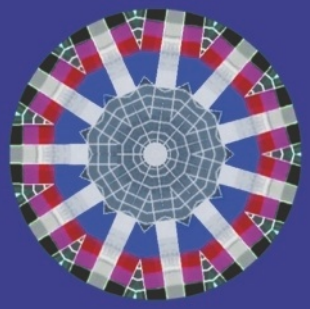
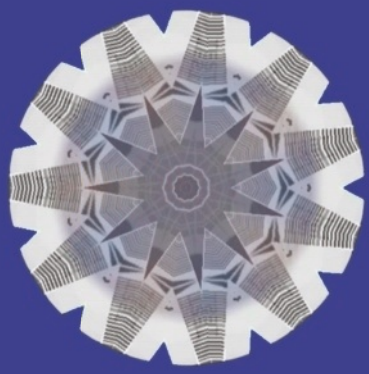
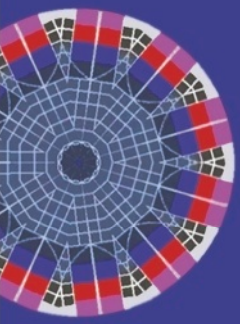
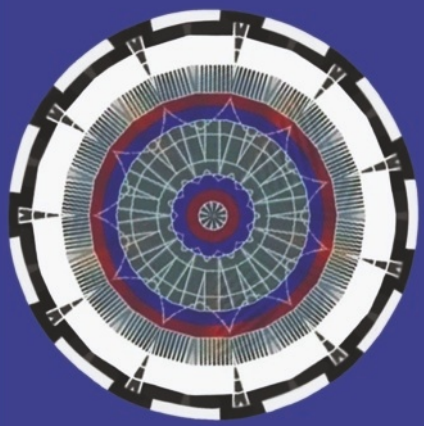


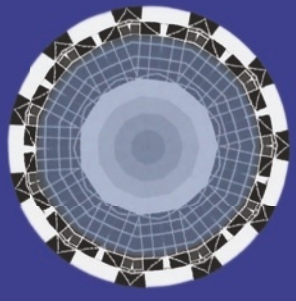


Contemporary Psychiatric-Mental Health Nursing

PARTNERSHIPS IN CARE







MOXHAM
HAZELTON
MUIR-COCHRANE
HEFFERNAN
KNEISL
TRIGOBOFF

DETAILED CONTENTS

PREFACE

Millions of people around the world face the challenges that living with a mental health issue can bring. In fact, the World Health Organization (WHO) suggests that half of the leading causes of disability in the world today are related to mental health. This is unlikely to change while global mental health resources remain low, and the necessary improvements in early detection and intervention are not addressed by governments locally and nationally.

Adding to the challenges that living with mental health issues brings is the ongoing issue of stigma. The stigma of mental illness is based on a misguided societal perception that mental illness is a blemish of individual character, and is a worldwide problem experienced in all segments of society. Stigma hurts, punishes and diminishes people. Unfortunately, stigma continues to grow around the globe, and is perhaps the main obstacle to better mental health care and quality of life for consumers and their families.

Our goal for this textbook, *Contemporary Psychiatric–Mental Health Nursing: Partnerships in Care*, is to provide the user with a contemporary, evidence-based, culturally competent, authoritative and comprehensive resource. Importantly and most notably, the textbook was co-authored by people with a lived experience of mental illness. Indeed, we set out quite purposefully to ensure a consumer voice was prominent in each chapter of the text. Thus the co-produced resource is designed to enhance your ability to become a therapeutic, non-judgmental, competent and confident psychiatric–mental health nurse. We encourage you to think seriously about what constitutes mental health and mental illness. We would urge you to appreciate the humanity of people who experience mental illness, and to undertake your nursing practice with unconditional positive regard. We think it likely that this will challenge your assumptions about mental illness and those who live their lives with it; we hope it does!

