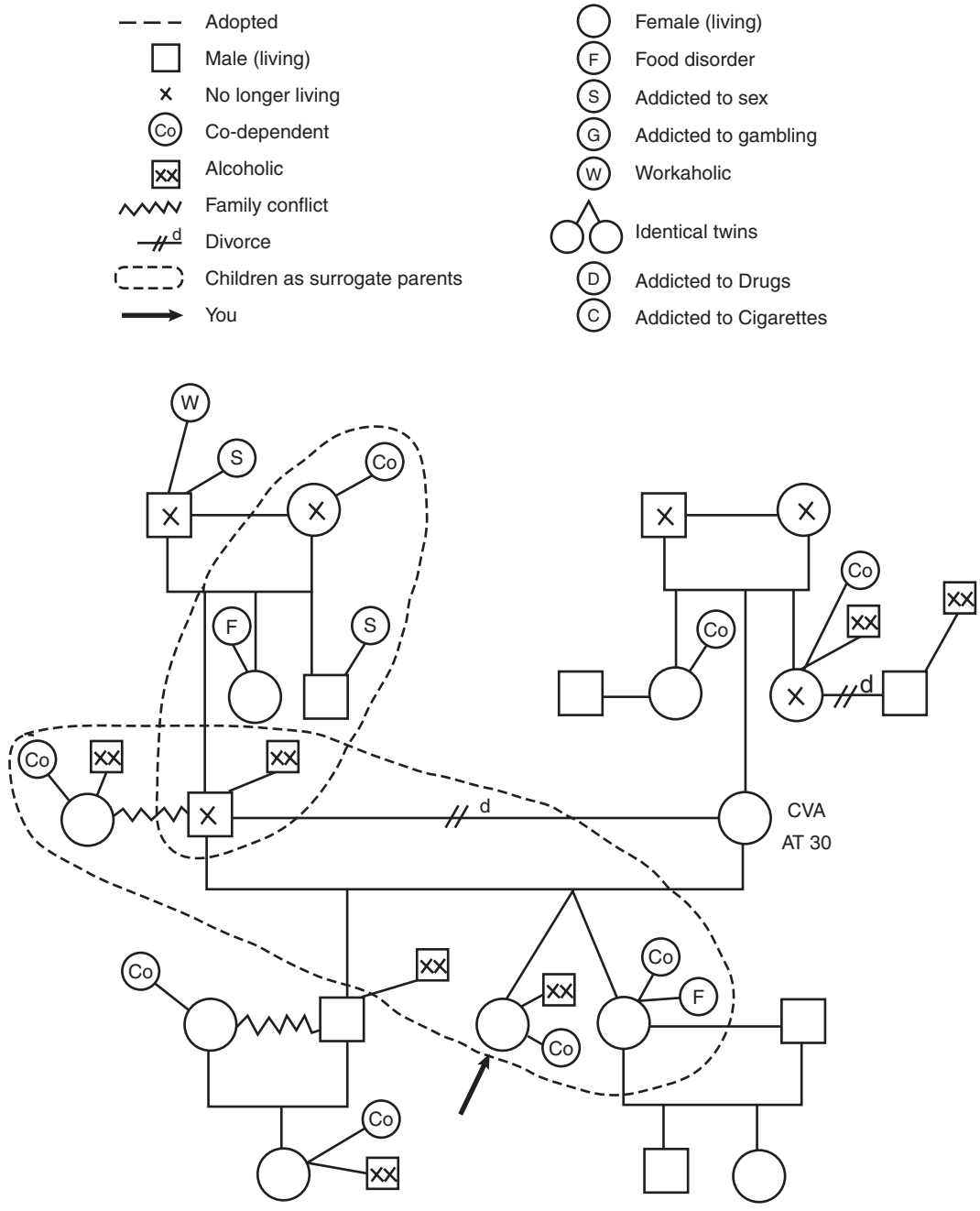


**Figure 1-5** **An example of a genogram.**

deaths, marriages, cohabitation, children, pregnancies, adoptions, divorces and separations, ethnic and religious origin, health and illness, risk factors, and geographic locations.

Structural family therapy is based on understanding the individual within a social context.

