INTRODUCTORY

Mental Health Nursing

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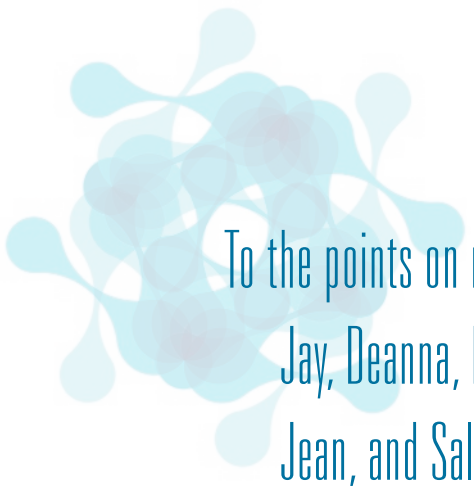

To the points on my compass that help guide me:
Jay, Deanna, Kathryn, Kinley, Deloris, Mary, Paula,
Jean, and Sally.

—Cynthia

Preface

New to This Edition

- NEW! Cultural Considerations boxes familiarize you with cultural, ethnic, and religious considerations that may affect care.
- NEW! Test Yourself recall exercises throughout each chapter help you identify areas you have mastered and areas requiring further review.
- UPDATED and redesigned Nursing Process sections in all chapters on specific disorders clarify each step in the nursing process.
  - NEW! Two Nursing Care Focus subsections were added to each Nursing Process section with examples of goals, implementations, and evaluations of outcomes to help you understand how the nursing process can be applied to the care of mental health clients.
- UPDATED! Language reviewed and revised for inclusive terminology that strengthens your clinical communication.
- REVISED and IMPROVED Case Studies:
  - NEW! Each case study now includes a picture of the client to help you immerse yourself in the scenario and focus on client care.
  - UPDATED! Case Studies have been added so all chapters have a minimum of two per chapter.
- STREAMLINED Appendices, including two NEW Appendices:
  - Sample Patient Health Questionnaire-9 (PHQ-9)
  - Sample Abnormal Involuntary Movement Scale (AIMS)
- UPDATED! Key Terms in each chapter with a REVISED Glossary in the back of the book for a quick review of all Key Terms and definitions included in the text.
- UPDATED! Student Worksheet in every chapter with new and revised questions to test your understanding.
- NEW! Chapter 17 has been heavily revised and renamed from "Sexual Disorders" to "Mental Health Issues Related to Gender Identity and Sexuality," broadening the focus to discuss mental health concerns of people with a range of sexual and gender identities. Content in this chapter has been updated with the latest terminology, discussion of historical social discrimination, and a tool to help nurses self-assess beliefs that may influence care.

A Note From the Author

I am excited to present the fifth edition of this textbook. It is my mission to continue to update and streamline the basic principles and foundations of mental health nursing for the LPN/LVN student. As mental health is a component of the whole client, it is essential for every nurse to have a basic understanding of the essential information presented in this text to provide holistic nursing care to a variety of clients in a variety of settings. Awareness has been made to keep the focus of the text on the nursing model of care. It is my intent that the fifth edition of this textbook will continue to help students better understand mental health and its presence and impact in the nursing care of all clients.

LPN/LVN student nurses do not always have the opportunity for in-depth inpatient psychiatric unit experience, but they will encounter mental health concerns and issues in a variety of health care settings as both students and graduates. To help supplement their learning experience, case studies are included in every chapter to help the student tie the content to potential situations they may encounter. I have attempted to discuss different practice settings and functional roles of the LPN/LVN.

This book presents mental health and illness by first establishing the essential groundwork related to this subject. Unit I presents an overview of mental health concepts including cultural, ethnic, and religious influences. A basic understanding of how mental health is viewed and approached is essential for caring for clients from multicultural and diverse backgrounds. Factors that affect mental health are also discussed in this unit. Stress, anxiety, grief, and loss are discussed along with variations of human responses to these factors. The delivery of mental health care, including historical views, is presented. The section on outpatient and community mental health details information on services offered in various settings. The various practice settings for mental

health care are included to provide an all-encompassing picture of how mental health is a common encounter for the nurse in every health care setting. Legal and ethical considerations, including client rights and nursing accountability, are addressed. The unit concludes with an overview of various theories of personality and psychological development to help provide a foundation for understanding human behavior.

In Unit II, the treatment process is discussed, beginning with an introduction to the treatment team, holistic and different approaches to treatment, and the client's role. The various types of psychotherapy are presented along with an overview of psychotropic medications used in the treatment of mental illness. The importance of establishing a therapeutic relationship between the nurse and the client is described. Difficult client situations, including the impact of anger, violence, bullying, and abuse are discussed. The subjects of crisis and suicide prevention are presented including client risk factors, exhibited behaviors, nursing interventions, and nursing care.

Unit III looks at the fundamental nursing roles in mental health nursing. This unit begins with a discussion of therapeutic communication. Techniques that facilitate communication and interactions with the mental health client, as well as what can hinder them, are discussed. A detailed discussion of the nursing process, including specifics to mental health nursing, is provided. Application of the nursing process in relation to mental health is included as part of the chapter case studies.

Unit IV deals with specific mental health disorders. The different disorders are discussed in terms of symptoms exhibited, risk factors, populations seen in, and treatments for the disorder. Medications, including action and therapeutic use, are incorporated into the discussion of treatment. Current research and references are used to substantiate the information presented and are also included in the end-of-chapter bibliography. Nursing care of the client with a mental illness specific to the chapter topic is described in the Nursing Process section.

Unit V examines disorders that have diagnostic criteria or are influenced by age. The first chapter in the unit is on disorders specific to the child and adolescent, and those that are commonly first diagnosed in childhood or adolescence. The final chapter addresses issues and types of mental disorders seen in older adults.

To help supplement the content, there are several features throughout every chapter to aid the LPN/LVN student's understanding. Opening each chapter are chapter objectives, which are written concisely and purposefully to guide learning outcomes. They are also intended to provide an outline for the student as they read the chapter. Key terms are boldfaced in the manuscript to provide easy access to their meaning. In addition, the key terms are listed in the glossary for easy reference. Enhanced features for content understanding are presented multiple times throughout every chapter in the form of specialty call-out boxes. Thought-provoking questions are presented to encourage critical thinking in the "Mind Jogger" boxes. Important information is summarized or added in "Just the Facts" boxes. A new feature has been added, the "Test Yourself" box, which helps to break up the chapter and provides an opportunity for students to quiz themselves on the information presented. Boxes and tables are located throughout the chapter to give the student a summary of information in an easily viewed and compressed format. A minimum of two case studies are integrated into each chapter to provide opportunities for reflection and content application. Last, another new feature, the "Cultural Considerations" box, has been added at the end of each chapter to provide multicultural information related to a topic in the chapter.

Each chapter is followed by a study guide, or worksheet, with various methods of appraising the student's recall of the content presented. This component is designed for the student to practice deductive thinking and reasoning. Questions are written so that the answers are easily discernible after reading the chapter. Terminology and key terms are reinforced through completion and matching exercises. Multiple-choice questions are written using an NCLEX item-writing format to help prepare the LPN/LVN student for entry-level testing. Included are questions that ask the student to select all answers that are applicable. An answer key is provided for all worksheets at the end of the textbook. A supporting bibliography for content is provided at the end of each chapter that includes internet addresses to references as applicable.

Building Clinical Judgment Skills

Nursing students are required to obtain nursing knowledge and apply foundational nursing

processes to practice effective clinical judgment. Being able to apply clinical judgment in practice is critical for patient safety and optimizing outcomes. The content provided in this text includes features such as Case Studies; Nursing Process Sections; and Mind Jogger, Test Yourself, and Just the Facts boxes that strengthen students' clinical judgment skills by giving them opportunities to apply knowledge and practice critical thinking. In addition, accompanying products CoursePoint and Lippincott NCLEX-PN PassPoint provide an adaptive experience that allows students to build confidence by answering questions like those found on the Next Generation NCLEX (NGN) examination.