UNDERLYING THEMES

Throughout this book, we value cultural competence in increasingly diverse societies, collaborative-centered care, the relevance of lived experience to shaping recovery and treatment choices, and the need to improve quality and access to mental health care. We believe that mental health nursing must concern itself with the quality of human life, and its relationship to optimal psychobiological health, feelings of self-worth, personal integrity, self-fulfilment, and collaborative care. Thus, we emphasise the importance of empathy and empowerment in the therapeutic relationship.

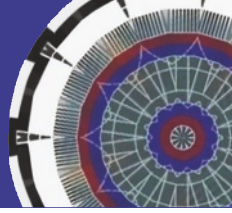
Understanding people who are searching for personal recovery through interaction in complex times demands the most authoritative and contemporary knowledge and clinical competence. It is through the power of knowledge and clinical competence that psychiatric–mental health nurses work with people as they progress through the journey of personal recovery. Psychiatric–mental health nursing is concerned with sustaining and enhancing the mental health of both the individual and the group, while its practice locale is often found in the community.

In acknowledging the importance and value of lived experience, each chapter offers the voice of the person who lives with a mental health issue. These voices, which are often silent, are vital in knowledge production, and know best how they need to recover. As such, the themes, ideas, knowledge, tools and organisation of this textbook are designed for nursing students who are committed to making a difference in view of contemporary trends. Specifically, this text expects students to recognise the value of lived experience.

Nursing is both a science and an art, and because of advances in neuroscience and the enhancements in the study of the human genome, a solid grounding in psychobiology is threaded throughout the book. Brain imaging and concise yet comprehensive information on the expanding array of psychopharmacological treatment is yet another strong emphasis. *Contemporary Psychiatric–Mental Health Nursing: Partnerships in Care* is explicitly linked to contemporary practices in our field.

ORGANISATION

The book engages with the people you will encounter in your practice and with whom you will work collaboratively. It describes what it means to be a mental health nurse, the professional



and personal attributes that enable artful therapeutic practice, and the importance of basing the therapeutic relationship on theoretical understandings, appropriate clinical techniques and the needs and wants of the person who lives with a mental illness.

This text also provides comprehensive coverage of interdisciplinary mental health theories, the biological basis of mental illness, the science of psychopharmacology, the methods by which people attempt to handle stress, and the importance of developing cultural competence. Topics traditionally associated with mental health nursing, such as therapeutic communication, assessment, ethics, advocacy, rights, legal and forensic issues, and therapeutic environments for care are also discussed. Caring for people with a specific DSM mental diagnosis is described by outlining the defining characteristics of each diagnosis, the biopsychosocial theories necessary to understand them, and, importantly, how to apply the nursing process to work with people who live with these illnesses. The authors have also turned their attention to vulnerable populations that require comfort and care from psychiatric–mental health nurses. These populations include people at risk for self-harming behaviour, sexual abuse and family violence, and specific age groups. The textbook provides authoritative coverage of nursing intervention strategies and desired outcomes, including a wide range of modalities from therapeutic groups to family-focused strategies, crisis intervention, and cognitive behavioral interventions; to psychopharmacology, recovery and psychiatric rehabilitation, and complementary, alternative and integrative healing practices; and anger management and violence in psychiatric settings.

AUSTRALIAN EDITION

As lead and chapter authors who have all practised, taught and researched as psychiatric–mental health nurses in the Australian context, we felt it important that Australian nursing students were offered an opportunity to be exposed to contemporary Australian mental health nursing knowledge. Most importantly, though, we felt it important for future health professionals to hear from people with a lived experience. Not only do we believe this is absolutely the right thing to do, it is also the major point of difference about this textbook.

THE TEXTBOOK AS A MAP, A COMPASS AND AN INSPIRATION

Psychiatric–mental health nursing is poised at a crossroads, and every nurse can make a difference. We are challenged to bring complex thinking to a complex world if we are to reduce stigma and actualise our contribution to global mental health—the vision to which this text is dedicated. This book has been crafted to provide you with the best possible evidence generated in research to help you achieve your goal of excellence in practice. It offers a fully integrated perspective, which most importantly includes the voice of people with mental illness. It encourages you to become personally and professionally willing to muster the courage and hope necessary to forge proactive steps in our future, and to make a commitment to work globally in a contemporary landscape and mindscape.