Structural family therapy was developed by family therapist Salvatore Minuchin. It is based on understanding the individual within a social context. Minuchin postulated that behavior is a consequence of the family's organization and the interactional patterns between members. Changing the family organization and the feedback processes between members changes the context in which a person functions. Thus, the person's inner processes and behavior change (Stuart et al., 1998).

## Group Therapy

**Group therapy** became a standard intervention for the treatment of persons diagnosed with a mental illness during and immediately after World War II. A group is an identifiable system composed of three or more individuals who engage in certain tasks to achieve a common goal. The therapeutic group differs from a social group because its goal is to assist individuals to alter their behavior patterns and to develop new and more effective ways of dealing with the stressors of daily living. This goal may be achieved through many forms of group therapy, including task groups, socialization groups, self-help groups, psychotherapy groups, teaching and learning groups, and supportive therapy groups.

The therapeutic group differs from a social group because its goal is to assist individuals to alter their behavior patterns and to develop new and more effective ways of dealing with the stressors of daily living.

There are four developmental phases for all groups: the preaffiliation phase, the power and control phase, the working phase, and the termination phase.

Regardless of their type, all groups go through four developmental phases, and certain group behaviors characterize each phase. The first phase is the preaffiliation phase, during which members become acquainted with each other and develop trust in one another and in the group leader. Some groups are never able to move beyond this first phase. If the group is successful in achieving trust, it enters the second phase, termed the power and control phase. During this phase, intragroup conflict is experienced as members test each other and the group leader. If this phase is successfully negotiated, the group enters the third phase, termed the working phase. During this phase, the goal of the group is addressed directly. For example, in a task group the members are now able to address the task the group was formed to accomplish.

Group theorist Irvin D. Yalom identified 11 operative factors that influence the therapeutic efficacy of groups.

The final phase is the termination phase. Group members integrate what they have learned about themselves and the behavioral changes they have made so that they can use these skills in the future. The success of the group is determined to some extent by the skill of the group leader or co-leaders whose interventions must be appropriate to the group's development. For example, the question "What is our purpose?" in the first phase is likely to be an attempt to set boundaries and orient group members. Therefore, a direct, factual answer is most appropriate. The same question asked during the next stage of group development is likely to represent a testing behavior and is best answered by reflecting the question back to the group as a whole.

Group theorist Irvin D. Yalom has identified 11 operative factors that appear to account for the therapeutic efficacy of groups: the imparting of information, the instillation of hope, universality, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, existential factors, catharsis, and group cohesion (Yalom & Leszcz, 2005).

## Milieu Therapy

**Milieu therapy** is the use of the environment as a therapeutic tool. The basis of milieu therapy is the belief that all human beings are affected by their physical, social, and emotional climate. Therefore, the physical, social, and emotional climate may be structured to help those who have a mental illness. For example, research has documented that clients who are acutely ill respond best to a structured, consistent, and non-stimulating environment. In contrast, individuals with a mental illness who are well enough to live in the community often benefit from treatment environments they have actively helped to create and maintain (Taylor, 1994). Therapeutic treatment settings have the following characteristics:

- The client's physical needs are met.
- The client is respected as an individual with rights, needs, and opinions and is encouraged to express them.
- Decision-making authority is clearly defined and distributed appropriately among clients and staff.
- The client is protected from injury from self and others, but only those restrictions necessary to afford such protection are imposed.
- The client is afforded increasing opportunities for freedom of choice, commensurate with his or her ability to make decisions.
- The staff remains essentially constant.
- The environment provides a testing ground for the establishment of new patterns of behavior.

Milieu therapy is the use of the environment as a therapeutic tool.

- Emphasis is placed on social interaction between and among clients and staff, and the environment's physical structure and appearance facilitate this interaction.
- Programming is structured but flexible.

The **therapeutic community** is a type of milieu therapy that strives to involve clients in their therapy, restore their self-confidence by providing many opportunities for decision making, increase their self-awareness, and focus their attention and concern away from the self and toward the needs of others. This treatment modality has been most successful with groups of clients who are in contact with reality (Taylor, 1994).

The therapeutic community is a particular type of therapeutic environment that has been very successful for clients who are in contact with reality.