Inclusive Language

A note about the language used in this book: Wolters Kluwer recognizes that people have a diverse range of identities, and we are committed to using inclusive and nonbiased language in our content. In line with the principles of nursing, we strive not to define people by their diagnoses, but to recognize their personhood first and foremost, using as much as possible the language diverse groups use to define themselves, and including only information that is relevant to nursing care.

We strive to better address the unique perspectives, complex challenges, and lived experiences of diverse populations traditionally underrepresented in health literature. When describing or referencing populations discussed in research studies, we will adhere to the identities presented in those studies to maintain fidelity to the evidence presented by the study investigators. We follow best practices of language set forth by the *Publication Manual of the American Psychological Association, 7th edition* but acknowledge that language evolves rapidly, and we will update the language used in future editions of this book as necessary.

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To further facilitate teaching and learning, a carefully designed ancillary package has been developed to assist faculty and students.

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An exciting set of free learning resources is available on thePoint® to help students review and apply vital concepts in mental health nursing. Multimedia engines have been optimized so that students can access many of these resources on mobile devices. Students can access all these resources at http://thepoint.lww.com/Kincheloe5e using the codes printed in the front of their textbooks.

- **Journal Articles** offer access to current research relevant to each chapter and available in Wolters Kluwer journals to familiarize students with nursing literature.
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I close by restating what Donna so eloquently stated in the 4th edition, and what I also heartfully believe and acknowledge: "I am thankful most of all to my Heavenly Father for blessing me with the ability to give back to others what experience has taught me. My hope and prayer is that the students who read and study this textbook will continue to offer knowledgeable and compassionate care to those who search for the balance of mental health and those who encounter the challenges of mental illness along life's path."

Contents

Appendices

Unit I | Introduction to Mental Health and Mental Illness

1 Mental Health and Mental Illness

LEARNING OBJECTIVES

After learning the content in this chapter, the student will be able to:

1. Describe the nature of mental health and mental illness.
2. Describe factors that influence mental health.
3. Describe how culture affects the perception of mental health.
4. Differentiate between adaptive and maladaptive coping strategies.
5. Define stress and its relationship to anxiety.
6. Identify factors that contribute to stress and anxiety.
7. Differentiate between the four levels of anxiety.
8. Identify and describe different types of grief.
9. Describe grief as a process.
10. Describe the different stages of grief.
11. Discuss ways to assist individuals to cope with the grieving process.

KEY TERMS

adaptation
adaptive coping
anticipatory grief
anxiety
bereavement
conventional grief
cultural identity
distress
dysfunctional grief
eustress
external stressors
"fight-or-flight" response
grief
internal stressors
job-related burnout
loss
maladaptive coping
mental health
mental illness
palliative coping
reframing
stress
stress reaction
unresolved grief
visualization

Defining Mental Health and Mental Illness

We exist in a society composed of many different types of people. Although genetics provides a blueprint for the physical body, the human mind is unique in that it contains a combination of thoughts, perceptions, memories, emotions, will, and reasoning. Each of these is developed as the individual grows, thinks, feels, and reacts to the world around them. The individual interprets, and interacts with, their own thoughts in a private way, with the ability to communicate them to others as they choose. The well-being of this aspect of the body may be referred to as the state, or health, of the mind. While the terms "mental health" and "mental illness" sound similar, they are actually two different concepts.

Mental Health

Many large bodies (e.g., Centers for Disease Control and Prevention, World Health Organization, American Psychiatric Association, and National Alliance on Mental Illness) have defined mental health. While their definitions vary slightly, **mental health** involves the components of emotional, psychological, and social well-being; the balance between the individual's cognitive, behavioral, and emotional states; and the individual's ability to handle stress and adversity, relate to others, emote (express) their feelings, and make healthy choices.

There are many factors that influence an individual's mental health. These include socioeconomic, biologic, and environmental factors. In addition, mental health is affected by the individual's ability to realize their own abilities; to work productively (examples of work can include, but are not limited to, attending school, holding a job, or tending a family); contribute to their community or family; and to enjoy life. It is important to understand that mental health is *not* characterized by the absence of a mental illness.

Mental health impacts the way an individual sees their surroundings, how they think, and the decisions they make. How the individual feels about themselves and those around them has an influence on how they cope with life and meeting the expectations it creates. The ability to act independently, directed by inner values and strengths, to face life with assurance and hope, and seek a meaningful balance between work, play, and love produces satisfying relationships with others. Further evidence of mental health is seen in the ability to function well alone or with others, to make sound judgments and accept responsibility for the outcomes, to love and be loved, and to adapt when faced with adversity.

Mental Illness

Definitions of mental illness, like mental health, vary slightly depending upon the focus of the organization defining it. In **mental illness**, the individual demonstrates a change in one or more of the following: emotions (sometimes referred to as mood), thinking, or behavior. These changes are accompanied by problems relating to others in personal, work, or social relationships or an inability to perform activities of daily living (ADLs).

In the individual with mental illness, interpersonal relationships are often stressed or ineffective as mental distress impacts the emotional stability and coping efforts of the individual. Thinking is often distorted as misconceptions and thinking errors take the place of rational and realistic processing. The distress experienced in the mind sets in motion the behavioral patterns characteristic of the various mental disorders. Box 1.1 lists some warning signs that might indicate a mental illness. Since medical issues can present with symptoms similar to those of a mental condition, the client who presents for medical or mental health treatment should have data collected for both possibilities.

BOX 1.1

Warning Signs of a Mental Health Issue

- Changes in eating or sleeping routines
- Feelings of hopelessness or like nothing matters
- Increase in drinking or illegal drug use
- Withdrawing from close family and/or friends and/or activities
- Hyper or reckless activity
- Hearing voices that others do not hear
- Thoughts of self-harm, or harming others
- Neglecting activities of daily living (eating, bathing, dressing, work, or caring for dependents)
- Change in thinking that include illogical ideas or magical thinking (e.g., believing that one can control the behavior of a television character)

Adapted from Parekh, R. (2018). *Warning Signs of Mental Illness.* American Psychiatric Association. https://www.psychiatry.org/patients-families/warning-signs-of-mental-illness

TABLE 1.1 Comparison of Mental Health and Medical Conditions

Mental Health Condition(s)	Symptoms	Medical Condition(s)
Anxiety	Sweating, headaches, tremors	Hyperthyroidism, Pheochromocytoma
Depression	Lethargy, increased sleeping, weight gain, difficulty concentrating	Hypothyroidism
Schizophrenia, Bipolar	Psychosis	Systemic lupus erythematosus

Chapter 2 also details medical issues that have major psychological effects.

Table 1.1 lists some common mental health conditions that have similar symptoms to medical conditions.

Causes and descriptions of mental disorders vary. Reasons for these variances include, but are not limited to, the organization's focus of treatment, the individual's response to medications or treatment, and the culture of the individual or the health care professional.

Often the terms "mental illness" and "mental disorders" are used interchangeably. For the purpose of this textbook, "mental disorder" will refer to a specific, or group of similar, conditions while "mental illness" will encompass a broader issue or a global discussion of disorders.

Impact and Incidence of Mental Illness

Mental illness is seen in all cultures, socioeconomic levels, and genders. The National Institute of Mental Health (NIMH) estimates that in 2019 there were 51.5 million adults in the United States that have some form of a mental condition that ranges from mild to severe. This is roughly 20.6% of the population (close to 1 in 5 adults). This number does not include individuals with a developmental or substance use disorder. Most mental health hospitalizations are seen among individuals with a serious mental illness. Serious mental illness (SMI) is, "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (NIMH, 2022). The estimated number of those adults with serious mental illness in 2019 was 13.1 million, or 5.2% of the US population.

In 2019 the United States spent $225 billion on mental health services (Leonhardt, 2021). Although spending for mental health services has been increasing, there are still issues to access of care due to cost and lack of availability of services, compounded by stigma related to seeking, and receiving, mental health care.