We have the opportunity to forge a new synthesis of professional wisdom in the face of tough mind–body–spirit problems and needs, and the stigmatisation of mental illness. We need to face critical transitions with intelligence, stamina, wit, creativity, skill and moral courage. Global mental health can become a shared, emergent vision constructed in a way that is respectful of the rich diversity of the citizens of our contemporary world. We have created this book to provide you with a map, a compass and an inspiration to succeed in your current work. We hope that it encourages you to become a participant and leader in facing the broader challenges ahead of us.

A GUIDE TO *CONTEMPORARY PSYCHIATRIC–MENTAL HEALTH NURSING*

KEY TERMS alert you to the vocabulary used in the chapter. The page numbers indicate where the term is defined.

LEARNING OUTCOMES indicate what important information or skills you will have gained after studying the chapter.

LIVED EXPERIENCE reflects the 'lived-experience' voice of the consumer, which discusses mental health issues that health consumers have encountered.

6

The biological basis of behavioural and mental disorders

MERRILEE HARRIS, SIMON SWINSON AND MIKE HAZELTON

KEY TERMS

amygdala *97*
anxiety *108*
brain stem *99*
cerebellum *99*
cerebrum *92*
dopamine *101*
genetic variation *105*
hippocampus *97*
hypothalamus *98*
limbic system *96*
neurons *100*
neuroplasticity *104*
neurotransmitter (NT) *91*
noradrenalin (NE) *101*
serotonin *103*
schizophrenia *105*

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Understand the basic structures of the brain that are believed to affect thought, behaviour, memory and emotions.
2. Describe the structure and function of a neuron, and the role of neurotransmitters and neuromodulators in neuronal communication.
3. Understand the concept of neuroplasticity and its role in the development of, and recovery from, mental illness.
4. Identify ways in which the endocrine and immune systems are thought to affect a person's neuronal development and mental health.
5. Describe ways in which genetic variation and epigenetic changes might contribute to the development of mental illness.
6. Partner with people living with mental illness and their families to teach the biological implications of psychiatric illnesses.
7. Analyse how your own personal feelings, opinions or beliefs about psychobiology can enhance or diminish your ability to take part in a support person and advocate for people living with mental illness and their families.

LIVED EXPERIENCE

In the early stages of my journey with schizophrenia, science was one source of information about what I was experiencing; I did this through reading and attending conferences on mental illness (to the surprise and alarm of my doctor!). My interest in the scientific explanations of mental illness waned for a time, as I was unable to make headway in understanding an increasingly complex field. I was fortunate that my sister-in-law is a senior health professional, and through her I have been able to keep up with developments in how schizophrenia is understood and treated. At times science has also played an important role in helping me maintain hope. Being able to discuss treatment options in an open, informed and trusting way with my doctor has been very important; nowadays I have a much better understanding of the medications I take and this has influenced my decision to keep taking them.

DEVELOPING CULTURAL COMPETENCE boxes are an important link to the cultural forces that influence the experience and expression of mental disorders and pose critical thinking questions.

DEVELOPING CULTURAL COMPETENCE

Culture and dementia

Developing cultural competence when working with people who have dementia and their families is important. Cultural factors influence perceptions about what is normal ageing. Look for cultural bias (language, expected response, speed, etc.) in cognitive screening tools, and discuss these biases with colleagues.

Nurses promote effective health practices in the community setting; for example, taking blood pressure, discussing healthy diet, and noticing early symptoms of dementia. Education and outreach to diverse populations can provide support for people with dementia and their families.

CRITICAL THINKING QUESTIONS

1. What are some possible explanations for why different cultures have different attitudes about ageing?
2. Which cultures do you think treat older people with the most respect? Why?