## Crisis Intervention

A **crisis** is a "state of disequilibrium resulting from the interaction of an event with the individual's or family's coping mechanisms, which are inadequate to meet the demands of the situation, combined with the individual's or family's perception of the meaning of the event" (Taylor, 1994, p. 456). Thus, not every untoward event precipitates a crisis state in all individuals and families. Crisis intervention is of great interest to mental health professionals, because it provides a specific opportunity to prevent mental illness and to promote mental health. Research has documented that there are three potential outcomes to a crisis state: (1) the individual or family may re-integrate at a lower or less healthy level of functioning than the one before the crisis; (2) the individual or family may re-integrate at the same level of functioning as previously; or (3) the individual or family may re-integrate at a higher, healthier level of functioning than the level before the crisis experience. This last potential outcome promotes mental health and is most likely to be achieved with skilled intervention.

A crisis results when the individual's or family's coping mechanisms are inadequate to deal with the demands of a particular event, causing a state of disequilibrium.

There are two types of crises, developmental and situational. The events that precipitate **developmental crises** are predictable and occur in conjunction with normal developmental transitions with which the individual and family are not prepared to cope. For example, the demands placed on a young couple by the birth of their first child may precipitate a crisis state if their idea of parenthood was fashioned by romantic notions of baby powder and teething biscuits. Developmental crises may be averted by **anticipatory guidance**, an educative process in which individuals and families are prepared for the normal life changes expected at each stage of development and are told about successful coping strategies. Self-help groups and books are common sources of anticipatory guidance.

In contrast, **situational crises** are precipitated by unpredictable events for which people cannot prepare, such as the sudden death of a child. Whereas the death of one's parent is a normal developmental event, the sudden death of one's child is an untoward event for which no one can be prepared. In such events, parents have no recourse other than general coping strategies, such as their religious faith and family cohesiveness. If these are adequate, a crisis state may be averted. If these or similar strategies do not exist or are insufficient, a crisis state occurs.

There are three potential outcomes to a crisis state and two types of crises, developmental and situational.

The goal of crisis intervention is to assist the individual and family to seek new and useful adaptive mechanisms within the context of the social support system. The steps of crisis intervention are deceptively simple: clients must achieve an accurate perception of the event that precipitated the crisis state, become aware of the human and material resources available to assist them, and learn how to manage their feelings. Even though these three steps seem simple, the crisis intervention counselor often spends hours helping clients tell and retell their experiences to identify the significance of the events and to identify and plan the use of resources. This process often must be repeated several times, but the reward of promoting the mental health of clients more than justifies the amount of time spent and the flexibility required.

The goal of crisis intervention is to assist the individual and family to seek new and useful adaptive mechanisms within the context of the social support system.

## Somatic Therapies

**Somatic therapies** are physiologically based interventions designed to produce behavioral change. Somatic therapies are based on the belief that an inextricable relationship exists between the mind and the body. In other words, the dichotomy between mind and body and between mental and physical illnesses is false. The most commonly used somatic therapies are electroconvulsive therapy (ECT) and pharmacologic therapy. These interventions are discussed in depth in Chapters 5 and 16.

Somatic therapies are physiologically based interventions designed to produce behavioral change. The most commonly used somatic therapies are ECT and pharmacologic therapy.

# The Therapeutic Relationship

Many consider the therapeutic relationship between nurse and client the hallmark of psychiatric nursing. In 1947, *Nurse-Patient Relationships in Psychiatry* by Helena Willis Render was published. Render was the first to introduce the

The therapeutic relationship between the nurse and client is a hallmark of psychiatric-mental health nursing.

idea that the relationship the nurse establishes with the client (patient) has a significant therapeutic potential. However, it was the 1952 publication of *Interpersonal Relations in Nursing* by Dr. Hildegard E. Peplau that essentially revolutionized the teaching and practice of psychiatric nursing in the United States. Peplau's text focused on the therapeutic potential of the one-to-one relationship at the same time that psychotropic drugs were starting to be used, enabling clients (patients) to benefit from interpersonally based treatment modalities (Taylor, 1994).

**Critical Thinking Question** What factors contribute to making the therapeutic relationship between the psychiatric nurse and the client the hallmark of psychiatric nursing?