Factors That Affect Mental Health

Mental health is achieved as the individual successfully maintains a balance between the ups and downs of everyday life. Daily there are enumerable issues encountered that require adaptation, both physically and emotionally. Stress, anxiety, grief, and loss are unavoidable issues of daily life, making it necessary for the individual to be flexible and adaptive. Faced with these challenges, their mental equilibrium may become temporarily disrupted. The ability to reestablish a stable state depends on them being able to utilize coping strategies and adapt.

Many factors influence mental health and the individual's perception of their mental health or mental illness. Cultural influences, including religion, help shape their view of what constitutes mental health, who the individual goes to for mental health advice, and acceptable treatment options. Additionally, mental health is affected by factors related to family, sleep, substance use, and exposure to trauma or violence. Coping strategies that the individual has experienced to be effective are utilized. Past experiences with stress, anxiety, grief, or loss help shape how the individual responds to the current situation.

Chapter 6 further discusses issues of anger, violence, abuse, crisis, and suicide. These all have the ability to disrupt an individual's mental state temporarily, with most individuals adapting and growing from the experience.

Cultural Heritage—Beliefs, Norms, and Values

Culture is a term that describes a common heritage and a set of social practices that are central to that group. This binding force between members of each group is often referred to as **cultural identity** and may include a common language, family structure, customs, country of origin, religious

and political beliefs, food, dress or clothing, traditions, and holidays. Factors related to the group to which an individual belongs also affect how they relate to other groups. Individual behavior often, but not always, mirrors that of their group and may be altered as changes occur within the group.

With so many cultures in the world, it is not surprising that variances can be seen among the exhibition, explanation, perception, coping, and management of mental health symptoms or issues. While some individuals may respond outwardly to life situations, others may be reluctant, or discouraged, from visibly showing emotional and mental problems. This expression can be influenced by their culture. The tendency to seek help from religious or faith healers within the cultural group rather than professional providers is common. Although many families meet the challenge of a member's mental illness by seeking professional care, the stigma and shame created by a mental illness can lead some families to hide or dismiss the issue and to deal with the affected person in their own ways. Some families may simply deny that a problem exists. Others may see the symptoms as a punishment or judgment for wrongdoing.

Religious coping may include prayer, religious music, talking to God or a higher power, reading religious materials, or meditation. Some cultural beliefs conclude that mental symptoms are related to witchcraft, demon possession, or substance use and can be eliminated by traditional healing remedies or a ritual. Rituals may include the use of prayer, touch, candles, eggs, pollen, roots, herbs, or religious medals. The ritual is often provided by those seen as healers within the group and viewed by the group as an acceptable practice.

Cultural approaches remain the customary choice for some individuals to manage mental illness regardless of the availability of mental health services. Different cultures have specific syndromes that involve mental health. These syndromes are involuntary, familiar to the members, widespread in the specific culture, and treated by a healer of that culture. These conditions are referred to as culture-bound syndromes. Recognizing the client may be experiencing a culture-bound syndrome is important to provide culturally appropriate care. Also, the nurse should explore the client's meaning of the terms used (e.g., what does it mean to the client when they talk about "nerves"?). Table 1.2 lists some of these syndromes and a generalized description of each.

Religion

Religion provides routine, structure, and coping for some individuals, while for others it may be a stressor. If the client identifies a religious preference, it is important for the nurse to obtain information on what practices the client finds beneficial and if there are parts that they identify as stressors. Some individuals may not practice an organized religion but may have spiritual practices that are important to them. Religious themes are frequently seen in mental illness, especially in themes of delusions or hallucinations that are seen in psychosis. For example, a client experiencing psychosis may draw a religious symbol or write out a specific religious term repeatedly.

Family

Similar to religion, the individual's family can either be a protective factor against, or a stressor that can exacerbate, mental health issues. A strong family system can provide the individual with needed support. Conversely, if the individual has a dysfunctional or absent family, the individual will need to rely on other support systems for help.

Culture can influence the way a family views mental illness and the support they provide. In some cultures, families may view the individual with mental illness as an embarrassment or disgrace to the family name; some may even go to the extreme and disown the individual. In other cultures, the family may deny the presence of the mental illness and be unwilling to provide support but still include the individual in the family. In both cases, the individual with a mental illness will need extra support from outside the family system.

In individuals with a long history of mental illness, the family may experience caregiver burnout and may no longer be able to provide support. It is important for the nurse to be nonjudgmental when caring for a person whose family is not acting as a support system.

Sleep

Sleep is an important component of mental health. An individual who has balanced sleep and is well rested is better equipped to face daily challenges. Sleep also enhances coping mechanisms. A lack of sleep can impair the individual's ability to cope and can magnify their mental health issues. An increase or decrease in sleeping habits is seen in mental health issues such as in manic

TABLE 1.2 Common Examples of Culture-Bound Syndromes

Syndrome	Predominant Culture(s)	Description
Amok	Malaysia Indonesia Philippines	An acute outburst of unrestrained violence, such as attempts to kill or seriously injure anyone encountered, and ends with exhaustion and amnesia.
Ataque de nervios	Latin America Mediterranean	Uncontrollable shouting, attacks of crying, trembling, heat in the chest and head, and verbal and physical aggression.
Brain fag	West Africa	Headaches, blurring or watering of eyes, difficulty grasping meaning of words, poor retention of information, and sleepiness while studying.
Dhat *Shenkui*	India China	Fear of loss of power due to loss of semen through premature ejaculation, masturbation, or from passing semen in the urine. Symptoms may include weakness, fatigue, palpitations, insomnia, guilt, or anxiety.
Hikikomori	Japan	Social withdrawal (usually longer than 6 months) and the individual exhibits a strong focus on personal interests or is apathetic with no interest in hobbies or activities.
Koro *shook yang*	Southeast Asia China	Extreme anxiety or panic that the penis will retract into the body or even may disappear.
Latah	Malaysia Indonesia	The afflicted person responds to a frightening stimulus with an exaggerated startle or jump, utters improper words, and imitates the words or movements of people nearby.
Piblokto	Some Inuit or arctic populations	Screaming, uncontrolled wild behavior, depression, insensitivity to extreme cold (such as running around in the snow naked), and echolalia.
Susto (also known as "fright sickness" or "soul loss")	Latin America	After a traumatic, or frightening, experience the individual has symptoms of nervousness, loss of appetite and strength, insomnia, listlessness when awake, depression, and introversion.
Taijin kyofusho	Japan	Excessive nervousness or fear in social situations, extreme self-consciousness, fear of contracting disease. Also an intense fear that they (or their body part or body function) will displease, embarrass, or offend others. The fear is of offending or harming other people with a focus on avoiding harm to others (rather than to oneself).
Zar	East Africa Middle East	Experience of spiritual possession, which may include dissociative episodes of laughing, hitting, singing or weeping. Apathy and withdrawal may also be seen.

Note: This is not a complete list. These are some of the more common syndromes discussed in various sources. Different cultures may have a syndrome with similar symptoms but with a different name.

Sources: Correll, C. U., Stetka, B. S., & Harsinay, A. (2018). *Culture-specific psychiatric syndromes: A review.* Medscape. https://www.medscape.com/viewarticle/901027#vp_1
Teodoro, T., & Afonso, P. (2020). Culture-bound syndromes and cultural concepts of distress in psychiatry. *Revista Portuguesa De Psiquiatria E Saúde Mental, 6*(3), 118–126. https://doi.org/10.51338/rppsm.2020.v6.i3.139

or depressive disorders. Tracking the individual's hours, and quality, of sleep is important in determining their mental health balance and the effectiveness of treatment therapies. Sleep, therefore, is an important vital sign in mental health nursing.

Substance Use

Substance use includes alcohol, medications, and illegal drug use. Individuals who use substances are at an increased risk for mental illness as the substance can cause changes to the brain's function and structure. An example of this is the individual who huffs an aerosol to get high. The aerosol physically damages the brain, leading to behavioral and cognitive changes.