EVIDENCE-BASED PRACTICE boxes show how research evidence shapes the plan of care for a particular client. Critical thinking questions follow each vignette.

EVIDENCE-BASED PRACTICE

Life roles and anorexia nervosa

Suzy, age 45 years, is extremely thin and jogs for several hours every day to maintain her (under) weight. She is 174 centimetres tall, and weighs 55 kilograms. You work with her in an outpatient clinic where she is receiving counselling for marital problems.

Suzy has maintained the same weight since she was 17 years old. Her eating habits have always been tied to her weight. Since she was a teenager, Suzy has added extra distance to her running route, decreased her calorie count, or fasted whenever she was 500 grams over what she considered her ideal weight. The literature reports that adolescence is the peak time for developing eating disorders. Recovery studies will be most helpful to you in understanding and working with Suzy.

As indicated in the following research, many people, through therapy and close relationships, find non-bodily means to express their distress. Events such as committing to a relationship, forming a family, and settling into an identity and occupation all serve to provide a stable platform for overall functioning. Women's drive to be thin tends to decline as they age (conversely, men's drive to be thin tends to increase as they age), but Suzy does not follow that trend. You explore her life roles and what gives her a sense of positive identity (is she a wife, a mother, a daughter, a business executive, a socialite, a student, an athlete, etc.?). Identify the ways in which she expresses a range of negative emotions to determine whether your work with her needs to focus on problematic expression of feelings that may contribute to perpetuating her eating disorder.

You should base action on more than one study, but the following research would be helpful in this situation:

Jenkins, J., & Ogden, J. (2012). Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review, 20*(1), e23–e31.

CRITICAL THINKING QUESTIONS

1. If Suzy has been maintaining an underweight condition since the age of 17, what are her chances for improvement?
2. What conditions would be necessary for improvement to take place?

WHAT EVERY NURSE SHOULD KNOW

boxes emphasise the importance of recognising mental health problems and applying these practices in all nursing situations.

WHAT EVERY NURSE SHOULD KNOW

Suicidal ideation in primary care

Imagine you are a nurse working in a primary care setting, such as a general practice surgery. It is not unusual in primary care settings to see people with suicidal ideation or at high risk for suicide. It is also not unusual for primary care providers to fail to recognise those at high risk for suicide. Suicide risk is increased in both physical and mental illness, especially when both are present. It is important to remember that there is also a strong association between depression, risk for suicide and chronic medical illness. The possibility of suicide risk should be considered in all people with chronic illness, including those with solely physical symptoms.

Although there are more effective medications available to primary care practitioners to treat depression, suicide rates have remained unacceptably high and may be under-reported if unexplained deaths are considered. In instances where uncertainty surrounds a person's death, a psychological autopsy may be performed. A **psychological autopsy** is an assessment tool that reviews the circumstances and events that preceded an individual's completed suicide. Reviews of psychological autopsies and other similar methods have revealed that a high percentage of suicide victims have a comorbid mental disorder (such as mood disorders and/or substance use disorders) and, furthermore, that they were under-treated, despite contact with mental health or other health care services. Recognising this association, screening for it, and providing treatment is a primary care imperative and may prevent unnecessary tragedies.

COLLARBORATIVE CARE

boxes emphasise the value of including the family in psychiatric–mental health care. This feature provides key topics to discuss with families, allowing them to understand the characteristics of the disorder.

COLLABORATIVE CARE

Teaching about a low-tyramine diet

MAOIs combined with certain foods and medications may produce a significant increase in blood pressure, which can be a health hazard. In general, foods that cause this reaction are those that have been ***pickled, fermented, smoked or aged***. The list below includes the main foods, fluids and medications that should be avoided while taking a MAOI and for at least two weeks after discontinuation of a MAOI. It should be noted that preservatives in foodstuffs and beverages can change over time, and thus dietary restrictions should be updated regularly.