To be truly helpful to clients, nurses need to understand the difference between professional and social relationships. Social relationships are interactions in which the needs of both persons are of equal importance. In contrast, professional relationships are those in which the needs of the client are paramount. To engage in professional relationships with clients, nurses must have a highly developed degree of self-awareness. Self-awareness means that nurses know those areas in which they are emotionally vulnerable, although they may not have an understanding of why these vulnerabilities exist.

Nurses need to understand the difference between professional and social relationships. A relationship exists between the client and nurse only when they become significant to each other.

All intentional interactions with clients that are helpful are considered therapeutic. However, not all nurse-client interactions constitute a relationship. A relationship exists between the client and the nurse only when they become significant to each other (i.e., the opinion of the other makes a difference in how one views oneself). When this occurs, the potential for corrective emotional experiences exists. If it is achieved, the relationship becomes therapeutic.

There are three phases of the nurse-client relationship: the orientation phase, the working phase, and the termination phase.

Nurses need to be aware that boundaries are critical in maintaining a professional therapeutic relationship. At the beginning of the relationship, an agreement or contract between the nurse and client should be established. This is an excellent opportunity to establish the rules and behaviors or boundaries that are expected between the nurse and client, such as the time and frequency of meetings; reimbursement for services; contact with family members, significant others, and other therapists; and prohibition against socialization.

## Phases of the Nurse-Client Relationship

There are three phases of the nurse-client relationship. The initial phase is termed the *orientation phase* or *getting acquainted phase*. During this phase the nurse and client agree on a mutually acceptable contract that establishes the relationship's parameters. The goals of this phase are to develop trust and to establish the nurse as a significant other to the client. Although consistency and acceptance are desirable during all phases of the relationship, these behaviors are essential during the orientation phase. The client learns to trust the nurse only if the nurse is able to convey acceptance of the client (as a parent would of a child) and exhibit consistent behavior. Interestingly, once the client begins to trust the nurse, he or she may engage in behaviors designed to test the nurse's sincerity. During this stage, clients commonly arrive late for an appointment. Although the nurse should not condone all the client's behaviors, it is important to consistently convey acceptance of the client as a valued, worthwhile person.

Once trust has been achieved, the second phase of the relationship ensues. This phase is termed the *maintenance* or *working phase*. The goal of this phase is to identify and address the client's problems. Therefore, this phase is characterized by the highly individualized nature of the problems being addressed. During this phase the nurse assumes one or more of the roles identified by Peplau—socializing agent, counselor, or teacher—as the nurse and client tackle the issues facing the client.

The final phase of the relationship is the *concluding* or *termination phase*. The goal of this phase for both the client and nurse is to integrate helpful experiences so that what has been learned may be used in future relationships. Paradoxically, the more successful the relationship, the more emotionally painful is the termination. As a result, both the nurse and client are tempted to deny the inevitable and pretend that their parting is only temporary. They may use phrases such as "Keep in touch," "I'm sure we'll run into each other," and "See you later." These strategies are comforting in the short term but do not help either in the long run.

The therapeutic relationship remains the most useful tool available to nurses who work with a mentally ill client. However, the effectiveness of the relationship depends on the nurse's self-awareness.

## Summary

Historically, mentally ill persons have been poorly treated by society, suffering abandonment, beatings, starvation, and imprisonment. More humane models of treatment were short-lived until the recent advent of therapeutic models of care and the availability of reliable psychopharmaceuticals. Because of the current scope and complexity of the burgeoning knowledge about the causes and treatment of mental illness, it is necessary for the multidisciplinary treatment team to work closely together to achieve the goals of preventing mental illness and effectively treating those who are ill.

The major conceptual models are the psychoanalytic, interpersonal, behavioral, cognitive, developmental, and neurobiologic models. These models of care are supplemented by the conceptual nursing models of Peplau, Orlando, King, Orem, and Riehl-Sisca. The treatment modalities commonly utilized include individual, family, group, milieu, and somatic therapies, with consideration of the need for crisis intervention. Establishing a professional therapeutic relationship is critical. The therapeutic nurse-client relationship is the hallmark of psychiatric nursing.

## Annotated References


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This text presents a discussion of the theories of all major nurse theorists. A lengthy reference list for each theorist is included.

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This standard text about group psychotherapy covers all aspects of group psychotherapy with helpful hints for addressing difficult situations.


## Additional Resources


Beers, C. (1923). *A mind that found itself.* New York: Doubleday.
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