Substance use is frequently seen in individuals who have an existing mental illness. Often the individual uses the substance to help cope with or lessen the symptoms of the mental illness. An example of this would be the individual with post-traumatic stress disorder (PTSD) who drinks alcohol to help forget the events that led to the post-traumatic stress disorder (PTSD). This is referred to as "self-medication."

Trauma and Violence

Exposure to trauma and violence can cause mental health issues. A child who is exposed to violence or trauma at a young age, when the brain is developing, is at risk for mental health issues. A traumatic

brain injury can create mental health issues in an individual who did not previously have a mental illness. Disorders that affect the brain, such as Parkinson disease or a cerebral vascular accident (CVA, also known as a stroke), can cause mental health issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) states that trauma is "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2019).

Coping

When dealing with stress and the unpleasant situations that cause stress, the individual will need to cope to manage the emotions that arise. The ability to cope is learned from previous unpleasant experiences and by observing how others deal with similar situations (e.g., children learn to cope with situations by watching and imitating family members). Coping can be either conscious or unconscious and learned or automatic. It can also be positive or negative. For example, after a busy day at work, the individual who practices 30 minutes of yoga "to unwind" would be demonstrating positive coping while the individual who drinks heavily to "forget about work" would be demonstrating negative coping.

In most situations, the sense of control an individual feels over a particular stressor determines how they think about or perceive it. The first step in coping with a threatening situation is to assess if it really is what it seems to be. Once this has been determined, options can be reviewed to resolve the problem. The solution may be trying to deal with the situation itself or trying to control the emotional reaction that is felt in response to the stressor.

Coping Strategies

Not everyone copes the same way in a similar situation. For example, a student who feels overwhelmed by requirements of a full semester course load with a fear of failing may decide to drop one or two classes to perform better in the remaining subjects while another student with the same course load may decide to work out in the gym each day, along with budgeting time between the required subjects. Both students coped with the similar situation in the way they felt was best for them—in other words, they used different coping strategies.

Coping strategies are the methods used to manage stress and anxiety. Coping strategies generally fall into four categories: adaptive, palliative, maladaptive, and dysfunctional. Adaptive and palliative coping strategies usually result in a positive outcome. On the other hand, maladaptive and dysfunctional strategies usually do not result in a positive outcome. Behavior is the result of the individual's perception regarding the situation and thought processes. Behavior provides a clue to the underlying motive for action.

An individual's successful management of stress or anxiety is referred to as **adaptation**. Therefore, when a rational and productive way of resolving a problem to reduce stress or anxiety is used, it is said to be **adaptive coping**. The students mentioned above both demonstrated adaptive coping skills, as they both took steps to address and successfully resolve their problems. Conversely, **palliative coping** is when the solution temporarily relieves the stress or anxiety but the problem still exists and must be dealt with again at a later time. Examples of palliative coping would be when a drama student feels anxiety as time for a performance approaches and asks a classmate to review the script to refocus on the lines. A second student who feels anxious about the performance goes jogging with music to relieve the anxiety and increase their mental alertness to remember the lines. For both students, the stressor of performing their lines still exists but the stress of learning the lines has been temporarily relieved.

If unsuccessful attempts are made to decrease the anxiety without attempting to solve the problem, the strategies are described as **maladaptive coping** and the stress or anxiety remains. For example, the drama student might decide to ignore the anxiety and go to a movie the afternoon before the performance and rapidly look over the lines immediately before going on stage. During the performance, they forget several lines and need to be prompted.

The individual who does not attempt to reduce the anxiety or solve the problem is considered to have dysfunctional coping. For example, another student decides to get drunk the night before the performance, fails to show up for the performance until the second act, and is replaced by their understudy.

Mind Jogger 2 Does avoidance of a conflict situation create or reduce anxiety?

Promoting Adaptive Coping Strategies

In managing and coping with the anxiety experienced in response to stress, it is important to accept and deal with the anxiety rather than fight it. Stress is a part of life. The individual has a choice to replace negative feelings with more positive ones. They can stand back and look realistically at the situation while functioning along with the anxiety. The outcome is rarely as bad as what is feared the most. Negative thoughts drive a perception that the worst is likely to happen. Coping strategies, whether adaptive or maladaptive, are learned by observation of those who model them in the family and social environment. When dealing with life stressors, the individual tends to use the coping skills that they know best.

Nurses play a major role in helping clients cope more effectively with anxiety. To help clients deal with their stress levels, the nurse must learn to handle their own stress. Each success the individual has in dealing with an anxiety-producing situation provides a foundation for helping to manage or control the anxiety the next time. Two examples of effective coping strategies are reframing and visualization.

Reframing is a way of restructuring thinking about a stressful event into a form that is less disturbing and over which the individual can have some control. Table 1.3 illustrates examples of how irrational beliefs can be reframed into rational thoughts. By changing the view to a more realistic expectation, the individual can pursue a solution more effectively.

Visualization involves mentally viewing a place of peaceful solitude to allow the individual a momentary reprieve from the stress (e.g., visualizing a vacation spot or pastime that brings relaxation such as imagining oneself on the seashore listening to the sounds of water and seagulls). The reprieve provides a temporary defense of withdrawing from the anxiety, gives the individual renewed energy, and is another effective means of coping with stress.

Test Yourself

- ✔ Describe the difference between mental health and mental illness.
- ✔ How does palliative coping differ from adaptive coping?
- ✔ Name seven factors that can affect mental health.

Stress and Anxiety

Stress and anxiety can arise from any thought or issue that creates frustration or a feeling of uneasiness. Situations are seen differently by everyone with some things being stressful to one and not to another. What causes the uneasy feeling is not necessarily apparent to the person experiencing it, which adds to the tension experienced.

Defining Stress

Stress is defined as the condition that results when a threat or challenge to one's well-being requires the person to adjust or adapt to the environment. There are two kinds of stress: distress and eustress. **Distress** is a response to a threat or challenge and is harmful to one's health. This is a negative stress and demands an exhausting type of energy. **Eustress**, on the other hand, is positive and motivating, increasing one's confidence in the ability to master a challenge or stressor. This type of stress may enhance the feeling of well-being. For example, eustress is demonstrated in a football player whose stress about an upcoming football game challenges them to play better. Distress, on the other hand, might be seen in the student who is disqualified from the football team because of poor grades, resulting in a feeling of low self-worth.

TABLE 1.3 Examples of Reframing Irrational Thoughts

Irrational Belief	Restructured Positive Thought
I always mess things up.	Even if things didn't turn out right this time I can do it differently next time.
He never does what I want him to do.	If I want him to do something I need to communicate that to him.
She never pays any attention to me.	If I give her more attention, she might be more attentive to me.
I should have done better on the exam.	I can study harder and do better on the next one.
I can't be happy unless I am loved by the person I really care about.	If this person does not return my love, I can give my energy to finding someone better.

Figure 1.1 Stress is a common experience. Common sources of stress include work, family, financial problems, and world events.

Stress is further defined in terms of acute or chronic stress. Acute stress is the reaction to an immediate threat, commonly called the **"fight-or-flight" response**, occurring when there is a surge of the adrenal hormone epinephrine (also known as adrenaline) into the bloodstream. It is referred to in this way because it provides the energy or instant strength to either fight the threat or danger or run away from it. This type of response can occur in situations where there is a sense of imminent danger, such as when walking in a darkened parking lot or upon losing track of a child in a crowd. The response is usually reversed to a relaxation mode once the danger is past. Chronic stress occurs when the situation is ongoing or continuous, such as chronic illness of a family member or job-related responsibilities (Fig. 1.1).

There are common symptoms that are seen in both acute and chronic stress (Box 1.2). Common symptoms of stress generally fall into four categories: physical, mental, emotional, and behavioral. The physical response to the stressor, or the **stress reaction**, is triggered by the arousal of the autonomic nervous system.