Foods and beverages to avoid completely

Meats and fish: Pickled herring, dried fish, aged/dried/cured meats, unrefrigerated fermented fish, liver, caviar, fermented sausage (salami, pepperoni), fermented oyster sauces used in Asian dishes, jerky, meat extracts, miso, soy sauce, teriyaki sauce.
Vegetables: English broad beans, Chinese pea pods, fava beans, banana peels, Italian or broad green beans, fermented cabbage, lentils, lima beans, sauerkraut, overly ripe fruits, peanuts, spinach.
Dairy products: Yoghurt, many types of cheese (e.g. English Stilton, mozzarella, Parmesan).
Beverages: Chianti, aged wines, imported beers, aged beers.
Combination foods: Breads made with aged cheeses, and meats, or yeast extracts; homemade or high-yeast breads; pizza; lasagna; macaroni and cheese; quiche; liver pâté; Caesar salad; all yeast products (e.g. brewer's yeast, yeast extracts such as Vegemite and Marmite).
MSG: MSG is frequently used in Asian dishes as a meat tenderiser and flavour enhancer; many prepared and processed foods also use MSG (e.g. canned soups, packaged noodle meals, frozen prepared meals, salad dressings).
Medications: Cough and cold medications, nasal decongestants (tablets, drops, sprays), hayfever and allergy medications, weight-reduction preparations, anti-appetite medications, asthma inhalants.

Foods and beverages that can be taken in small amounts

Dairy products: Most processed cheeses bought in a supermarket.
Fruits: Raisins, prunes, bananas, avocados, plums, canned figs.
Caffeine sources: Coffee, chocolate, colas.
Beverages: Domestic red wines; domestic beers, ales, stouts; sherry. (Note: alcohol is a CNS-depressant, and so should be avoided by individuals in treatment for depression.)

Allowed foods

Beverages: White wines. (Note: alcohol is a CNS-depressant, and so should be avoided by individuals in treatment for depression.)
Baked goods: Raised with yeast, but not high in yeast.
Dairy products: Cottage cheese, cream cheese, milk, cream, ice cream.

Additional information

St John's wort: This naturally occurring MAOI, less potent than pharmaceutical grade; is not regulated and may cause inconsistent access to the active ingredient. It has the same dietary and medication restrictions as pharmaceutical-grade MAOIs.

PRACTICE EXAMPLE

features provide real-life scenarios that students may encounter, and point out the challenges involved.

Practice example

A young man who was hospitalised at a mental health assessment unit complained to other consumers and staff members that he had been 'odenated', and he became increasingly frustrated and anxious when it became apparent that he wasn't being understood. Rather than simply writing him off as confused, his primary nurse recognised that 'odenated' most likely had a private meaning. With some help, he was able to explain that he was upset about having been moved to a different room. The room was, he said, so dark and dingy that it looked like a cave. Animals live in caves that are called 'dens'. In his view he had been o-den-ated—put into a cave.

MENTAL HEALTH IN THE MEDIA

features depict how mental illness in the media affects our attitudes and behaviour. They also highlight the successes and difficulties faced by those in the media.

MENTAL HEALTH IN THE MEDIA

Michael Clayton

Michael Clayton is a movie about an attorney, Michael Clayton (played by George Clooney), who fixes problems in law firms caused by the idiosyncratic behaviours of various attorneys. Crimes, sexual misconduct and ethics issues, along with behaviours related to mental disorders, are his usual assignments. One of the attorneys he is asked to extract from an embarrassing situation is a brilliant man who happens to have bipolar disorder. Arthur Edens (played by Tom Wilkinson) has had a bizarre outburst in the middle of a deposition in a class action lawsuit against a conglomerate. Michael arrives to fix the situation for his good friend and colleague. He convinces the authorities to let Arthur out of jail, and brings him back to their hotel where he is successfully sedated. However, Arthur escapes from the hotel in the middle of the night.