Just the Facts

When the perception of a stressful situation lessens, the stimulation to the autonomic nervous system decreases and symptoms of stress begin to resolve.

Defining Anxiety

Anxiety is defined as a feeling of apprehension, uneasiness, or uncertainty that occurs in response to a real or perceived threat. It is an automatic and unconscious biologic response to a stressor that cannot be controlled by the conscious mind. Anxiety is an unavoidable natural occurrence that is an instinctive response to a threat to the individual's well-being.

Anxiety is a basic emotion and occurs at a deeper level than fear. Fear is a reaction to a specific, defined danger. Normal anxiety is necessary for survival and provides the energy needed to manage daily life and pursue life goals. One may experience acute anxiety when faced with a short-term stressor, such as undergoing surgery or a series of diagnostic testing. When anxiety persists over a long period, such as when an individual experiences a chronic illness, the individual may demonstrate symptoms of chronic fatigue, insomnia, poor concentration, or impairment in work and social functioning. If the feelings of anxiety become too overwhelming, those feelings may then be expressed through behavior.

Anxiety can be thought of as a smoke detector that alerts the senses to the possibility of danger and prepares the individual to respond by either flight or fight. When the "alarm" sounds, it prevents logical thinking about the situation. Therefore, anxiety may be present whether or not an actual danger exists. Anxiety can cause the individual to act impulsively not only when there is actual danger but also when there is the perception of a possible threat, allowing logical

BOX 1.2

Common Signs and Symptoms of Stress

- Increased heart rate and blood pressure
- Heart palpitations
- Increased respirations
- Abdominal cramping, nausea, diarrhea
- Headaches
- Insomnia
- Lack of concentration and memory
- Difficulty in making, or inability to make, decisions
- Forgetfulness
- Confusion
- Anxiety
- Nervousness
- Irritability
- Frustration and worry
- Fidgety movements
- Nail-biting
- Smoking or drinking
- Yelling
- Throwing objects

and realistic thought processes to be overshadowed. Disorders related to anxiety are discussed in Chapter 9.

Just the Facts

Behavior is the result of perceptions and thought processes related to a particular situation.

There are four levels at which anxiety may occur, with each level more severe than the previous one. The levels are mild, moderate, severe, and panic. The severity of the anxiety is determined by an individual's perception of the situation and their reaction to the stressor. This is exhibited in their physical, emotional, and mental behaviors. Regardless of the level of anxiety, the individual experiences an internal need to try to relieve the anxiety as soon as possible.

Mild anxiety is natural and motivating, increasing productivity and improving one's sense of well-being. Anxiety that increases to a moderate level becomes uncomfortable and difficult to tolerate for extended periods. If this level of anxiety is not relieved, it progresses to a severe state that is physically and emotionally exhausting. If steps are not taken to decrease a severe level of anxiety, the state of panic may develop, possibly leading to hysteria, suicide attempts, or violence. The physical and psychological symptoms for each level of anxiety are described in Table 1.4.

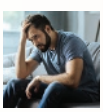
Contributing Factors to Stress and Anxiety

An individual can experience both external and internal stressors (Box 1.3). **External stressors** are adverse aspects of the environment, such as an abusive relationship or poverty-level living conditions. **Internal stressors** are from within the individual and can be physical, such as a chronic illness or terminal condition, or psychological, as in continued worry about financial burdens or a disaster that may never happen. Chronic stress is known to have physical consequences on the body. Stress increases the heart rate, blood pressure, and the release of the hormone cortisol. Over time, this can increase the individual's risk for hypertension, myocardial infarction, and cerebral vascular accident (CVA, also called a stroke).

Both positive and negative aspects of life include stress. For example, an individual experiencing their first day on the job after a promotion might experience a pounding heart and tense muscles as they adapt to the new position. By contrast, an environment of everyday stress such as marital discord or a difficult work environment may eventually pose a threat to the individual's health. It is important to recognize that many times external circumstances are viewed as the cause of stress, but in reality, most stress is created from the individual's perception of the circumstances. Irrational thinking tends to overgeneralize and exaggerate the situation, which gives the thoughts an "all or

CASE STUDY 1.1

"Viktor"



YAKOBCHUK VIACHESLAV/ Shutterstock

You are working in the emergency department (ED) when a client, Viktor, is brought in by paramedics after he was involved in a low-speed car accident involving his vehicle and a city bus. You have collected the following data: he did not lose consciousness, denies pain, and there are no apparent injuries. He was restrained and the airbag deployed. His pulse is 102 and bounding, B/P 156/90. He has stated several times that he feels the need to urinate and is mildly diaphoretic. You notice he is quietly lying on the stretcher but is wringing his hands and patting his pockets as if looking for something. As you continue to collect data on Viktor he keeps repeating "I was hit by a bus" and "It was my wife's new car." His speech is slightly increased. You are trying to reinforce the information given to him by the health care provider and he occasionally interrupts with "I was hit by a bus" in a very matter-of-fact manner.

Digging Deeper

1. *What signs/symptoms of anxiety does Viktor have?*
2. *What level of anxiety would he be experiencing?*
3. *What interventions are important for the nurse to include based on his level of anxiety?*

TABLE 1.4 Common Signs and Symptoms of Anxiety

Level of Anxiety	Physical Symptoms	Psychological Symptoms
Mild Level	Increased awareness Increased energy Slight discomfort Restlessness Irritability Mild tension-relieving behaviors (fidgeting, nail-biting, foot-tapping, lip-chewing)	Sharp perception of reality Alert and aware of environment Able to identify things producing anxiety Motivated Preoccupied at times Good concentration Reasoning and logical thought processes Attentive
Moderate Level	Voice tremors Muscle tension Rapid speech—change in pitch Difficulty concentrating Shakiness Repetitive questioning Misperception of stimuli Inability to complete tasks Autonomic response Headaches, insomnia Pacing Decreased eye contact	Reduced perceptual ability Decreased attentiveness Needs things repeated to grasp Still functional but problem-solving ability decreased (requires guidance) Decreased motivation and confidence Increased irritability Feeling of being tied in knots Bouts of crying and outbursts of anger Inability to learn or problem-solve
Severe Level	Feelings of impending doom Confusion Purposeless activity Increased somatic complaints Hyperventilation Palpitations Loud and rapid speech Threats and demands Increased pacing Diaphoresis Poor or no eye contact Insomnia Rapid speech Eye twitching Tremors	Distorted perception of reality Attention to details—loses sight of whole picture Focused totally on self and anxiety Defensiveness Oversensitive to comments from others Verbal threats Lacks reasoning or logical thought processes Unable to problem-solve
Panic Level	Hysteria Incoherence Suicide attempts Violent behavior Unintelligible speech Feelings of terror, extreme fear Immobility Dilated pupils Withdrawal Out of touch with reality	Irrational and disorganized thought processes Absent perceptual ability Unaware of reality Unable to perceive environment Depersonalization Delusional thinking Disorientation

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BOX 1.3

Internal and External Stressors

EXTERNAL STRESSORS

- Physical environment (noise, bright lights, weather, crowds)
- Major life events (death of a loved one, divorce, loss of a job, marriage)
- Work-related (rules, deadlines, production pressures, gossip, being short-staffed)
- Social (bossy or aggressive persons, strained friendship, marital affairs)
- Everyday life (schedules, household duties, family conflict)
- Financial (bills, mortgage, bankruptcy)

INTERNAL STRESSORS

- Physical (chronic illness, terminal diagnosis)
- Personality traits (perfectionist, workaholic, worrier, loner)
- Negative self-talk (pessimism, irrational thinking, self-criticism)
- Thinking snags (all-or-none approach, unrealistic and inflexible expectations)

none" frame of thinking (e.g., "Nobody likes me."). This type of thinking also leads to anticipating the worst possible outcome for situations. This is illustrated by an individual who is hit by the car behind them while driving in traffic. Believing that if they ever drive a car again, they will have an accident, the individual no longer drives a vehicle.

Some events create more stress than others. Unpredictability of and lack of control over situations greatly increase the strain the stressor causes the individual. For example, a firefighter faces uncertainty and ongoing threat of danger or injury with each call of duty. Emotional triggers for higher levels of stress are those that are uncontrollable, repetitive, unexpected, and intense in nature. These are seen often in first responders and health care workers in critical care situations. Stress is greater and damage more likely in these situations, and can lead to job-related burnout or mental, physical, and emotional exhaustion.

Just the Facts

Job-related burnout is a condition of mental, physical, and emotional exhaustion with a reduced sense of personal accomplishment and apathy toward one's work.

Mind Jogger

What types of stress might be more damaging than others?

BOX 1.4

Techniques for Managing Anxiety

- Reframing irrational thinking
- Visualization
- Positive self-talk
- Assertiveness training
- Problem-solving skills
- Communication skills
- Conflict resolution
- Relaxation techniques
- Meditation
- Support systems
- Journaling
- Practical attitude
- Sense of humor
- Self-care (diet, exercise, sleep, leisure activities, avoiding caffeine and alcohol)
- Faith in spiritual power and in self

Managing Stress and Anxiety

Managing stress and anxiety is an ongoing process. To be most effective, techniques often need to be practiced before a stressful or anxiety-causing event occurs. Not every technique is effective for all individuals; therefore, the individual may need to use a "trial and error" approach to see what works best for them. In addition to reframing and visualization, some other effective techniques for managing anxiety are listed in Box 1.4.

Mind Jogger

How might failure to achieve one's ambition be seen as a positive experience?

Test Yourself

- ✔ Identify 10 common signs of stress.
- ✔ Name the four levels of anxiety and identify the thinking exhibited in each.
- ✔ What is the difference between internal and external stressors?
- ✔ Give an example of reframing.

Grief and Loss

Grief is defined as the emotional process of coping with a loss. This is often associated with the death of a loved one, such as a spouse, parent, or child, or of any person who is important in the individual's life. In a broader sense, the concept of grief can be applied to the loss of anything that is significant or meaningful to the individual.

With the loss, the attachment bond that is seen as strong and secure is suddenly shattered, making the person vulnerable to the emotional response. Grief is the emotion encountered when an individual is confronted with a loss. It is a feeling of sadness and despondency centered on the loss. These feelings may lead to behaviors such as forgetfulness and crying at unpredictable times. It is helpful for the person to be reassured that this is a common reaction to grief. Tears are accepted as a part of the healing that takes place in the months after the loss. How an individual mourns a loss is also influenced by their personal, familial, and cultural beliefs or customs. The amount of time allotted to the mourning period or how families may view sympathy and support during the time of sadness is often determined by these factors. For example, some prefer to be alone as they mourn a loss, while others may do so openly for a specified time or with specific rituals and family gatherings.

Although a person may experience sadness or sorrow in response to making a mistake or doing something that is hurtful to another, the grief felt as the person adjusts to the absence of the endeared person or object is a deeper and longer-lasting emotion that involves time and emotional energy.

Just the Facts

Grief is the process of working through the emotional response to loss, reorganizing one's life, and accomplishing some degree of resolution or closure.

Loss can be an actual or perceived change in the status of one's relationship to a valued object or person. This concept is easily associated with the death of a valued person or pet. The concept of loss can be applied to a separation or divorce, loss of a body part, threat to one's health, loss of a job or source of income, losses that result from a natural or imposed disaster, and the loss of an ideal (e.g., having a cesarean section when a vaginal delivery was most desired). Losing a home to fire or natural disaster is also a major loss, with a lifetime of memories suddenly gone from view and reality. Another type of loss involves the lack of certainty that a goal or desired outcome will be achieved, such as not receiving a job promotion or experiencing an academic failure.

All of these events or circumstances may leave the person with a sense of emptiness, hopelessness, and detachment from the meaning that previously was found in life. The extent to which emotional energy was previously invested in these objects, persons, and relationships will determine the intensity with which an individual responds to the absence of that object.

Developmental Understanding of Grief and Loss

Children and adolescents respond according to the level at which they understand the concept of death or loss. Table 1.5 shows how the response reflects the age-related cognitive and psychological developments of the child. For example, a toddler may respond to separation from a parent or attachment figure with anxiety but has no concept of loss. Should that attachment figure not return, the child will usually adapt to another attachment figure who is nurturing. The preschool child reacts with magical thinking. In magical thinking, the individual believes their ideas, thoughts, actions or words can cause a real event to happen. An example of this would be a 5-year-old child who says, "Grandpa died because I hit my brother." The concept of death as a finality is not yet understood. An example of this would be the 5-year-old child who says "Grandpa is sleeping. Will he wake up in time to take me to the park"? Associated with the growing moral concept of right and wrong, the school-age child may feel a sense of guilt or responsibility for a loss, such as when a parent is

TABLE 1.5 Age-Related Concepts of Loss

Age Group	Conceptual Understanding of Loss
Toddler	Egocentric and concerned with themselves Do not understand concept of loss
Preschool	Use magical thinking and may feel shame or guilt when thinking is associated with loss (i.e., belief that their behavior is reason a parent is gone such as in divorce) Primitive coping mechanisms result in more intense response Do not understand death or its permanence (e.g., believe that the deceased person will come back to play with them)
School-age	Still feel guilt and responsibility in associating negative actions with loss Respond to concrete, simple and logical explanation of death such as in the death of a pet Understand permanence of death and that some losses may be temporary
Adolescent	Able to understand the concept of death, but have difficulty accepting loss Perceive loss as a threat to their identity

absent following a divorce. Although adolescents understand the concept of death as finality, it is difficult for this age group to fit death or loss into their search for an identity.

Adults may view loss as temporary or permanent, and most adults are able to accept their losses and grow from these situations. Acceptance often opens the door of opportunity for new and expanded life experiences. An example of this is seen when one experiences failure in a given situation such as divorce, job promotion, or academic challenges. Failure, if viewed realistically, can allow the individual to try again and achieve more success. Learning what contributed to the loss can open the door to a new challenge. During this time the individual experiences **bereavement**, which is expected reaction of grief and sadness after a loss. It is important to remember that regardless of age or circumstances, bereavement is a natural, healthy, and healing process that emerges in response to any significant loss.

Mind Jogger

How might environmental factors during childhood affect a person's ability to cope with loss?

Types of Grief

Anticipatory grief may be seen in individuals and families who are expecting a major loss in the near future. This concept can help nurses understand the reaction of the terminally ill client and the family members who will be left to mourn the death of their loved one. In this case, death is inevitable, and there is a time of preparation and closure that can ease the emotional pain at the actual time of death. This is the premise for hospice care, which provides palliative nursing and supportive interventions to assist the client and family members in coping with the imminent loss. The nurse can also apply this concept to those in the acute care setting who may be anticipating the loss of a body part (e.g., amputation of a limb or a mastectomy) or change in body functioning (e.g., bowel diversion with a stoma creation or a chronic illness such as diabetes) that may inflict a major alteration in lifestyle.

Conventional grief is primarily associated with the grief that is experienced following a loss. The process of bereavement or adapting to loss may take days, weeks, or years, depending on the sense of loss for the person involved. Each person responds to loss in a personal and unique way and time. This response is based on the person's level of development, past experiences, and current coping strategies.

BOX 1.5

Contributing Factors to Dysfunctional Grief

- Socially unacceptable death such as suicide or homicide
- Missing person related to war, mysterious disappearance, or abduction
- Multiple losses or losses in close succession (loss of several family members in short period with financial loss or disaster loss)
- Ambivalent feelings toward the lost person or object
- Unresolved grieving from a previous loss
- Guilt regarding circumstances at or near the time of death
- Survivor's guilt (the survivor feels that they should have died with or instead of, the deceased)

Dysfunctional grief is a failure to complete the grieving process and cope successfully with a loss. If the person experiences a prolonged and intensified reaction, they may feel that life has become meaningless and that they are merely existing, longing for what is lost.