The lawyers for the conglomerate obtain Arthur's briefcase and discover that Arthur has documentation detailing the conglomerate's decision to manufacture a chemical they know to be carcinogenic. Public knowledge of this decision would severely disrupt the finances of the conglomerate. In addition, the lawyers know about Arthur's bipolar disorder, his failure to take his medications and his outbursts. They follow Arthur, tap his phone and bug his apartment. The conglomerate's lawyers have Arthur assassinated in a manner designed to resemble suicide, a common occurrence with people who are bipolar and unmedicated.

Michael, saddened by the death of his friend and colleague, is suspicious about the circumstances. He cannot reconcile his friend's beliefs and energies with suicidal intent. Because he searches for and finds Arthur's evidence and plans to publicise it, he is also targeted for assassination. However, the attempt is botched. The movie resolves with Michael recording the admission of murder and attempted murder.

Photo courtesy of CAP/FB Supplied by Capital Pictures/Newscom.

HOW I WILL USE MY MENTAL HEALTH SKILLS IN PRACTICE *AND* WHY I CHOSE TO WORK IN MENTAL HEALTH present the personal stories of those who work in mental health nursing.

HOW I WILL USE MY MENTAL-HEALTH SKILLS IN PRACTICE

Madison's story

I was 17 years old when I began working as a nurse's aide in a small long-term care facility. I was just starting university to become a nurse, and wanted experience working in the field. There were not very many people being cared for in the facility, because it was a private enterprise with the goal of making it as homelike as possible. I became close to all of the residents while learning to take care of them.

One woman, Louise, was extra special. She was only 50 years old, but had such debilitating and deforming arthritis that she could not care for herself and was no longer able to work as a psychiatric–mental health nurse. She was bright and personable, and I admired her strength of character in dealing with a chronic illness. Louise's roommate, Ida, was a bitter and negative woman, who rarely said anything neutral about her world or the people in it. A positive statement from Ida was unheard of. Ida's granddaughter came in to visit her, and she was so excited to show off her boyfriend's gift—a pretty pearl ring in a gold band. Ida's only comment was: 'Pearls mean sorrow.' Ida's granddaughter was devastated and left in tears. Ida's response to her roommate was: 'See? Pearls do mean sorrow.' Louise then reassured Ida that, even though her granddaughter was becoming close to her boyfriend, no one could take Ida's place. Ida, Louise told her, would always be Grandmother, and nothing could change that.

When I asked Louise later, in private, what was the connection between Ida being mean-spirited and Louise reassuring Ida, Louise's reply opened my eyes to the value of psychological sophistication. Louise said, 'When people feel threatened about being hurt by someone, they will put the energy into hurting that person first. Ida wasn't being mean, she was being hurt.' Being able to help someone cope with feelings, with what I now know are psychiatric–mental health nursing interactions, helped me choose the area for my nursing career.

WHY I CHOSE TO WORK IN MENTAL HEALTH

Kim Ryan

I first began my nursing career as a general registered nurse, and then under took psychiatric nurse training. Back then it wasn't uncommon for nurses to hold double or triple certificates—in general, midwifery and psychiatry.

During my general nurse training, I didn't really learn about mental health—as a result, when I first started psychiatric nursing I had little understanding of mental illness or the way in which people exhibited mental illness. What I discovered was that it's not that easy to divide a person into 'the mind' or 'the body'—so much that happens in the mind affects the body and vice versa.

Deinstitutionalisation had also just started: the big psychiatric hospitals were being opened up, and people who had lived in institutions, in some cases for many years, were being transferred back into the community. I quickly realised that most of society didn't understand mental illness. I was humbled by the very difficult lives that many of the people I encountered had experienced. They were misunderstood, they were stigmatised, they were removed from their family, and the medications they were taking could have debilitating side-effects. However, they were (and still are) some of the most resilient people I have ever had the privilege to meet. I guess that is why I stayed in mental health, rather than moving on to another nursing specialty.

Mental health nursing is a wonderful career, you meet some great characters, you laugh and you cry, but, best of all, you can make a difference to people's lives.