Chronic sorrow is seen in a situation where the grief resurfaces at times, but never fully goes away. For example, parents with a child who is developmentally disabled may experience periods of grief when their child does not reach milestones at the same rate, if at all, as others in their age group, such as learning to drive a car or get married.

Unresolved grief describes situations when the grief process is incomplete, and life is burdened with maladaptive symptoms continuing months after the loss has occurred. With unresolved grief, symptoms seen can include consuming feelings of worthlessness with suicidal tendencies; physiologic response to the loss with marked decrease in functioning; or delusional thinking or hallucinations of seeing the image or hearing the voice of the deceased. Factors that may contribute to unresolved grief, which can lead to dysfunctional grief, are listed in Box 1.5.

Grief as a Process

The grieving process includes a series of occurrences in the resolution of the loss. This process provides resolution as an individual works

BOX 1.6

Common Grief Reactions

- Anger
- Fear
- Guilt
- Anxiety
- Panic
- Blame
- Insomnia/excess sleeping
- Anorexia (loss of appetite)
- Inability to focus

through the feelings of anger, hopelessness, and futility that accompany loss. It provides time to put things into perspective, to place into memory that which is gone, and to emerge with a new perspective on life. Life is an evolving challenge of events that inevitably requires the individual to cope with disappointment and loss. Learning to deal with these situations in small increments better prepares them to deal effectively with a major loss. The individual can learn to accept loss as part of living or can choose to react negatively. If the anger that is seen naturally in grief is suppressed, the hidden feelings may eventually erupt in negative or maladaptive patterns of behavior such as substance abuse or suicidal ideation. Learning to cope or adapt to loss involves taking advantage of the right to grieve in whatever timeframe is needed to go through the process. The nurse should provide the grieving client with information regarding the feelings that are normal, and appropriate, to grieving (Box 1.6).

Growth occurs as the bereaved person comes to the point of letting go of the past. This does not reduce the importance of the loss but allows the person to continue living with new perspective. In time, the sadness and loneliness felt because of the void left by the cherished object are replaced with an acceptance that the loss is permanent. This acceptance indicates that the grief process is ending.

When the process of grieving becomes prolonged it may be considered atypical or maladaptive with symptoms of a major depressive episode such as extreme sadness, insomnia, anorexia, and weight loss. The person may dismiss emotional symptoms as part of the normal grief process but may seek professional help to treat physical symptoms like insomnia or appetite loss. In doing so, they can receive treatment for maladaptive emotional symptoms as well.

Mind Jogger

What objective signs might indicate a person has reached acceptance?

Stages of Grief

There are several theories that have evolved concerning the grief process, and while not absolute, theories that define distinct stages of grief supply a framework for understanding this process. A person may experience all stages in rapid succession or rally back and forth between stages, remaining in some longer than others. Perhaps the best-known theory of the stages of grief has been described by Dr. Elisabeth Kubler-Ross, a German psychiatrist. Dr. Kubler-Ross identified five stages that humans go through each time they are confronted with a loss or death. The stages are: denial, anger, bargaining, withdrawal/depression, and acceptance (Box 1.7).

The first step is denial that the event is happening, an immediate reaction of "this can't be real." This shock, or disbelief, is driven by an impulse to avoid the reality of the loss. The individual may act as if nothing has occurred or as though the lost object or person is still present. Denial actually allows for an adjustment period in which to gather coping strategies for the grieving work ahead.

Once the individual realizes the loss is real, the denial gives way to feelings of anger. Anger is expressed in many ways, often demonstrated openly in behaviors such as hitting an object or person, blaming someone for the loss (can include self-blame), or expressions of guilt. Some may turn the anger inward, resulting in physical illness or psychological dysfunction.

BOX 1.7

Stages of Grief

- Shock and denial
- Anger and pain
- Negotiation and bargaining
- Withdrawal and depression
- Acceptance and resolution

Anger usually is followed by bargaining as an attempt to postpone acceptance of the loss. As is often seen with terminal illness, this is a time when deals with God or a higher power are attempted as a way to prolong the inevitable. During this period, frequent labile moods are common and are often intermingled with continued anger and unwillingness to accept the loss.

The bargaining period is gradually followed by a deep sense of loss as the reality of what has happened, or is anticipated to happen, settles. At this point the individual may withdraw from social interaction, choosing to spend hours and days alone. Depression, the persistent and prolonged mood of sadness, is a normal response in this process while adjusting to the full impact of the loss and living without the loved object. As opposed to the persistent feelings of sadness and desolation that are seen in depressive disorder, in grief, these feelings may be intertwined with good days of positive emotions. The self-esteem of the survivor is usually intact, and their thoughts are primarily focused on the deceased. For some individuals, this period may be overwhelming, and recovery from the depth of sorrow felt is unlikely without professional support and guidance.

The final stage is acceptance. This is when the person begins to experience peace and serenity. This is the time of letting go and allowing life to provide new experiences and relationships.

Mind Jogger 2 How might body language indicate a sense of guilt or self-blame for a death or loss?

Coping with Grief and Loss

To deal effectively with clients experiencing grief, the nurse must first self-reflect on the reality of their own mortality, the concept of death, and any previous experiences they have had with death and how they perceive those events. The nurse develops their own response pattern toward death and loss that is conditioned by experience and by personal, cultural, and religious beliefs. Most clients experiencing a crisis of major proportion require assistance and support to help navigate the grief process. The nurse needs to respect, and attempt to understand, the unique manner of grieving for every individual.

It is important for the nurse to avoid clichés, such as, "I know how hard it is" or "It was for the best" or "I have been there before." The nurse does not know how the client feels and these statements are unhelpful, can minimize the grief, or may be viewed as hurtful by the grieving person.

Using open-ended statements (e.g., "Tell me what you are feeling now" or "Tell me about what has happened"), can help the nurse determine where the client is in the grieving process. The nurse should also determine what support systems the client identifies as available (e.g., family, friends, religious community) and what coping strategies they may have used in the past that could be used to deal with the present situation.

Using leading statements (e.g., "You seem to regret some things. Tell me about that."), the nurse can determine whether the client has any ambivalent feelings, guilt issues, anger, or feelings of helplessness. Remember that because the process of grieving is individualized, each client will progress in the stages of grieving at a different pace, with some clients taking longer than others.

Interventions that will assist individuals to cope during the grieving process should encourage clients to be open and honest about their feelings with reassurance that they are acceptable and normal as the process follows its course. Having the client journal their feelings or write a letter to the deceased can help to bring closure to the past relationship. Referral to a grief support group can provide additional help. Encourage the client to identify and utilize family, friends, religious, or other groups for meaningful support. Success is measured by the client's progress in establishing new relationships and putting the loss in perspective. A client who expresses hope for the future and reinvestment in personal interests is demonstrating a positive self-image that is separated from the past relationship.

Test Yourself

- ✔ How would a child in each developmental stage view death differently than an adult?
- ✔ Identify four different types of grief and give an example for each.
- ✔ Name the stages of grief.
- ✔ List three interventions that aid coping in the grieving process.

CASE STUDY 1.2

"Art"


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The clinic nurse is assessing Art, a 56-year-old farmer, whose wife died 6 months ago from ovarian cancer. He describes himself as "lost, forgetful, and unable to concentrate." He states, "I seem to cry at the most inconvenient moments, so I just stay to myself." The nurse notes his expression is sad and he avoids eye contact. Art says he has no appetite and "doesn't care anymore." When asked about his farming operation, he states he has lost interest in doing anything and has turned the farm over to his son.

Digging Deeper

1. *What feelings might be responsible for Art's symptoms?*
2. *How should the nurse respond to Art?*
3. *What stage of the grief process is Art likely experiencing?*
4. *What referrals may be appropriate for Art?*

Cultural Considerations

Names of Cultural Healers

Many people seek care from traditional healers for their primary health care. The healer may provide mental, physical, and/or spiritual care. When collecting client data, ask the client who they first go to for care. Do not refer to their healer as a "witch doctor" as this most often has a negative connotation.

Here are a few names for healers from different cultures:

- Curandero/curandera (Hispanic, Latin America)
- Sangoma (Zulu)
- Medicine man (Native American)
- Shaman (North Asian, Native American, Aboriginal Australian)

When a client reports seeing a traditional or complementary healer, ask about the frequency of visits and treatments received including herbal therapies. Document this information, using the client's own words and terms, and report the information to the health care provider or the Registered Nurse (RN).

Sources: van der Watt, A. S. J., van de Water, T., Nortje, G., Oladeji, B. D., Seedat S., Gureje, O., & Partnership for Mental Health Development in Sub-Saharan Africa (PAMD) Research Team. (2018, April 25). The perceived effectiveness of traditional and faith healing in the treatment of mental illness: a systematic review of qualitative studies. *Social Psychiatry and Psychiatric Epidemiology, 53*, 555–566. https://doi.org/10.1007/s00127-018-1519-9; World Health Organization. (2013). WHO Traditional medicine strategy: 2014–2023. https://www.who.int/publications/i/item/9789241506096

SUMMARY

- Mental health is seen as a state of well-being in which the individual has an awareness of their own abilities and weaknesses, copes with normal stressors of life, works productively, and makes a meaningful contribution to society.
- Mental illness denotes clinically significant behavioral or psychological patterns that occur in an individual causing distress or disability in the person's life. Disorders manifest as inappropriate behavioral patterns that result from the distortions and discomfort experienced in the mind of the individual. Thinking errors and misconceptions often lead to irrational and unrealistic processing.
- Mental health is achieved as the individual forges a balance between the ups and downs of everyday life. Factors that require them to adapt both physically

and emotionally and may affect mental health include stress, anxiety, grief, loss, religion, family, sleep, substance use, trauma, and abuse.

- Stress and anxiety are considered a part of everyday living. Mild stress is motivating and propels individuals to function at optimum levels toward accomplishment and success.
- Acute stress is triggered by an overwhelming sense of danger or threat over which one feels a lack of control. Chronic stress relates to a situation that is experienced on a continuous basis.
- Stress triggers an autonomic nervous system response that results in an unconscious feeling over which the conscious mind has no control. Both internal and external stressors can cause various responses. How an individual perceives a situation directly affects the sense of control felt over the stressor. An individual's response may be either adaptive or maladaptive based on this perception.
- Anxiety in response to stress can range from mild to panic. Coping strategies are learned behaviors. Successful resolution of previous stressful situations will lead to more effective coping methods. Ineffective coping and emotional strategies lead to ineffective and unsuccessful interpersonal relationships.
- If a stressful situation is unresolved, a state of crisis or emotional disorganization can result. The ability to function is impaired and intervention by a support system is required to reestablish homeostasis and control.
- Grief is a response to the anticipation of or the result of a loss. It is the process of mourning for, and coming to terms with, the reality of the loss and putting it into perspective as the individual moves forward. Reaction to loss changes with growth and maturation of individual's cognitive ability.
- Elizabeth Kubler-Ross defined five stages of grief: denial, anger, bargaining, depression, and acceptance. Once the loss is accepted, a new period of growth beyond the object or person can emerge.
- Dysfunctional grief results from a failure to complete the grieving process in which the person experiences a prolonged and intensified sense of loss. Multiple factors may contribute to this unresolved grief.
- Interventions that assist individuals with the grieving process should encourage openness and honesty about their feelings, as well as expressions of hope for the future and reinvestment in life interests.

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STUDENT WORKSHEET

Fill in the Blank

Fill in the blank with the correct answer.

1. Mental health is achieved as individuals forge a _____ between the ups and downs of everyday life.
2. Acute stress is a response to an immediate threat, commonly called the_____ or _____ response in which there is a surge of adrenalin into the blood.
3. When feelings of anxiety become too _____, those feelings may then be expressed through _____.
4. A major factor in whether a stressor becomes a strain on an individual is the _____ of situations over which little or no control is possible.
5. Statements made to the person who is grieving that are seemingly appropriate but tend to be empty and show little support are termed _____.

Matching

Match the following terms to the most appropriate phrase.

1. _____ Anxiety
2. _____ Eustress
3. _____ Adaptation
4. _____ Denial
5. _____ Bargaining
6. _____ Cultural identity
7. _____ Reframing
8. _____ Burnout
9. _____ Distress

a. Positive restructuring of thinking about a stressful event
b. Binding force between members of a cultural group
c. Feeling of apprehension, uneasiness, or uncertainty in response to a perceived threat
d. Adjustment period in which the reality of a loss is avoided
e. Positive and motivating stress
f. Condition of mental and emotional exhaustion
g. Harmful response to a threat or challenge
h. Manner in which individuals manage their anxiety
i. Labile moods and attempts to make deals to postpone a loss

Multiple Choice

Select the best answer from the available choices.

1. Which of the following statements made by a client might indicate a possible problem with the individual's present state of mental health? *(Select all that apply)*
   a. "I am involved in many community activities."
   b. "My children don't care about me anymore."
   c. "I enjoy the solitude of living by myself."
   d. "I try not to let the little things upset me."
   e. "I used to enjoy doing things with my friends."

2. A client diagnosed with a mental illness would demonstrate which of the following?
   a. Rational and realistic thought processing
   b. Ability to function alone or with others
   c. Disrupted interpersonal relationships
   d. Motivation by inner values and strengths

3. An LPN/LVN has worked in the dementia unit of a long-term care facility for the past 8 years. Recently, they have been calling in with various physical complaints and saying "I just don't care about the clients like I used to." It is most likely that the nurse is experiencing:
   a. Distress
   b. Crisis
   c. Burnout
   d. Stress

4. Which of the following statements reframes the irrational thought, "I will always be a failure," into a rational thought process?
   a. "I may fail at some things, but I am not always a failure."
   b. "I don't have to fail at anything."
   c. "I am my own worst enemy."
   d. "I usually fail because most things are just too difficult for me."

5. Your client owns a small business that has recently been experiencing reduced sales and profits. They have obtained a bank loan which will be due for repayment in 6 months. Which of the following describes the client's solution?
   a. Adaptive coping strategy
   b. Palliative coping strategy
   c. Maladaptive coping strategy
   d. Dysfunctional coping strategy

6. A client is scheduled for a radical mastectomy and states to the nurse, "It would be easier if I just didn't wake up from the surgery." Which of the following would be an appropriate response for the nurse to make? *(Select all that apply)*
   - **a.** "You are just afraid now. Everything will look different tomorrow."
   - **b.** "You feel it would be easier to die than to face the loss of your breast?"
   - **c.** "Some people feel the way you do, but this does not mean the end of your life."
   - **d.** "You seem very anxious about your surgery. Tell me more about your feelings."
   - **e.** "Why do you think it would be easier to die than to wake up after surgery?"

7. Your client has been in a comatose state for the past 8 months as a result of an automobile accident. Although doctors have told the family the client does not have brain function, the family insists that the client has purposeful responses. Which stage of grief is the family demonstrating?
   - **a.** Bargaining
   - **b.** Anger
   - **c.** Denial
   - **d.** Depression

8. The nurse is caring for a client who has been told the radiation treatment of their cancer is not working. The client has been placed on hospice care with palliative relief of pain. Which of the following will this client likely soon experience?
   - **a.** Unresolved grief
   - **b.** Conventional grief
   - **c.** Dysfunctional grief
   - **d.** Anticipatory grief

9. The nurse is caring for a client whose wallet was stolen. The client is experiencing palpitations, hyperventilation, diaphoresis, and confusion. Although alert and talking, the client is unable to provide their name and address. How would the nurse document the client's response?
   - **a.** Mild anxiety
   - **b.** Moderate anxiety
   - **c.** Severe anxiety
   - **d.** Panic level