Are there any aspects of Kim' story that you relate to? What is important to you about the work that you do? When you are at the other end of your nursing career and you look back, what would you like to have achieved, what would you like to have stood for?

SELF-AWARENESS boxes engage the reader in a process of introspection and self-questioning that is essential to the therapeutic use of self.

SELF-AWARENESS
Reflecting on feedback from consumers and carers

Input—both positive and negative—from consumers, carers, classmates, tutors, staff, family and friends can help you to become aware of your 'blind spots', the characteristics about yourself that you ignore, deny or defend. Protecting oneself through self-deception interferes with both relating and communicating. To become more self-aware, do the following:

- think about a recent interaction with a consumer and how they responded to you
- identify the positive/negative elements in the interaction
- try to determine what the consumer was telling you about yourself in this interaction (i.e. What characteristic(s) do you have that enables people to openly express their thoughts and feelings? What characteristic(s) do you have that prevents people from openly expressing their thoughts and feelings?)
- discuss the interaction and your interpretation of it with a supervisor
- ask for feedback on your behaviour from others—family members, classmates, staff, friends.

DIAGNOSTIC FEATURES provide diagnostic criteria for mental health disorders, followed by descriptive text.

DIAGNOSTIC FEATURES
Cognitive disorders

Delirium: Delirium is a disturbance of consciousness with a reduced ability to focus, sustain or shift attention. There is a change in cognition, and the disturbance develops over hours to days, and tends to fluctuate during the day. Medical conditions can also contribute to these difficulties.

Dementia of the Alzheimer's type (DAT): DAT involves multiple cognitive deficits, with memory impairment and aphasia, apraxia, agnosia and/or a disturbance in organising. This causes impairment and decreased functioning in important areas. It starts gradually and is progressive, and problems are not due to other sources.

COMMUNICATION boxes offer sample dialogues between nurses and clients. In addition, they provide the rationale for at least two different but helpful alternatives. This feature is designed to provide students with a beginning repertoire of useful communication interventions when interacting with mental health clients.

COMMUNICATION

A person with clang associations

PERSON: 'The dining room lining trying to eat forever.'

NURSE RESPONSE 1: 'Jack, are you having a problem getting your food?' *RATIONALE:* A direct question allows the person experiencing clang associations to answer with a 'yes' or 'no' response, models how the communication can be stated, and labels the situation as a problem.	**NURSE RESPONSE 2:** 'Come with me and let's get you set up.' *RATIONALE:* This response reinforces the appropriateness of the person coming to the nurse with a problem and concretely shows the person how to resolve the problem.

NURSING CARE PLANS are included in the chapters dealing with specific disorders. They represent a different way to view care for clients diagnosed with specific mental disorders according to the DSM-5.

NURSING CARE PLAN: AN ADULT SURVIVOR OF CHILDHOOD SEXUAL ABUSE

Identifying information

Jill is 35 years old and, with her husband John, co-owns and operates a local newsagent business. The couple have been married for 15 years, and have three children aged 14, 12 and 7.

Jill was sexually abused by her grandfather from a very young age until she was about 11 or 12. She states that she told her mother about the abuse when she was 9 or 10, but that her mother just ignored it. Her mother now denies that Jill told her about the abuse when it was occurring. Jill has tried to ignore her abuse history, until several months ago when she saw a television program about incest. She has periods when she is filled with rage at her parents and grandfather.

History

No prior psychiatric history.

Jill is the third child of five in an intact family. She describes her mother as 'strict . . . she would threaten by saying "wait until your dad comes home".' When asked about her father, Jill states, 'He wasn't around . . . he was working . . . he was always distant.' She describes the family communication as 'dysfunctional; only certain people talked to certain other people. For example, none of us kids could talk directly to Dad. We always had to go through Mum.'

Jill describes herself as a 'homebody'; she works in the newsagency several days a week while the children are at school, and says 'the shop is my chance to get out of the house each week.' In the past, she went out with her husband regularly, but says she never really enjoyed doing so. Since having children, Jill's life has increasingly involved parenting, home duties and the newsagency. She states that she has never had close friends and her only friend is her husband, but she also feels intimidated by him. She has a very close relationship with her children.

Jill has no current or past medical problems. She states that she is in good health except for feeling 'down a lot of the time'.

Current mental status

Jill is oriented to person, place and time. Her affect appears dysphoric, irritable and constricted in range. At times she is filled with rage, saying, 'I am mad . . . Mad at the world in general, and at having to deal with all of this.' She states that during her entire life she has spent much of her energy in 'not thinking', 'not imagining' and 'not remembering' the abuse. She has attempted to keep a sense of distance from her inner emotional life. After viewing the television program on incest, she now experiences 'painful, bitter, brooding thoughts about the abuse'. Jill is an anxious and angry woman with extremely low self-esteem and intense feelings of inadequacy. She views herself as unable to function in an autonomous, self-directed and self-reliant fashion, and sees the world as untrustworthy, betraying and often cruel.

Unable to rely on her own resources or depend on the support of others, Jill feels a sense of bitter futility and resignation.

YOUR INTERVENTION STRATEGIES

Reducing and modifying the occurrence of burnout

- Address staff–consumer ratios. Giving more attention to each person enables time to focus on the positive, non-problematic aspects of the person's life.
- Recognise that no one is perfect. The people to whom you provide care deserve the best you can provide; it may not always be perfect care, and it isn't 24-hours-a-day, 7-days-a-week care.
- Take sanctioned breaks rather than guilt-provoking escapes from the work situation.
- Talk over your problems to get advice and support when you need it. Clinical supervision is important for mental health nurses.
- Express, analyse and share your feelings about burning out. This lets you get things off your chest, and gives you the chance to get constructive feedback from others and perhaps a new perspective as well.
- Understand your own motivations in pursuing a mental health nursing career, and recognise your own expectations for working with consumers. Deal with the issues of the people you are caring for, not your own.
- Listen to and then attend to your own internal stress signals.
- Pursue happiness and satisfaction in your personal life, through things you enjoy and being around positive people.
- Work with a peer support worker to get a different recovery perspective.

YOUR ASSESSMENT APPROACH *AND* YOUR INTERVENTION STRATEGIES present clinically-relevant strategies in a succinct, user-friendly format. Your Assessment Approach contains lists of assessment points. Your Intervention Strategies list specific nursing intervention strategies along with their rationales.

YOUR ASSESSMENT APPROACH **Signs of a working relationship**

The following criteria may be useful in determining whether a one-to-one relationship is moving into the working, or middle, phase.

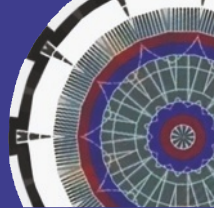
For nurse

- Sense of making contact with the person
- Sense that the person is responding well to the relationship
- Sense that the nurse can facilitate growth in the person regardless of the severity of dysfunction
- Sense of commitment to addressing the person's problems

For consumer

- Non-verbal and verbal evidence of liking the nurse
- Sense of relaxation with the nurse
- Sense of confidence in the nurse
- Non-superficial (in nature and depth) problems addressed

EDUCATOR RESOURCES



A suite of resources is provided to assist with delivery of the text, as well as to support teaching and learning.

SOLUTIONS MANUAL

The Solutions Manual provides educators with detailed, accuracy-verified solutions to all of the in-chapter and end-of-chapter problems in the book.

TEST BANK

The Test Bank provides a wealth of accuracy-verified testing material. Updated for the new edition, each chapter offers a wide variety of true/false, short answer and multiple-choice questions, arranged by learning objective and tagged by NMBA standards.
Questions can be integrated into Blackboard or Moodle.

POWERPOINT LECTURE SLIDES

A comprehensive set of PowerPoint slides can be used by educators for class presentations or by students for lecture preview or review. They include key figures and tables, as well as a summary of key concepts and examples from the text.